STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285260	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chimney Rock Villa	106 East 13th Street Bayard, NE 69334

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 49766 Licensure Reference 175 NAC 12-006.10D Based on observation, interviews, and record review, the facility failed to ensure residents are free of a signification medication error for 1 (Resident 4) or 3 sampled residents. The facility census was 29. Findings are: A record review of Resident 4's Admission Record indicated the facility admitted Resident 4 on 9/27/2021 with a diagnosis of seizures. A record review of Resident 4's Order Summary revealed the following orders: - Keppra - Give 1,000 mg by mouth once in the morning. - Keppra - Give 1,500 mg by mouth once in the evening. - Keppra blood level to be drawn every 12 months. An observation on 5/9/2024 at 7:22 AM revealed Medication Aide (MA)-B had begun to prepare Resident 4's medication. MA-B did not have the Electronic Medication Administration Record pulled up on the computer screen to perform the three checks of the five rights of medication administration. MA-B prepared Resident 4's Keppra (a medication for seizures) 500 milligrams (mg) tablet and Keppra 1,000 mg tablet for administration. Once prepared, MA-B administered Resident 4 a total of 1,500 mg of Keppra. An interview on 5/9/2024 at 8:00 AM with MA-B confirmed the dose of Resident 4's Keppra was ordered as 1, 000 milligrams (mg) in the morning. MA-B confirmed MA-B had administered Resident 4 a total of 1,500 mg of Keppra in error. An interview on 5/9/2024 at 8:27 AM with the Administrator confirmed the orders for Resident 4 were Keppra 1,000 mg in the morning and Keppra 1,500 mg in the evening. The administrator confirmed that MA-B had made a medication error by administering Keppra 1,500 mg that morning. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of National Institute of Health's document Nursing Rights of Administration indicated a standard of nursing medication administration to uphold patient safety include the five rights of medication: right patient, right drug, right route, right dose, and right time.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 49766 Licensure Reference 175 NAC 12-006.04B2c. Based on an interview and record reviews, the facility failed to employ a Dietician full-time or have a certified Food Service Director. This had the potential to affect 29 residents who ate from the kitchen. The facility census was 29. Findings are: An interview on 5/8/2024 at 2:15 PM with the Administrator revealed the facility's dietician is employed six hours a month. The interview also revealed the facility does employ a Food Service Director who is currently enrolled in a program but is not currently certified. A record review of the facility assessment, under Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies, revealed for food and nutrition services a Food Service Director was needed. A record review of the facility's Director of Food Services job description revealed requirements included being a graduate of an accredited course in dietic training and registered as a Food Service Director.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49263 Licensure Reference 175 NAC 12-006.17D Based on observation, interview and record review, the facility failed to perform hand hygiene, change gloves, and utilize a sanitary surface during catheter cares for 1 (Resident 1) of 1 sampled resident. The facility census was 29. The Findings Are: A record review of facility policy Handwashing/Hand Hygiene dated October 2023 revealed hand hygiene was indicated immediately before touching a resident, before performing an aseptic task, after touching a resident, after touching a resident's environment, before moving from work on a soiled body site to a clean body site on the same resident, and immediately after glove removal. The policy also stated that the use of gloves did not replace handwashing/hand hygiene. A record review of facility policy Catheter Care, Urinary dated August 2022 revealed a guideline that staff were to use aseptic technique (a set of practices that protects patients from healthcare-associated infections and protects healthcare workers from contact with blood, body fluid and body tissue.) when handling or manipulating the drainage system. A record review of Resident 1's Facesheet revealed the resident was admitted to the facility on [DATE] with a primary diagnosis of Multiple Sclerosis. A record review of Resident 1's Physician's Orders dated 1/31/23 revealed an order for Irrigate catheter with 60 ml (milliliters) of acidic acid or diluted vinegar solution two times a day. A record review of Resident 1's Physician's Orders dated 6/13/23 revealed an order for apply cavilon cream to suprapubic area near catheter. two times a day for irritation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 5/9/24 at 6:47 AM revealed Resident 1 was lying in their bed. LPN-A gathered their catheter irrigation supplies at the treatment cart near the nurse's station, carried them to Resident 1's room, opened the door, and entered the room. LPN-A sat the supplies down on the resident's roommate's dresser and applied a disposable gown and mask, stating Resident 1 was on enhanced barrier precautions due to their catheter. LPN-A then carried the supplies to Resident 1's side of the room. LPN-A asked another staff to remove some items that were sitting on top of Resident 1's roommate's overbed table. Once the items had been removed, the overbed table was moved to Resident 1's side of the room and LPN-A placed their supplies on the overbed table. LPN-A applied a pair of gloves without first performing hand hygiene (HH), opened the sterile irrigation kit, and applied sterile gloves over the other gloves using sterile technique. NA-C was wearing gloves and lifted Resident 1's catheter tubing up from on top of their leg and LPN-A put a sterile drape between Resident 1's leg and the catheter tubing. LPN-A then laid all of the other sterile supplies on the sterile glove packaging that was laying on the overbed table. LPN-A disconnected the catheter bag tubing from the suprapubic catheter tubing, threw the catheter bag and attached tubing away in the trash can, and placed the suprapubic catheter tubing into a sterile container that had been placed on the sterile drape on Resident 1's leg. LPN-A removed both pairs of gloves and then applied a new pair of sterile gloves without the benefit of performing HH. NA-C opened the sterile syringe package and LPN-A grabbed the syringe from inside the package and removed the plunger from the syringe, keeping both items in their hands. NA-C then opened the sterile saline bottle and poured the saline into the syringe being held by LPN-A. NA-C then opened a syringe with vinegar in it and squirted the vinegar into the syringe being held by LPN-A. LPN-A put the plunger back into the syringe. LPN-A wiped the open end of the catheter tubing with an alcohol pad, then inserted the syringe into the catheter and slowly administered the vinegar solution into the catheter. LPN-A removed the syringe, wiped down the opening to the catheter tubing with a new alcohol pad, and then attached a new set of tubing with a catheter bag attached to it. LPN-A secured the tubing to Resident 1's leg and threw their supplies away in the trash can next to the resident's bed. The new catheter bag was placed in a cloth dignity bag that was hanging on the side of the resident's bed. LPN-A returned the overbed table to the roommate's side of the room without disinfecting the table. LPN-A removed their gloves and put on a new pair of gloves without performing HH. LPN-A obtained a brief and a package of disposable peri-wipes from Resident 1's drawer while still wearing gloves. NA-C removed their gloves and put on a new pair of gloves. Resident 1 was then assisted to roll onto their side. NA-C wiped Resident 1's buttocks with peri-wipes, then rolled up the dirty brief and handed it to LPN-A, who threw it away in the trash can. NA-C then placed a new brief under the resident and had the resident roll onto their back. NA-C then cleansed the front of the resident's peri-area using peri-wipes. During the cleansing, NA-C identified open slits to the resident's skin in both sides of their abdominal fold. LPN-A removed their gloves and gown and threw them away. LPN-A then opened the resident's room door, exited, and closed the door without first performing HH. LPN-A went to get treatment supplies for the areas to Resident 1's abdominal fold. NA-C finished cleansing the resident's peri-area, removed their gloves and pulled up the front of the resident's brief. NA-C then threw their gloves away and performed HH via Alcohol Based Hand Rub (ABHR) and applied new gloves. LPN-A returned to the room, sat their supplies on Resident 1's roommate's overbed table, applied a gown, mask, and gloves without first performing HH and then picked the supplies back up. LPN-A used a clear measuring tool and a marker to measure the slits to Resident 1's abdomen, then placed the marker in their shirt pocket. LPN-A opened a sterile gauze packet, picked up a can of wound wash, sprayed it on the resident's abdominal fold, and then used the gauze to pat dry the areas. LPN-A applied Cavilon cream to the resident's abdominal folds and to their catheter insertion site after removing the split gauze that was on the site. LPN-A applied a new split gauze to the catheter insertion site and then NA-C and LPN-A secured the resident's incontinence brief in place. While still wearing the same gloves, LPN-A picked up the resident's bra while NA-C removed the resident's nightgown. NA-C and LPN-A applied the resident's bra. LPN-A then obtained the resident's deodorant from on top of their dresser, applied it to the resident's underarms and then put the deodorant back on the dresser. LPN-A then grabbed a dress from the resident's table. Both staff assisted the resident to put the dress on. LPN-A obtained a Hoyer lift sling from the back of the bathroom door. LPN-A and NA-C then removed their gloves, put the sling under the resident, attached it to the Hoyer lift and transferred the resident to their wheelchair without performing HH.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 5/9/24 at 7:23 AM with LPN-A confirmed they did not perform hand hygiene at any time while they were in Resident 1's room performing catheter cares and changing the resident's brief and clothing or when they left Resident 1's room to obtain the supplies for the resident's abdominal skin breakdown. LPN-A also confirmed they had used Resident 1's roommate's overbed table for Resident 1's catheter irrigation and wound care and did not sanitize it prior to using it.