| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 285263 | A. Building<br>B. Wing | 04/15/2024 |

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| Westfield Quality Care of Aurora | 1313 1st Street<br>Aurora, NE 68818 |

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

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| F 0567<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Honor the resident's right to manage his or her financial affairs.<br><br>49382<br><br>Licensure Reference Number 175NAC 12-006.05(19)<br><br>Based on observation, record review, and interview; the facility failed to ensure residents could access their personal resident trust funds on weekends. This affected 46 of 53 residents. With the facility stated census of 53.<br><br>Findings are:<br><br>In an interview with Resident 30 on 04/08/2024 at 11:36 AM, Resident 30 revealed [gender] was unable to access resident trust funds on the weekend.<br><br>In an interview on 04/10/2024 at 12:58 PM with Business Office Manager (BOM), confirmed that residents do not have access to resident trust account funds on the weekends, Saturday's, and Sunday's. BOM revealed [gender] was unaware that residents should have access to their funds on the weekends. BOM further revealed there was no policy or procedure in place for residents to access their funds on the weekends. |

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 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49382<br><br>The facility failed to ensure a Preadmission Screening and Resident Review (PASARR), (a screening program mandated by the federal Centers for Medicare and Medicaid Services (CMS) to ensure that nursing home applicants and residents with mental illness and intellectual/developmental disabilities are appropriately placed and receive necessary services to meet their needs) was completed prior to admission to the facility and reflected the residents mental illness for 1 resident, (Resident 34), of 4 sampled residents. The facility census was 53.<br><br>Findings:<br><br>Review of a facility policy titled Resident Assessment-Coordination with PASARR Program dated 01/2024 indicated that all applicants to the facility will be screened for serious mental disorders, (which are disorders that affect mood, thinking, and behavior), upon admission and a comprehensive evaluation by the appropriate state-designated authority to determine whether the individual has a mental disorder, intellectual disorder (which are disorders that limit a person's ability to learn at an expected level and function in daily life), or related conditions prior to admission.<br><br>Review of an Admission Record indicated the facility admitted Resident 34 on 03/10/2022 with diagnoses that of Type 2 Diabetes, (which is a condition that happens because of a problem in the way the body regulates and uses sugar as fuel), unspecified psychosis, (which is a diagnosis for psychosis with out a known cause not due to a substance or physical condition), and cerebral infarction, (which is when the blood floor to the brain is slowed or stopped causing brain cells to die off).<br><br>The Quarterly Minimum Data Set (MDS, which is a mandatory comprehensive assessment tool that measures the health status of nursing home residents and is used for care planning), with an Assessment Reference Date (ARD) of 03/28/2024 revealed that Resident 34 had a Brief Interview for Mental Status score of 13 indicating the resident was cognitively intact. The resident had no mood or behavior problems and was receiving no psychotropic (mood altering) medications. The MDS revealed that Resident 34 had an active diagnosis of a Psychotic Disorder, (which is mental disorder characterized by a disconnection from reality) other than schizophrenia.<br><br>Review of a facility supplied document titled Kepro Level 1 Screen dated 03/11/2022 revealed documentation in section 3 part 1 that no mental health diagnosis was known or suspected of Resident 34.<br><br>In an interview on 04/09/2024 at 3:30 PM with the Social Worker (SW), SW confirmed that Resident 34 was admitted to the facility on [DATE] with a diagnosis of unspecified psychosis. SW confirmed that this mental illness was not reflected on the Kepro Level 1 Screen that was completed on 03/11/2022. SW confirmed that Resident 34 was admitted to the facility on [DATE] and the PASARR was not completed until 03/11/2022 and the facility policy is for this to be completed prior to admission. |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50253<br><br>Licensure Reference Number 175 NAC ,d+[DATE].09<br><br>Based on record review, observations, and interviews, the facility failed to complete control testing on the facility glucometers (a machine that is used to monitor blood sugar levels) each night in order to maintain accurate blood sugar readings for the administration of sliding scale insulins and to ensure the accuracy of all blood sugars being monitored in the facility. This affected 6 residents who received Sliding Scale Insulin. (Residents 8, 9, 17, 30, 31, and 34). The facility failed to ensure that thorough skin checks were implemented for 1 Resident (Resident 30), of 4 sampled Residents. The facility census was 53.<br><br>Findings are:<br><br>A.<br><br>Record Review of the Medline Evencare Proview Users glucometer manual reviewed at the facility dated 2018 states the following: The purpose of the control solution testing is to validate that the EVENCARE ProView Meter is working properly with the test strips. You should perform a control solution test when: 1.) Using the meter for the first time. 2.) Using a new package of EVENCARE ProView Blood Glucose Test Strips. 3.) At least once per week to verify that the meter and test strips are working properly together. 3.) If the test strip bottle is left open. 4.) The meter is dropped. 5.) You suspect the meter and test strips are not working properly together. 6.) A patient's test results do not agree with how they feel. 7.) A patient's readings appear to be abnormally high or low. 8.) Test strips have been exposed to a condition outside the specified storage conditions. 9.) Practicing your testing technique IMPORTANT: If the control test result falls outside of the range provided, do the following: 1.) Do not test the patient's blood glucose. 2.) Make sure you are using EVENCARE ProView Glucose Control Solution. 3.) Make sure the testing environment is between 50?F-104?F. 4.) Make sure glucose control solution and test strips have not expired. 5.) Repeat the test with a new test strip. 6.) Control solution test results will be stored in the meter memory with a control solution bottle symbol. 7.) If the problem persists, contact Medline Technical Service Center at [DATE]-2131 between 8:00 am and 5:00 pm (Central Time), Monday through Friday. IMPORTANT: 8.) DO NOT reuse test strips. 9. ) Repeat with another level of control solution. IMPORTANT: o Use only EVENCARE ProView Glucose Control Solutions with the EVENCARE ProView Blood Glucose Test Strips. Other brands of control solutions will produce inaccurate results. o Always check the expiration date of the control solution. DO NOT use expired control solution. 22 ProView EVENCARE(R) (Trademark) Meter Setup o Record the date on the bottle when opening a new bottle of control solution. Discard any unused control solution three months after the opening date. o Control solutions are good three months after opening date or until the last day of the month of expiration, whichever comes first. o DO NOT FREEZE. Store the control solutions at room temperature of 39.2 degrees F - 86 degrees F. https://www.medline. com/media/catalog/Docs/MKT/MAN_EvenCare%20ProView%20Users%20Guide.pdf Dated 2018.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record Review of the Glucometer QC (calibration) log dated [DATE] revealed calibration information for [DATE] to [DATE]. The Glucometer QC log contained four columns: 1. Date, 2. High, 3. Low, and 4. Signature. The boxes for the high and low contained two numbers separated by a slash without an identifier for which glucometer from which the numbers corresponded. There were no columns for the high and low control ranges and no differentiation of which numerical entries corresponded to which of the two glucometers the nursing staff calibrated on the Glucometer QC log. Numbers for the HIGH and the LOW were completed only on [DATE], 7, 15, 17, 19, 20, 21, 26, 30, and 31. All other dates were blank. There was a signature with each entry. [DATE] there is a recorded reading of low for one glucometer in the low column. There is no indication that the glucometer was discarded or a new one calibrated. [DATE] both low readings were recorded as low/low. There are no further readings recorded or indication that either glucometer was discarded or replaced. [DATE] both readings recorded are low/low. There is again no indication that either monitor has been discarded or replaced nor is there a recalibration recorded. [DATE] has one low reading of low is recorded with no verification of replacing the glucometer and no further recalibration recorded. [DATE] has a recorded calibration of the low number as low. This has not recorded recalibration or indication that the monitor has been replaced. Because the control ranges differ and records do not include the ranges or parameters for the actual calibration numbers, it is impossible to ascertain what the correct ranges were for the month of January.<br><br>Record Review of the Glucometer QC (calibration) log dated February 2024 revealed calibration information for [DATE] to [DATE]. The Glucometer QC log contained four columns: 1. Date, 2. High, 3. Low, and 4. Signature. The boxes for the high and low contained two numbers separated by a slash without an identifier for which glucometer from which the numbers corresponded. There were no columns for the high and low control ranges and no differentiation of which numerical entries corresponded to which of the two glucometers the nursing staff calibrated on the Glucometer QC log. Numbers for the HIGH and the LOW were completed only on February 1, 2, 4, 5, 8, 9, 11, 15, 16, 19, 20, 23, 24, 27, 28, and 29. All other dates were blank. There was a signature with each entry. Because the control ranges differ and records do not include the ranges or parameters for the actual calibration numbers, it is impossible to ascertain what the correct ranges were for the month of February.<br><br>Record Review of the Glucometer QC (calibration) log dated [DATE] revealed calibration information for [DATE] to [DATE]. The Glucometer QC log contained four columns: 1. Date, 2. High, 3. Low, and 4. Signature. The boxes for the high and low contained two numbers separated by a slash without an identifier for which glucometer from which the numbers corresponded. There were no columns for the high and low control ranges and no differentiation of which numerical entries corresponded to which of the two glucometers the nursing staff calibrated on the Glucometer QC log. Numbers for the HIGH and the LOW were completed only on [DATE], 7, 13, 14, 15, 20, 21, and 22. All other dates were blank. There was a signature with each entry. Because the control ranges differ and records do not include the ranges or parameters for the actual calibration numbers, it is impossible to ascertain what the correct ranges were for the month of March.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record Review of the Glucometer QC (calibration) log dated [DATE], and reviewed on [DATE], revealed information through the date of [DATE]. The Glucometer QC log contained four columns: 1. Date, 2. High, 3. Low, and 4. Signature. The boxes for the high and low contained two numbers separated by a slash without an identifier for which glucometer from which the numbers corresponded. There was no column for the control range and no differentiation of which numerical entries corresponded to which of the two glucometers nursing staff calibrated on the Glucometer QC log. Numbers for the high and the low were completed for the , d+[DATE] through the ,d+[DATE] with two numbers in each box. Signatures were only on the dates of , d+[DATE], ,d+[DATE], and ,d+[DATE]. Because the control ranges differ and records do not include the ranges or parameters for the actual calibration numbers, it is impossible to ascertain what the correct ranges for the dates prior to [DATE]. However, [DATE] going forward, the ranges were on the glucometer strips that were being used.<br><br>Record review of the Glucometer QC (calibration) log dated [DATE], and reviewed on [DATE], had now been completed through [DATE], had no entry on ,d+[DATE], had new entries for the ,d+[DATE] and ,d+[DATE], and all entries now had a signature except for ,d+[DATE] and ,d+[DATE]. No late entry was noted on the signatures. As of [DATE] the ranges were not recorded but the survey team was able to observe the ranges on the glucose monitoring strips.<br><br>Calibration concerns are as follows:<br><br>-The recorded calibration numbers on [DATE] were (,d+[DATE]) high and (,d+[DATE]) low with no indication as to which entry matches which of the two glucometers used daily.<br><br>-The recorded calibration numbers on [DATE] were (,d+[DATE]) high and (,d+[DATE]) low with no indication as to which entry matches which of the two glucometers used daily.<br><br>-The recorded calibration numbers on [DATE] were (,d+[DATE]) high and (,d+[DATE]) low with no indication as to which entry matches which of the two glucometers used daily.<br><br>-The acceptable range for the glucometer strips for the calibration for the low range was 70 to 94 and the acceptable range for the high was ,d+[DATE].<br><br>-The calibration numbers for the high ranged from 302 to 330 on the three nights recorded and none fall within the acceptable range of (,d+[DATE]).<br><br>-The calibration numbers for the low ranged from 39 to 48 on the three nights recorded and none fall within the acceptable range of (,d+[DATE]).<br><br>-There is no indication that the DON (Director of Nursing) had been informed.<br><br>-There is no indication that the calibration had been done again.<br><br>-There is no indication that the glucometers were replaced.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | An observation on [DATE] at 10:30 AM revealed that two different boxes of glucose control solutions were opened on the medication cart. Neither box nor any of the 4 glucose control solutions were label with the date opened. Glucose strips were opened and not labeled with the date opened. The Control range for the low solution (solution 2) was (70 to 94) and the high solution (solution 3) was (221 to 301).<br><br>An observation on [DATE] at 10:30 AM. Registered Nurse (RN)-A performed a glucose calibration test on the current glucose monitor. RN-A first opened one box of the glucose control solution and then the second box stating RN-A was looking for the box and vials that were labeled. Two boxes were in the medication cart opened, but not labeled. RN-A labeled the glucose controls to be used for the control test prior to proceeding. RN-A stated that the night shift does the Controls every night and RN-A had not done a control test for quite some time so took the time to read through the Medline Evencare manual. The blood glucose test strips were also not labeled, and RN-A labeled the test strips. After rolling the testing solution, RN-A prepared to test the monitor. The first step performed was to clean the monitor with a disinfectant wipe, then donned gloves, inserted the test strip into the monitor and tried to add a drop of the low solution for the first test. Unable to get the test drop on the test strip, RN-A then took a clean plastic medicine cup, dropped the solution in the cup and dipped the test strip into the cup. The result was 84. At this point, RN-A checked to see that the control number fell within the control range that was noted on the Glucose strips, which it did. She repeated this process with the second control solution and got a reading of 237 which fell within the range of the controls. RN-A then logged these readings in the newly created Glucose Calibration logbook.<br><br>Interview on [DATE] at 10:30 AM with RN-A confirmed it is the night staff that performs the Glucometer Calibration check each night. Day staff do not do the calibrations. The facility always uses 2 glucometers. If the resident glucometer readings are high or low, no recheck of the blood sugar is performed at that time. Instead, a new glucometer check will be completed once the resident has eaten or about an hour after the insulin has been given a spot check may be done. RN-A confirmed that if a blood glucose is either high or low, they will not go back to check to see if the calibration has been completed. RN-A revealed that they had been taught only to retest the controls if opening a new test lot and had not completed new control tests when RN-B opened new bottle of glucometers strips that morning. RN-A further revealed that if the tests are out of range, one is not to use the test strips and must obtain a new bottle. RN-A revealed that the glucose controls and the Glucometer strips only last 30 days after opening. RN-A confirmed there had been no education on the new Glucose Calibration logbook.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Observation on [DATE] at 10:45 AM RN-B was then asked to perform a quality control test of the blood glucose monitor using the other monitor kept on the medicine cart. RN-B does work nights occasionally and performs the Glucose calibration testing on those nights worked. Using the same control solutions that were now dated and the same glucose control strips, RN-B cleaned the surface of the area where the test took place with a disinfectant wipe, then laid a clean tissue down on the surface. Each bottle of glucose control solution was then cleansed with alcohol, the lid removed, and the bottle and corresponding lid set in front of each bottle of control solution. RN-B then dropped on drop of solution from the first bottle on the tissue and the next bottle on the top of the cap. This was repeated for the second bottle of control solution. Each control was tested . The low solution result was 87 and the high solution result was 278. Each of these test results were checked against the glucose strips and were within range. RN-B then record the test results on a different page than RN-A had recorded on and had a difficult time trying to note what needed to be recorded on the new glucose control sheets that RN-B had not yet been educated on. After the calibration tests were completed, RN-B put all the testing supplies away and discarding the used test strips and the tissue, the surface was cleansed with another disinfecting cloth.<br><br>Interview on [DATE] at 10:45 AM with RN-B confirmed that RN-B does occasionally work the night shift. Night shift does do the Glucometer controls and day shift does not. If a blood glucometer control reading is out of range, controls should be run once again. If the controls are still out of range, one should try a new box of controls. The other option would be to call the DON at home or get a new glucometer in the med room and test the new glucometer. RN-B stated the glucose controls, and the glucose test strips are only good for 30 days each once opened. RN-B confirmed there had been no training or education for entering information into the new Glucose Calibration logbook.<br><br>Observation on [DATE] at 10:30 to 11:00 AM was made that the facility uses two different glucometers each day and that neither glucometer had been labeled to differentiate the two glucometers from each other.<br><br>Observation on [DATE] at 11:45 PM with the DON reveals that there are no numbers in the glucometer memory that are in the 30's or 40's for the past 9 days. (The recorded numbers for the Glucose QC calibration for the lows were all within the 30's and 40's on the calibration log and were the easiest to search for at the time.) The glucometer memory was searched in its entirety. The second glucometer that had been used by RN-A had just been replaced as the battery life was finished and the DON was unable to access any glucometer readings from that glucometer as it had been destroyed.<br><br>Interview on [DATE] at 11:45 PM with the DON confirmed that there were no numbers on the glucometer for the past 9 days that were in the 30's or 40's and thus no calibrations had been completed on the monitor. Because these numbers were not identified, the recorded numbers for the high control calibrations were not searched. DON stated that this was extremely concerning to her and close to her as these readings must be accurate when giving the sliding scale insulin.<br><br>Record review of the facility's policy on Blood Glucose Monitoring states in paragraph 6 of the policy explanation that calibration checks on glucometers must be performed nightly as per manufacturer's instructions. In paragraph 20 under procedures the policy states that critical test results must be reported to the physician timely.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview on [DATE] at 11:00 AM with Human Resources and Staff Educator (HR) confirm there are no education or nursing staff competencies or testing annually for Blood Glucose Calibrations or the use of Insulin Pens.<br><br>Interview on [DATE] at 11:04 with a representative from EvenCare Proview monitors confirm that glucose control ranges do differ from one bottle of test strips to the next. However, at no time when doing glucose control calibrations should the monitor ever read high or low. The representative again confirm that if the monitor has a reading of high or low during the calibration, then there is something wrong with the glucometer itself.<br><br>45613<br><br>B.<br><br>Interview on [DATE] at 09:35 AM with Licensed Practial Nurse (LPN-L) confirmed that there is a folder at the nurse's desk that has a log sheet and calibration of the glucometers is completed during the night shift.<br><br>Interview on [DATE] at 10:39 AM with LPN-M confirmed that calibration of the glucometers only happens about 50% of the time during the night shift and when it the control solution test is out of range staff is supposed to call the DON. During the night shift of [DATE]-[DATE] calibration did not get done due to being the only nurse working and it was a busy night. It was also confirmed that LPN-M did not know when the bottles of solution and/or the testing strips expired after opening or if they were dated. LPN-M confirmed that night shift doesn't ever run out of testing supplies and (gender) has never had to open a new bottle.<br><br>The facility completed the following plan of correction to correct the concern on [DATE].<br><br>Abatement Statement:<br><br>The Director of Nursing will provide hands on training including demonstration and teach back with every professional nurse in the facility prior to professional nurse working on the floor or administering insulin. Teaching will start [DATE] with nurses on duty currently.<br><br>If the the glucose reading is out of range, the professional nurse will:<br><br>-Make sure the glucose strips being used are accurate for glucose machine being used.<br><br>-Make sure the glucose strips strips have not expired.<br><br>-Repeat the test with a new test strip.<br><br>-If continues to be out of range do not use the glucose monitor. Place out of range monitor in Director of Nursing's mailbox.<br><br>-Use alternate monitor after completing control checks.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Director of Nursing or Designee will attempt controls on out-of-range glucose monitor during daily audit. If in range, glucose monitor can be returned to the floor for use. If continues to be out of range, Director of Nursing or Designee will call Medline technical service for further direction.<br><br>The above steps will be placed in the front of the glucose log for staff to reference. Will also be added to the competency training packets.<br><br>-All professional nurses that work the floor will be trained by Tuesday, [DATE]th, 2024.<br><br>-New glucometer logs have been put in place with all required information including lot number, expiration date, control values, glucose reading, and nurse completing check. The above training will also include a detailed explanation of the new logs with visual reminders placed in glucose logbook for refreshers if needed. The Director of Nursing or designee will audit the glucometer logs daily for 30 days verifying log documentation to glucometer memory by verifying date, time, and value.<br><br>-Going forward any new hired professional nurses will be required to complete the same training prior to working without a trainer on the floor.<br><br>50105<br><br>C.<br><br>An interview on [DATE] at 11:19 AM with Resident 30 revealed there was a sore on the top the left foot, pointing to the tongue portion of the shoe. When interviewed about treatments or pain, the Resident stated no treatments are done because nursing has not seen it and there is some irritation.<br><br>An interview on [DATE] at 1:34 PM with Resident 30 revealed nursing completed skin checks while in the shower or whirlpool bath. Resident 30 revealed that baths are provided 3x's a week and the scheduled dates are on Monday, Wednesday, and Friday's.<br><br>A record review of Resident 30's assessment titled Skin Observation dated [DATE] revealed redness to bilateral abdominal folds, groin and under breasts. Oral cavity pink/moist. There was no documentation about a sore on top of the foot. The skin observation was signed by Registered Nurse (RN)-A on [DATE].<br><br>Record review of Resident 30's chart revealed no Skin Observation documented between [DATE] and [DATE]. The facility did not complete a skin assessment for 12 days and the facility policy indicated a skin assessment was to be completed at least weekly.<br><br>A record review of Resident 30's assessment titled Skin Observation dated [DATE] revealed redness to bilateral abdominal folds, groin and under breasts. Oral cavity pink/moist. There was no documentation about a sore on top of the foot. The skin observation was signed by RN-A on [DATE].<br><br>During an interview on [DATE] at 02:45 PM with RN-A and an additional surveyor revealed that RN-A completed a skin check with Resident 30 and revealed that the feet for Resident 30 were not observed during the skin observation.<br><br>(continued on next page) |

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|---|---|---|---|
| | 285263 | A. Building<br>B. Wing | 04/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview on [DATE] at 2:49 PM with the DON about the expectations of a thorough skin observation and if not observing the feet were part of the skin observation process. The DON revealed that a thorough skin check is to be completed weekly and that it includes observations of the Resident's feet.<br><br>On [DATE] at 2:54 PM, the DON and nursing surveyor went to Resident 30's room to identify the sore Resident 30 were reporting to the surveyor. The observation with the DON and the nurse surveyor of Resident 30's foot revealed a popped blister on the top of Resident 30's foot.<br><br>Record review revealed documentation in the progress notes dated [DATE] reporting to the physician via fax about the popped blister on top of Resident 30's foot and a request for treatment. The facility was unable to locate the fax from the physician. No specific cause was identified for the blister; therefore no preventative measures were put into place. Additional progress notes dated [DATE] revealed a response from the physician for treatment and continued monitoring.<br><br>Review of a facility policy titled Pressure Injury Prevention Guidelines dated 2021 with a revised date by the facility on [DATE] revealed that to prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of this facility to implement evidence-based interventions for all Residents who are assessed at risk or who have a pressure injury present.<br><br>The policy explanation and compliance guidelines for the facility provide:<br><br>a. individualized interventions will address specific factors identified in the Resident's risk assessment, skin assessment, and any pressure injury assessment (e.g. moisture management, impaired mobility, nutritional deficit, staging, wound characteristics).<br><br>b. in the absence of prevention orders, the licensed nurse will utilize nursing judgement in accordance with pressure injury prevention guidelines to provide care and will notify physician to obtain orders.<br><br>Review of a facility policy titled Pressure Injury Prevention and Management dated 2022 with a revised date by the facility on [DATE] revealed: this facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries.<br><br>The policy explanation and compliance guidelines for the facility state:<br><br>a. the facility shall establish and utilize a systemic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate.<br><br>b. the interventions for prevention and to promote healing reveals: after completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan hat includes measurable foals for prevention and management of pressure injuries with appropriate interventions.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | c. monitoring: the DON, or designee, will review all relevant documentation regarding skin assessments, pressure injury risks, progression towards healing, and compliance at least weekly, and document a summary of findings in the medical record. |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a plan that describes the process for conducting QAPI and QAA activities.<br><br>45613<br><br>Licensure Reference Number 175 NAC 12-006.07C<br><br>Based on record review and staff interviews; the facility Quality Assessment Performance Improvement plan (QAPI) failed to identify ongoing issues relevant to F567, F645, F684, F865 and F880 and Emergency Preparedness (EP) regulation relevant to E-0004, E-0006, E0015, E0024, E0036. This deficient practice had the potential to affect all residents who reside in the facility. The facility staff identified a census of 92.<br><br>Findings are:<br><br>Review of the facility's policy dated 3/2023, titled Quality Assurance and Performance Improvement (QAPI) revealed, that it is the policy of the facility to develop, implement, and maintain an effective, comprehensive, data driven QAPI program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides. It is the responsibility of the Quality Assessment and Assurance Committee (QAA) to design the QAPI program.<br><br>The QAPI plan will address the following:<br><br>- Design and scope of the facility's QAPI program and QAA Committee responsibilities and actions.<br><br>- Policies and procedures will be in place for feedback, data collection, and monitoring. Data is to be collected from all departments.<br><br>-A priority of the program will focus on resident safety, health outcomes, and quality of care. A commitment to quality assessment and performance improvement by the management. The QAPI program will be ongoing, comprehensive, and will the full range of quality care and services provided by the facility. The facility will maintain documentation and evidence of it's ongoing QAPI program.<br><br>Results of the standard and extended survey revealed the facility was cited for failing to follow regulations:<br><br>-E-0004 The facility failed to develop, implement and updated the EP plan.<br><br>-E-0006, The facility failed to implement an all hazard approach for the facility EP plan.<br><br>-E-0015, the facility failed to have good faith notice of action for subsistence needs in the emergency plan.<br><br>-E-0024, The facility failed to have policies and procedures for volunteers for emergency staffing strategies.<br><br>-E0036, The facility failed to implement and maintain an emergency preparedness plan with a testing and training plan for communication, risk assessment and return demonstration of staff knowledge of emergency procedures.<br><br>(continued on next page) |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -F567, The facility administration failed to ensure residents funds were available from trust accounts.<br><br>-F645, The facility failed to ensure a Preadmission Screening and Resident Review (PASARR), (a screening program mandated by the federal Centers for Medicare and Medicaid Services (CMS).<br><br>-F684, The facility failed to ensure education and competencies were reviewed with licensed practical nurses and registered nurses annually prior to performing glucometer calibrations.<br><br>-F865, The facility failed to have an effective QAPI program that identified ongoing issues and failed to implement plans to address the ongoing issues.<br><br>-F880. The failed to develop and implement a water management program for the prevention of Legionella. This had the potential to affect all residents residing in the facility, and perform indwelling catheter (tube placed into the bladder to drain urine) care in a manner that reduced the risk of infection.<br><br>Interview on 4/15/24 at 11:59 AM with the Infection Preventionist (IP) revealed that IP was in charge of QAPI. The IP further confirmed there was no active facility Performance Improvement Program (PIP) and the facility has not done one in the last year. It was also confirmed there was no system in place for data collection to identify ongoing concerns in the facility or a way to monitor and correct them for the QAPI process.<br><br>Interview on 4/15/24 at 12:02 PM with the Administrator (ADM) revealed they were unaware there should be a ongoing and active QAPI Program for the facility to identify problems within the facility or a way to monitor and correct them.<br><br>Interview on 4/15/24 at 12:05 PM with the ADM revealed the areas of deficient practice were not identified or monitored by the QAA committee or QAPI. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>49382<br><br>Licensure Reference Number 175NAC 12-006.17D<br><br>Based on observation, record review, and interview the facility failed to develop and implement a water Legionella management program in the facility. This had the potential to affect all residents residing in the facility, and failed to perform indwelling catheter (tube placed into the bladder to drain urine)care in a manner that reduced the risk of infection for 2 residents, (Resident #27 and Resident #21), of 4 sampled residents. The facility stated census was 53.<br><br>Findings are:<br><br>A. Review of a facility policy titled Water Management Program dated 03/19/2024, indicated A water management team has been established to develop and implement the facility's water management program. The Maintenance Director maintains documentation that describes the facility's water system. A copy is kept in the water management program binder. A risk assessment will be conducted by the water management team annually to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water system.<br><br>Review of a facility policy titled Legionella Surveillance dated 01/2024, indicated Legionella surveillance is one component of the facility's water management plan for reducing the risk of Legionella and other opportunistic pathogens in the facility's water system.<br><br>In an interview conducted on 04/10/2024 at 2:00 PM the Physical Plant Manager (PPM) stated was not aware of a facility water plan would discuss with the facility Administrator.<br><br>In an interview conducted on 04/10/2024 at 2:30 PM the facility Administrator (ADM) revealed the facility had no completed water management program.<br><br>B. Review of an Admission Record revealed the facility admitted Resident #27 on 12/07/2020 with diagnoses that of Neuromuscular Dysfunction of the bladder, (which is a condition where a person cannot control their bladder function), history of urinary tract infections, (which is an infection in any part of the kidneys or bladder), and Multiple Sclerosis (which is a disease where then nerves of the central nervous system do not work correctly).<br><br>The Quarterly Minimum Data Set, (MDS, a federally mandated assessment tool used for care planning) with an Assessment Reference Date (ARD) of 02/22/2024 revealed Resident #27 had an indwelling urinary catheter and was dependent on staff assistance for personal hygiene and toilet use.<br><br>Review of Resident #27's Care Plan, which is a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident, listed a focus of urinary catheter due to neurogenic bladder with interventions to follow standards of care all dated 10/20/2022.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | In an observation completed on 04/09/2024 at 10:06 AM with Resident #27 in their room lying on their back in the bed Medication Assistant F (MA) used a washcloth moistened with soap and water and wiped Resident #27 left upper inner thigh then folded the cloth and wiped Resident #27 right upper inner thigh. MA-F discarded the cloth into a plastic bag at the foot of the resident's bed. MA-F obtained another washcloth moistened with soap and water and wiped Resident #27's pubic area in a downward motion. MA-F folded the cloth, used their left hand and grasped the catheter tubing at the level of the resident's outer pubic area and took the moistened cloth and wiped the catheter in a downward motion approximately 1-2 inches down the tubing. MA-F then discarded the cloth into the plastic bag at the foot of the resident's bed.<br><br>In an interview on 04/09/2024 at 10:32 AM with MA-F, MA-F confirmed that the labia should have been separated and cleansing of the catheter tubing should have started at Resident #27's meatus.<br><br>In an interview on 04/10/2024 at 1:30 PM with the Director of Nursing, the DON confirmed that the catheter should have been cleaned from the meatus down the catheter approximately 3 inches.<br><br>C. Review of an Admission Record revealed the facility admitted Resident #21 on 10/21/2023 with diagnoses of Intellectual Disability (which described a person with certain limitations in cognitive functioning and other skills for daily living), Chronic wound of the right mid foot and heel, history of urinary tract infections (which is an infection in any part of the kidneys or bladder), and Benign Prostatic Hyperplasia (which is an enlargement of the prostate gland that surrounds the male urethra).<br><br>The Quarterly Minimum Data Set with ARD) of 02/01/2024 revealed Resident #21 had an indwelling urinary catheter and was dependent on staff assistance for personal hygiene and toilet use.<br><br>Record review of Resident #21's Care Plan listed a focus of urinary catheter with interventions to follow standards of care all dated 11/01/2023.<br><br>In an observation completed on 04/09/2024 at 3:40 PM with Resident #21 in their room lying on their back in the bed Medication Assistant G (MA-G) used a washcloth moistened with soap and water to wipe Resident #21' left upper inner thigh, folded the cloth, then used the cloth to wipe the resident's right upper inner thigh. MA-G discarded the cloth into a plastic bag at the foot of the bed and obtained another soap and water moistened cloth. MA-G grasped Resident #21 catheter tubing at the meatus and used the cloth to wipe down the catheter tubing approximately 4 inches. MA-G then disposed of the cloth into the plastic bag at the foot of the bed. NA-G did not cleanse from the meatus down the shaft of Resident #21's penis.<br><br>In an interview on 04/09/2024 at 4:10 PM with MA-G confirmed that they did not cleanse the resident from the meatus and down the shaft of the penis.<br><br>In an interview on 04/10/2024 at 1:30 PM with the Director of Nursing, the (DON) confirmed that the MA should have cleansed the shaft of the penis with one cloth then the catheter tubing with another cloth.<br><br>B. Review of a facility policy titled Catheter Care, dated 01/2024 revealed the following information:<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -#9, gently separate the labia, which are the folds of skin of the female genitals, to expose the urinary meatus, which is the opening where the urine comes from the body.<br><br>-#10, wipe from front to back with a clean cloth moistened with water and perineal cleaner (soap).<br><br>- #11,use a new part of the cloth or different cloth for each side.<br><br>- #12,with a new moistened cloth, starting at the urinary meatus moving out, wipe the catheter making sure to hold the catheter in place to not pull on the catheter.<br><br>-#15 using a circular motion, cleanse the meatus with a clean cloth moistened with water and perineal cleanser (soap).<br><br>-#16 with a new moistened cloth, start at the urinary meatus moving down, cleanse the shaft of the penis.<br><br>-#17 with a new moistened cloth, starting at the urinary meatus moving outward, wipe the catheter making sure to hold the catheter in place to not pull on the catheter. |