STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285266	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gateway Vista	225 North 56th Street Lincoln, NE 68504

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45641 Based on observation, interview, and record review, the facility failed to ensure the accuracy of 1 (Resident 42) of 7 sampled resident's Minimum Data Set (MDS, a comprehensive resident assessment of a person's functional, medical, and mental function). The facility census was 68. Findings are: A record review of the Centers for Medicare and (&) Medicaid Services' Long-Term Care Resident Assessment Instrument User's Manual dated October 2023 revealed Federal regulations at 42 CFR (Code of Federal Regulations) 483.20 (b)(1)(XVIII), (g), and (h) require that (1) the assessment accurately reflects the resident's status. A record review of Resident 42's Clinical Census dated 06/11/2024 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 42's Medical Diagnosis dated 06/11/2024 revealed the resident had diagnoses of Chronic Inflammatory Demyelinating Polyneuritis (an abnormal immune response that can lead to nerve swelling and irritation), Anemia (low red blood cells), Acute Kidney Failures, Unspecified, Multifocal Motor Neuropathy (a rare and progressive disorder that affects motor neurons and cause muscle weakness in the extremities), and Thyrotoxicosis, Unspecified Without Thyrotoxic Crisis Or Storm (too much thyroid hormone). A record review of Resident 42's MDS dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS, a score of a residents cognitive abilities) of 5 of 15 which indicates the resident was severely cognitively impaired (confused). The resident was independent with oral and personal hygiene (cleaning), and upper body dressing. The resident needed supervision or touching assistance with toileting, lower body dressing and putting on footwear. The MDS revealed the resident was on Dialysis (a treatment that removes waste and excess fluid from the blood when the kidneys are not functioning properly). A record review of Resident 42's Care Plan did not reveal the resident was on Dialysis. An observation on 06/11/2024 at 11:12 AM revealed Resident 42 did not have a visible Dialysis catheter (a tube inserted into a vein) in the resident's chest, neck, or arm. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/11/2024 at 11:12 AM, Resident 42 confirmed the resident was not on Dialysis, but did have a procedure done every 2 weeks to separate the blood. Resident 42 confirmed the resident did not have a Dialysis catheter. A record review of the facility's MDS Resident Matrix dated 06/11/2024 did not reveal that Resident 42 was on Dialysis. In an interview on 06/12/2024 at 8:30 AM, The Director of Nursing confirmed Resident 42 was on Plasmapheresis (a process of removing the blood from the body, separating it into plasma and cells, and transfusing the cells back into the bloodstream) and was not on Dialysis. In an interview on 06/12/2024 at 8:58 AM, the MDS Coordinator-A confirmed Resident 42 was not on Dialysis and the MDS dated [DATE] was not accurate and Dialysis should not have been marked.

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NAME OF PROVIDER OR SUPPLIER Gateway Vista		STREET ADDRESS, CITY, STATE, ZIP CODE 225 North 56th Street Lincoln, NE 68504	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21492 Based on observation, record review and interview; the facility staff failed develop a Basline Care Plan (BLC, a plan of care that is developed to meet the residents basic needs until a comprehensive care plan can be established) for 1 (Resident 109) of 1 residents. The facility staff identified a census of 68. Findings are: A record review of a Order Summary report dated 6/11/2024 revealed Resident 109 admitted to the facility on [DATE] with the diagnoses of Hypertension, surgical amputation, falls, Osteomylitis and Non-displaced type ll dens fracture (neck fracture). Further review of Resident 109's Order Summary Report dated 6-11-2024 revealed Resident 109's practitioner ordered Resident 109 to have a cervical collar on at all time when upright or mobilizing. An observation on 6/11/2024 at 3:25 PM revealed Resident 109 was seated up-right in a wheelchair and had the cervical Collar in place. Record review of Resident 109's BLC initiated on 6-03-2024 revealed the use of the cervical collar was not identified on the plan. On 6/12/2024 at 3:30 PM an interview was conducted with the Director of Nursing (DON). During the interview the DON confirmed the sue of the cervical collar was not identified on Resident 109's BLC.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45641 Based on observation, interview, and record review, the facility failed to ensure Plasmapheresis (a process of removing the blood from the body, separating it into plasma and cells, and transfusing the cells back into the bloodstream) and the arteriovenous (AV) fistula (a surgical connection between an artery and a vein that creates a stronger entry point for needles necessary for residents that require Dialysis or Plasmapheresis) were identified on 1 (Resident 42) of 7 sampled resident's Care Plan. The facility census was 68. Findings are: A record review of the facility's Care Plans Guideline with a Date Implemented of 2023 revealed the care planning process would include an assessment of the residents needs and would incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the care plan. The care plan would describe the services that would be furnished to attain or maintain the resident's highest practicable (able to be done) physical, mental, and psychosocial (relating to thought and behavior) well-being. A record review of Resident 42's Clinical Census dated 06/11/2024 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 42's Medical Diagnosis dated 06/11/2024 revealed the resident had diagnoses of Chronic Inflammatory Demyelinating Polyneuritis (an abnormal immune response that can lead to nerve swelling and irritation), Anemia (low red blood cells), Acute Kidney Failures, Unspecified, Multifocal Motor Neuropathy (a rare and progressive disorder that affects motor neurons and cause muscle weakness in the extremities), and Thyrotoxicosis, Unspecified Without Thyrotoxic Crisis Or Storm (too much thyroid hormone). A record review of Resident 42's Minimum Data Set (MDS, a comprehensive assessment used to develop a resident's care plan) dated 04/02/2024 revealed the resident had a Brief Interview for Mental Status (BIMS, a score of a residents cognitive abilities) of 5 of 15 which indicates the resident was severely cognitively impaired (confused). The resident was independent with oral and personal hygiene (cleaning), and upper body dressing. The resident needed supervision or touching assistance with toileting, lower body dressing, and putting on footwear. A record review of Resident 42's Care Plan did not reveal the resident was on Plasmapheresis or had an AV fistula. A record review of Resident 42's Progress Note dated 03/09/2024 revealed an admission notes that the resident was on Plasmapheresis. A record review of Resident 42's Clinical Physician Orders dated 06/11/2024 revealed orders for: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Dialysis Fistula: No blood pressures (BP's), labs, jewelry or heavy lifting in extremity having fistula in right arm. every day and evening shift for hemodialysis (HD) catheter and fistula in right arm -Assess fistula site right arm. Palpate thrill (vibration felt when fingers are placed on AV fistula) and auscultate bruit (a sound that indicated how well an AV fistula is functioning) and note any concerns. Assess fistula appearance and document any concerns. Update/notify medical doctor (MD) as needed (prn) abnormal findings. every shift for fistula A record review of the facility's undated Daily Duty Sheet - 3rd Floor did not reveal the resident was on Plasmapheresis or had an AV fistula and required special precautions need related to the right arm AV fistula. An observation on 06/11/2024 at 3:21 PM revealed Resident 42's right arm had an AV fistula located on the inner elbow. In an interview on 06/11/2024 at 3:21 PM, Resident 42 confirmed the resident did leave the facility to have a procedure done every 2 weeks to separate the blood and did have an AV fistula located in the inner elbow of the right arm. The resident was not sure what the name of the procedure was. In an interview on 06/12/2024 at 8:30 AM, The Director of Nursing confirmed Resident 42 was on Plasmapheresis (a process of removing the blood from the body, separating it into plasma and cells, and transfusing the cells back into the bloodstream) and had an AV fistula in the right arm. In an interview on 06/12/2024 at 8:58 AM, the MDS Coordinator (MDS)-A confirmed Resident 42 had Plasmapheresis done every 2 weeks, had a AV fistula in the right arm. MDS-A confirmed Resident 42's Plasmapheresis and AV fistula was not on the Care Plan and should have been.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

21492

Based on record review and interview; the facility staff failed to implement assessed interventions to prevent significant injury for 1(Resident 35) of 4 sampled residents. The facility staff identified a census of 68.

Findings are:

Record review of Resident 35's Comprehensive Care Plan (CCP) with an initiation date of 3/14/2023 revealed Resident 35 had Activities of Daily Living (ADL's) self-care performance deficit related to the diagnosis of Parkinson Diseases. Further review of Resident 35's CCP with a initiation date of 3/14/2024 revealed Resident 35 was at a high risk for falls related to confusion, de-conditioning and gait/balance problems. The goal identified on Resident 35's CCP was Resident 35 would not sustain a serious injury. Interventions identified to meet the goal revealed the following:

-Anticipated and meets Resident 35's needs.

-Assistive devices in place with mobility.

-Audio monitor in room to be turned on at night.

-Bedside table with needed items within reach.

-Ensure gait belt (also known as a transfer belt) is in place with transfers and ambulation.

-Follow facility fall protocol.

A record review of Resident 35's Minimum Data Set (MDS, a federally mandated assessment tool used foe care planning) dated 3/12/2024 revealed the facility staff assessed Resident 35 as needing partial to moderate assistance with toilet transfer.

A record review of Physical Therapy (PT) notes for Resident 35 dated 4/23/2024 revealed Resident 35 had a history of falls. According to The PT notes dated 4/23/2024 revealed Resident 35 felt unsteady when walking and was worried about falling. Further review of the PT note for Resident 35 revealed the root cause of Resident 35's fear of falling was due to the Parkinson causing the resident to be unable to employ stepping strategies to maintain balance.

A record review of a Gateway Vista Restorative Program sheet dated and signed by a Occupational Therapist dated 9/18/2023 for Resident 35 revealed when transferring Resident 35, staff were to use a gait belt and the assistance of 1 staff member.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A record review of Resident 35's Progress Note (PN) dated 4/30/2024 with a time of 3:56 PM revealed Nursing Assistant (NA)-B was assisting Resident 35 from the toilet when Resident 35 took 2 steps forward. According to Resident 35's PN dated 4/30/2024 NA-B held onto Resident 35 as Resident 35 fell with NA-B falling with Resident 35. Resident 35's PN dated 4/30/2024 revealed NA-B's lower extremities may have fallen onto Resident 35 with resulting in a transfer to the hospital. A record review of Resident 35's PN dated 4/30/2024 at 7:29 PM revealed a Hospital Nurse called and reported Resident 35 had sustain a left side superior Pubic Ramus fracture (commonly known as a pelvic fracture). A record review of a Witnessed Fall sheet dated 4/30/2024 revealed Resident 35 was being transferred by NA-B when Resident 35 fell resulting in emergency services being called and Resident 35 transferred to the hospital. A record review of a facility investigation reported dated 5/03/2024 revealed Resident 35 required 1 person assistance with the use of a gait belt and a walker for ambulation and ADL's. Further review of the facility investigation report dated 5/03/2024 revealed Resident 35 sustain a left side superior Pubic Ramus fracture. On 6/12/2024 at 8:30 AM an interview was conducted with the Director of nursing (DON). During the interview the DON confirmed NA-B did not use a gait belt when transferring Resident 35 from the toilet. The DON further reported re-educating nursing staff on the floor Resident 35 resided on and some float staff. When asked was all of nursing re-educated on the use of gait belts, the DON stated no.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 21492 Based on observation, record review and interview, the facility staff failed to utilize hand hygiene and gloving, failed to ensure clean surface for treatment supplies,failed to clean scissors prior to wound care and failed to perform wound care in a manor to prevent potential cross contamination for 1 (resident 109) of 1 sampled resident. The facility staff identified a census of 68. Findings are: A record review of a Order Summary report dated 6/11/2024 revealed Resident 109 admitted to the facility on [DATE] with the diagnoses of Hypertension, surgical amputation, falls, Osteomylitis and Non-displaced type ll dens fracture (neck fracture). Further review of Resident 109's Order Summary Report dated 6/11/2024 revealed Resident 109's practitioner ordered a treatment to be completed to Resident 109's right 2nd amputated toe area that consisted of paint the wound with betadine, allow the betadine to air dry, then dress the wound with xereform (type of dressing), apply gauze and then wrap the area with ace wrap. An observation on 6/12/2024 at 10:40 AM of wound care and a transfer revealed Registered Nurse (RN)-C entered Resident 109's room and did not complete hand hygiene. RN-C removed resident's foot from [gender] wheelchair in preparation of a transfer. RN-C obtained and applied a gait belt (also known as a transfer belt) around Resident 109's waist and cued the resident for the transfer and transferred the resident into a recliner. RN-C removed the gait belt and explained to Resident 109 of the need to complete a treatment to the resident right toe area. RN-C without completing hand hygiene, left the residents room, obtained the required treatment supplies and returned to Resident 109's room. Further observation revealed upon entering Resident 109's room with treatment supplies, RN-C placed the treatment supplies on a corner room shelf without a barrier. The scissors that were included with the treatment supplies slid off the stack of the supplies onto the bare surface of the shelf. RN-C without completing hand hygiene donned (put on) gloves and removed Resident 109's right shoes and unwrapped the Ace wrap around Resident 109's right foot and lower right leg, RN-C removed the previous dressing revealing the wound to have stitches that measured approximately 2 centimeters in length. RN-C removed the soiled gloves, completed hand hygiene and donned clean gloves. RN-C then obtained a breadline swab and wiped downwards multiple times on the wound without changing the site on the swab. RN-C obtained the un-sanitized scissors and cut a portion of xereform dressing and placed the dressing onto Resident 109's right 2nd toe amputation site with the remainder of the xereform dressing placed back into the package. RN-C placed a 2 by 2 gauze dressing over the zereform dressing and without changing the gloves and completing hand hygiene wrapped Resident 109's right foot and leg with the Ace wrap and applied the resident shoe. RN-C removed the soiled glove and used hand sanitizer to clean the hand and scissors and placed the scissors into RN-C pocket. On 6/12/2024 at 11:00 AM an interview was completed with RN-C. During the interview RN-C confirmed soiled gloves had not been change and hands washed, soiled scissors were used and not sanitized after use and clean barrier for wound supplies was not used during the treatment on 6/12/2024 at 10:40 AM. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/2024 at 3:32 PM an interview was conducted with the facility Infection Control Preventionist (ICP). During the interview the ICP reported hand hygiene is to be completed before and after glove use, when using a betadine swab, the site on the swab needs to be changes with each swipe, a clean barrier needs to be in place for wound supplies and scissors need to be sanitized before and after use. A record review of the facility policy dated 2/2024 for Hand hygiene revealed the following: -Guidelines: -All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personal, residents and visitors. This applies to all staff working in all locations within the facility. -6.a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves.