

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Heritage Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 909 17th Street Fairbury, NE 68352	

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)
<p>F 0826</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide specialized rehabilitative services by qualified personnel, when ordered for a resident by a doctor.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45484</p> <p>Licensure Reference Number 175 NAC 12-006.09D1b</p> <p>Based on record review and interview, the facility failed to ensure Occupational Therapy (OT) Services were provided to Resident 3 as ordered by the physician. This affected 1 Resident sampled for rehabilitation. The facility census was 51.</p> <p>Findings are:</p> <p>A review of Resident 3's Admission Record printed 04/30/2024 revealed the resident was admitted on [DATE] and had diagnoses of major depressive disorder (MDD-a mood disorder that causes persistent sadness and loss of interest in activities), chronic obstructive pulmonary disorder (COPD-a group of lung diseases that block airflow and make it difficult to breathe), type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and arthritis (swelling and tenderness in one or more joints, causing joint pain or stiffness).</p> <p>A record review of Resident 3's Quarterly Minimum Data Set, dated dated [DATE] (MDS-a comprehensive assessment of each resident's functional capabilities) revealed a Brief Interview for Mental Status (BIMS-a screening tool used to assess cognition [relating to the mental process involved in knowing, learning, and understanding things]. The BIMS assessment uses a points system that ranges from 0 to 15 points: 0 to 7 points indicates severe cognitive impairment; 8 to 12 points indicates moderate cognitive impairment; and 13 to 15 points indicates that cognition is intact) score of 15 indicating the resident is cognitively intact.</p> <p>During an interview on 05/01/2024 at 9:29 AM, Resident 3 stated they had had a decline in the ability to stand up and to transfer from one surface to another. The resident stated this decline was fairly rapid, and that one day [gender] couldn't stand and had to use the sit to stand lift (a mechanical device used to assist residents who can bear some but not all of their weight to go from a seated to a standing position in order to transfer from one surface to another). Resident 3 denied having been sick prior to the decline.</p> <p>(continued on next page)</p>

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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<p>F 0826</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of a Physician Visit/Communication Form dated 03/07/2024 and signed by a physician on 03/08/2024 revealed orders for Physical Therapy (PT- treatment used to restore functional movements, such as standing, walking, and moving different body parts) and Occupational Therapy (OT-treatment that focuses on improving the patient's ability to perform activities of daily living [ADLs- skills required to independently care for oneself, such as eating, bathing, and mobility]) to evaluate and treat due to decline in functional transfers and ADLs.</p> <p>A record review of Resident 3's Physical Therapy PT Evaluation and Plan of Treatment with Start of Care date 03/15/2024 revealed the resident was evaluated by PT on 03/15/2024, and that PT was certified as medically necessary from 03/15/2024 through 06/12/2024. This certification was electronically signed by the resident's provider on 04/08/2024.</p> <p>The facility did not provide an OT evaluation or notes.</p> <p>A record review of Resident 3's Medicare B Nursing Notes dated 03/21/2024, 03/28/2024, 04/04/2024, 04/10/2024, 04/19/2024, and 04/25/2024 revealed no mention of OT.</p> <p>An interview on 05/01/2024 at 11:33 AM with the Director of Nursing (DON) revealed that Resident 3's decline was because the resident stopped doing things independently, and they got weaker due to that. When the facility noted the decline, Resident 3 was put back on the therapy workload to work with PT and OT to get more independent.</p> <p>An interview on 05/01/2024 at 3:49 PM with Nurse Aide (NA) A revealed that prior to [gender] decline, Resident 3 was starting to get anxious about transfers and was calling staff in for assistance.</p> <p>An interview on 05/02/2024 at 11:50 AM with the DON confirmed the OT evaluation ordered on 03/08/2024 was not done.</p> <p>An interview on 05/02/2024 at 12:04 PM with Certified Occupational Therapy Assistant (COTA) F revealed that nursing brought PT and OT orders into the therapy department when the orders were obtained. COTA F confirmed that Resident 3 was picked up for PT and not OT. COTA F further confirmed that the PT and OT orders were on same page, but they were unaware that the resident had an order for OT.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>50348</p> <p>Licensure Reference Number 175 NAC 12-006.17D</p> <p>Based on observation, record review, and interview, the facility failed to perform hand hygiene during catheter cares for 1 (Resident 54) of 1 sampled resident. Facility census was 51</p> <p>Findings are:</p> <p>A review of the Catheter Care steps for procedure dated 2019 revealed hand hygiene is to be completed during and after catheter care at the following times:</p> <ul style="list-style-type: none"> -before contact with catheter insertion site, -after coiling the catheter tubing to the resident's bed, -after cleaning supplies and returning to storage, -prior to leaving the resident's room, -Standard precautions should be always maintained, with no contamination. <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An Observation on 5/1/24 at 2:45 PM of Nursing Assistant-B (NA-B) and NA-H completing catheter cares on Resident 34 revealed the resident was in [gender] room lying in bed. NA-B and NA-H completed hand sanitization and donned (put on) gown and gloves. NA-B and NA-H enter residents' bathroom and gathered supplies from a cabinet located above the toilet. NA-H (with donned gloves) touched own face and door handle of bathroom before taking supplies to resident bedside and placing on bedside table. NA-B took supplies to resident bedside table also. NA-B placed paper towel on floor under Resident 54's catheter drainage bag. Both NA-B and NA-H returned to bathroom and performed hand hygiene redonned gloves. Both NAs returned to the resident's bedside. NA-B knelt on the floor, obtained the catheter drainage bag with both hands. NA-B then held drainage spout in left hand above the graduate. With the right hand the spout was cleansed with alcohol wipe. Alcohol wipe placed on paper towel that was under the graduate. After urine was emptied into the graduate NA-B then cleansed the spout with the same alcohol wipe used for initial cleaning. NA-B then placed the drainage bag into the dignity bag. NA-B then hands the graduate containing urine to NA-H. NA-B then removed paper towel from floor and placed into trash. Both NAs walked to the resident's bathroom. NA-H placed graduate on the sink to reveal the amount of urine. NA-B then emptied the graduate into the toilet and removed gloves. NA-B performed hand hygiene and redonned gloves. NA-H did not perform hand hygiene and continued to wear the same gloves. Both of NAs returned to the resident's bedside. NA-B attempted to raise the resident's bed with the bed remote and it did not work. NA-H then attempts the same thing. The bed remote was then dropped onto the floor and NA-H picked it up and placed it on the chair at bedside. NA-H did not perform hand hygiene. NA-B assisted resident to slide down pants and brief. Residents brief was then visible and noted on the left side crease there was a quarter sized amount of blood. Both side creases of the brief had a brownish tinge. NA-B obtained a cleansing wipe from package and used right hand to hold open residents left groin. A downward wiping motion was then performed using right hand. NA-B discarded wipe in trash and repeated the process to residents' right groin using opposite hands. NA-B then obtained another wipe (without hand sanitizing) with right hand out of package, held the catheter tubing with left hand and cleansed around entrance site of catheter and moved outward. NA-B then wiped downward on the catheter tube with the same wipe. NA-B obtained a bottle of cleansing spray that was located on the bedside table and with the right hand sprayed onto resident's catheter area. NA-B then placed the spray back onto the table and obtained a clean wipe from package with right hand. NA-B held the catheter in place with left hand and with the right-hand wiped catheter entrance site, then moved outward from the entrance site, and downward on the catheter tubing. NA-B then disposed of wipe and ensured catheter was secured to the residents left thigh. Both NA then assisted the resident to pull up the brief and pants. NA-B then pulled out trash bag from bin and tied bag. NA-H then moved the residents table back into position next to bed and ensured that call light was within reach. Both NA enter bathroom, and NA-B and used hand hygiene after gown and glove removal, then exited the room.</p> <p>During an interview on 5/1/24 at 3:03 PM with Director of Nursing (DON) confirmed the facility holds no policy for catheter cares, only a competency. Confirmation also received for the following:</p> <ul style="list-style-type: none"> -NA-B did not perform hand hygiene after wiping both sides of Residents groin and then performing catheter care and should have. -NA-B obtained a cleansing bottle from bedside table, returned to table, and replaced in cabinet all without performing hand hygiene and should have. -NA-H did not perform hand hygiene after handled a dirty graduate, touched own face, picked up a bed remote from floor, and touched a garbage can and should have. <p>(continued on next page)</p>		

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