STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285271	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northfield Retirement Communities Care Center	2100 Circle Drive Scottsbluff, NE 69361

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51122 Licensure Reference Number 175 NAC 12-006.04(F)(i)(5) Based on Interview and record review, the facility failed to notify the medical provider of 1 (Resident 22) of 1 resident's elevated blood pressures. The facility identified a census of 45. Findings are: A record review of a facility policy titled, Change in a resident's condition or status, last revised February 2021, revealed that the nurse will notify the resident's physician or physician on call in several situations which include the need to alter the resident's medical treatment, and a significant change in the resident's physical/emotional/mental condition. A record review of Resident 22's Continuity of Care Document, revealed Resident 22 was admitted to the facility on [DATE]. The document also revealed Resident 22 had diagnoses of dementia, hypertension, cognitive communication deficit, anxiety, and chronic pain. A record review of Resident 22's physician orders revealed an active order dated 11/19/21 which read, Blood pressure and pulse BID (twice daily) if out of parameters recheck 2 hours post B/P meds. A record review of Resident 22's care plan and physician orders revealed no evidence of recommended blood pressure range or parameter for the resident to maintain. A record review of Resident 22's vital sign records revealed the following dates, times, and blood pressure (BP) measurements: -On 5/5/25 at 8:26 AM their BP was 206/103, -On 5/5/25 at 12:17 PM their BP was 187/92, -On 5/4/25 at 4:33 AM their BP was 196/80, -On 5/3/25 at 9:07 AM their BP was 173/88, -On 4/27/25 at 5:12 AM their BP was 178/68, (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 4/20/25 at 8:19 AM their BP was 176/76 -On 4/16/25 at 8:59 AM their BP was 176/77, -On 4/15/25 at 8:29 AM their BP was 187/84, -On 4/14/25 at 7:18 AM their BP was 182/73, and -On 4/9/25 at 6:09 AM their BP was 192/81. A record review of Resident 22's nursing progress notes between 4/8/25 and 5/7/25 revealed no evidence that a physician was notified of Resident 22's high blood pressure. A record review of the 2017 American College of Cardiology (ACC) and American Heart Association (AHA) clinical practice guidelines for hypertension (originally published 11/13/17) revealed that lowering BP in isolated systolic hypertension (defined as systolic BP >160 with variable diastolic BP <90, <95, or <110) is effective in reducing the risk of fatal and nonfatal stroke, cardiovascular events, and death. (Full title: 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines; ahajournals.org) An interview with the Director of Nursing (DON) on 5/5/25 at 4:17 PM confirmed that nursing staff did not notify the medical provider of blood pressure values outside of Resident 22's baseline measurements (baseline is a reference point to track changes and assess the impact of treatments or interventions over time). The interview also confirmed that the nursing staff should have taken additional BP measurements to ensure Resident 22's well-being.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51122 Licensure Reference Number 175 NAC 12-006.05(G) Based on interview and record review, the facility failed to attempt gradual dose reductions or provide clinical rationale for not attempting a gradual dose reduction for 2 (Residents 19 and 24) of 5 sampled residents' psychotropic medications. The facility identified a census of 45. Findings are: Record review of a facility policy titled, Psychotropic medication use, last revised July 2022, revealed that psychotropic medications included anti-psychotics, anti-depressants, anti-anxiety medications, and hypnotics. The policy also revealed that residents on psychotropic medications receive gradual dose reductions (GDRs) unless clinically contraindicated. A. A record review of Resident 24's Continuity of care document, revealed Resident 24 was admitted to the facility on [DATE]. The document also revealed Resident 24 had diagnoses of dementia (a progressive condition marked by cognitive deficits including memory, thinking, and social abilities), falls, anxiety, drug-induced dyskinesia (uncontrolled involuntary muscle movements), and chronic pain. A record review of Resident 24's physician orders revealed active orders for the following psychotropic medications with the indications in parentheses: -Mirtazapine, an antidepressant, 15 milligrams (mg) daily at bedtime (anxiety), with the most recent order date of 10/28/24. -Quetiapine, an antipsychotic,12.5 mg daily in the morning (ordered for dementia), 25 mg at bedtime daily (ordered for anxiety). 6/19/24 and 10/28/24 were documented as start dates, respectively. A record review of Resident 24's care plan revealed a section, Psychotropic Drug Use, last revised 4/15/25 which revealed the following: Resident(name) has dementia with behaviors and anxiety. They take anti-depressants and anti-psychotic medication. The meds have been adjusted. Sees psych prn. Does have hx of TD. The care plan Approach stated that a GDR would be done if recommended by pharmacist and approved by the physician. Record review of facility document titled, Consultant pharmacist medication regimen review (MRR) and physician notification, for Resident 24 revealed a note in August 2024 which stated, If not contraindicated, would you consider a GDR (gradual dose reduction) of Lexapro or Remeron? There was no statement written in the space provided for physician response below the pharmacist's recommendation. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing (DON) on 5/07/25 at 9:34 AM revealed the physician did not respond to the pharmacist recommendation in August 2024. The DON also confirmed that no other pharmacist recommendations for psychotropic medication gradual dose reductions were suggested. The interview also revealed no physician documentation of clinical rationale for not attempting a GDR existed for this resident. The DON confirmed a GDR should have been attempted or a clinical rationale for not attempting a GDR should have been documented by the physician. 52169 B A record review of Resident 19's Significant Change Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and help nursing home staff identify health problems) dated 02/21/2025, revealed the resident had displayed disorganized thinking continuously. Resident had difficulty following what was being said and the resident's behaviors interfered with the resident's care and affected the resident's ability to participate in activities or social interactions. The MDS also revealed the resident rejected cares at times and had physical behavioral symptoms directed towards others which included hitting, kicking, pushing, scratching, grabbing, abusing others sexually. A record review of Resident 19's Continuity of Care document revealed Resident 19 had an order for Lexapro (Antidepressant) 10 mg once a day with an indication of major depression and a start date of 03/02/2023. A record review of Resident 19's Care Plan dated 03/05/2025 stated there would be a drug reduction as recommended by pharmacist and approved by physician. A record review of Resident 19's medical records revealed no evidence of a GDR being attempted or any clinical rationale for why a GDR should not be attempted. An interview on 05/07/2025 with the DON revealed the facility does not complete any GDRs unless the pharmacist identifies to do so during monthly reviews. Additionally, the DON confirmed the facility had no evidence a GDR had been attempted or was documented by their physician as clinically contraindicated for Resident 19.

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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** 49766 Licensure Reference Number 175 NAC 12-006.09(F)(i) Based on record reviews and interviews, the facility failed to develop a baseline care plan (BCP, a resident's plan of care that includes the minimum information needed to provide effective, person-centered care immediately upon admission) within 24 hours as required for 1 (Resident 41) of 2 sample residents. The facility identified a census of 45. Findings are: A record review of a facility policy, Care Plans - Baseline with a revised date of March 2022, revealed a BCP would be developed within 48 hours of admission to meet the resident's immediate health and safety needs. There was no evidence that a BCP would be developed within 24 hours as required by state regulation. Additionally, the policy revealed a BCP is to include initial goals, physician's orders, dietary orders, therapy services, social services, and Pre-Admission Screening and Resident Review (PASRR, a process which requires that all applicants to Medicaid-certified nursing facilities be given a preliminary assessment to determine whether they might have Serious Mental Illness or Intellectual Disability) recommendations. A record review of Resident 41's Face Sheet indicated Resident 41 had been admitted to the facility on [DATE]. Resident 41 had diagnoses of dementia (a usually progressive condition marked by the development of multiple cognitive deficits such as memory impairment, aphasia, and the inability to plan and initiate complex behavior), Pressure-induced deep tissue damage(DTPI, a type of pressure ulcer where the damage extends beyond the skin's surface into the underlying soft tissues), Refsum's disease (an inherited condition that causes vision loss, absence of the sense of smell, and a number of other symptoms), pain, acute kidney failure, history of blood clots in the leg, atrial fibrillation (a common heart rhythm disorder characterized by an irregular and often rapid heartbeat), high blood pressure, depression, anxiety, retention of urine, and abnormal weight loss. A record review of Resident 41's admission Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and help nursing home staff identify health problems) with an Assessment Reference Date (ARD) of 1/31/2025 revealed the following: -Resident 41 had short/long-term memory impairment with severe impairment of their cognitive decision-making skills. -Resident 41 required moderate assistance with eating and oral hygiene; substantial assistance with personal hygiene; and was dependent for assistance with toileting, bathing, and dressing. Additionally, Resident 41 required partial assistance for bed mobility and maximum assistance for transfers. -Resident 41 had a urinary catheter and was always incontinent of bowel. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident 41 received scheduled and as needed pain medication. Resident 41 displayed indications of pain through non-verbal sounds (such as crying, whining, moaning, etc.), vocal complaints, and facial expression (grimaces, furrowed brow, clenched teeth, etc.) on 3-4 days during the past 5 days of the ARD. -Resident 41 had a history of falls prior to admission and had 1 fall since their admission that caused injury. -Resident 41 had an order for a mechanically altered diet. -Resident 41 had one stage 2 (partial-thickness skin loss) and two unstageable pressure ulcers. Treatments included pressure-reducing devices for their chair and bed, repositioning program, and pressure ulcer care. -Resident 41 was taking an antidepressant (a type of medicine used to treat depression), an anticoagulant (blood thinner), an antibiotic, and an opioid (prescription pain medicine). -Resident 41 required oxygen use. A record review of Resident 41's medical record revealed no evidence a BCP had been developed. An interview on 5/7/2025 at 9:30 AM with the Director of Nursing (DON) confirmed the facility had not developed a BCP and should have developed one within 24 hours as required for Resident 41.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51122 Licensure Reference Number 175 NAC ,d+[DATE].12 Based on interview and record review, the facility failed to follow the physician's orders for 1 (Resident 44) of 1 sampled resident. The facility identified a census of 45. Findings are: A record review of Resident 44's Continuity of care document, revealed they were admitted on [DATE]. The document also revealed Resident 44 had diagnoses of lobar pneumonia (a lung infection that affects a specific area of the lungs, usually caused by bacteria), heart failure (an inability of the heart to pump effectively), chronic obstructive pulmonary disease (a lung condition that results in airflow limitation and persistent symptoms like shortness of breath, coughing, and mucus production), diabetes type 2, and chronic pulmonary edema (too much fluid in the lungs). A record review of Resident 44's nursing progress notes revealed the following: -Resident 44 returned to the facility from a hospital stay which ended on [DATE]. The resident was treated for respiratory failure and pneumonia. -A progress note on [DATE] at 9:15 AM revealed that the nurse called the physician's office to report Resident 44 had a 6 pound weight gain since the previous day. -A progress note on [DATE] at 2:33PM revealed that the physician called the facility and gave an order to start bumetanide (a diuretic, a medicine used to treat fluid retention) 0.5 mg and to re-weigh Resident 44 on [DATE] in the morning. -A progress note on [DATE] at 10:57 AM stated that Resident 44 had edema (swelling) in both legs. The progress note on [DATE] at 1:04 PM stated the physician ordered bumetanide 0.5 mg twice a day. -A progress note on [DATE] stated that the facility received signed orders for a blood test and bumetanide 0. 5 mg twice a day. -A progress note on [DATE] at 11:13 AM stated the resident had a weight gain of about 7 pounds since the prior day, [DATE]. -A progress note from [DATE] at 5:31 PM stated that the blood test results were received, then faxed to the physician's office. -A progress note from [DATE] at 3:42 AM stated the resident had shortness of breath and was given nebulized medication and refused to wear the bi-pap (a non-invasive breathing machine that uses two levels of positive air pressure to keep the airway open). -A progress note on [DATE] at 11:07 AM stated the Resident 44 had lost 4 pounds and still had edema in both legs. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A progress note [DATE] at 1:00 PM revealed that the nurse spoke with the physician regarding a bumetanide order that should have been implemented over the weekend, which was an increase over the prior order. The note also revealed the order was intended to be two 0.5 mg tablets in the morning and one 0. 5 mg tablet at bedtime for one week. -A progress note on [DATE] at 3:48 PM revealed Resident 44 had edema in both legs and arms and the nurse educated the resident to conserve energy. -A progress note on [DATE] at 9:10 AM revealed Resident 44's lung sounds included wheezes and the edema in their legs was increased. -A progress note on [DATE] at 9:45 revealed that Resident 44 had shortness of breath and dyspnea with exertion (difficulty breathing after physical activity). -A record review of the subsequent progress notes showed a decline in physical condition. Resident 44 died on [DATE] at 1:25 AM. A record review of Resident 44's Continuity of care document, revealed seven separate orders for bumetanide between [DATE] and [DATE]. The orders included different administration times and dosages. A review of Resident 44's medication administration record (MAR) revealed the following missed doses of bumetanide: -[DATE] ,d+[DATE]:00 PM dose of one 0.5 mg tablet was not administered, with the reason given: waiting for delivery. -[DATE] ,d+[DATE]:00 AM dose of one 0.5 mg tablet was not administered, with the reason given: drug unavailable, awaiting delivery. -[DATE] ,d+[DATE]:00 AM dose of two 0.5 mg tablets was not administered, with the reason: med cart not available, half tab available Qday, order needs clarification. The dose given was 0.25 mg. -[DATE] ,d+[DATE]:00 PM dose of one 0.5 mg tablet was not administered, with the reason given: on hold. An interview with the Director of Nursing (DON) on [DATE] at 12:18 PM confirmed that the facility should have obtained the bumetanide from their contracted pharmacy. The DON stated that when the medication was unavailable, the back-up pharmacy should have been contacted. The DON confirmed the medication should have been given as ordered. The interview also confirmed Resident 44 was put on comfort cares [DATE] and died on [DATE] at 1:25 AM.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51560 Licensure Reference Number NAC 175-12-006.09(H)(v) Based on observations, interviews, and record review the facility failed to provide treatment and care for contractures for 1 (Resident 1) of 4 sampled residents. The facility identified a census of 45. Findings are: An interview on 05/05/25 at 9:45 AM with Resident 1 in their room revealed that Resident 1 had contractures to bilateral hands which Resident 1 stated was from arthritis. Resident 1's fingers on bilateral hands were observed to be bent over stiffly into palms, with the exception of bilateral thumbs, which were observed to have free movement. Resident 1 stated the contractures did cause pain and denied being able to open fingers. Resident 1 stated that they still were able to grab and hold objects but that the contractures made it significantly more difficult to complete some tasks. Resident 1 stated that facility staff were not working with the contractures. Resident 1 denies receiving services from physical therapy, occupational therapy, or floor staff related to the contractures. A record review of Resident 1's admission summary revealed an admitted [DATE] with a primary diagnosis of Parkinson's Disease, a progressive neurological disorder that primarily affects movement, causing symptoms like tremors, stiffness, and slowness of movement. A record review of Resident 1's admission Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 7/1/20 revealed in Section G that Resident 1 had no functional limitation to range of motion with either upper or lower extremities- indicating that no contractures were present at the time of the assessment. A record review of Resident 1's quarterly MDS dated [DATE] revealed in Section G that Resident 1 had no functional limitation to range of motion with either upper or lower extremities- indicating that no contractures were present at the time of the assessment. A record review of Resident 1's quarterly MDS dated [DATE] revealed in Section G that Resident 1 had no functional limitation to range of motion with either upper or lower extremities- indicating that no contractures were present at the time of the assessment. A record review of Resident 1's quarterly MDS dated [DATE] revealed in Section G that Resident 1 had functional limitation to range of motion with both upper and lower extremities- indicating that Resident 1 had contractures present at the time of the assessment. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 1's care plan revealed a focus area for nutrition which revealed that Resident 1 was at nutritional risk related to contractures to bilateral hands. The focus area further indicated that Resident 1 had been offered adaptive silverware but refused to use it. No other documented evidence of interventions for Resident 1's contractures were noted in that focus area. The care plan further revealed a focus area of Activity of Daily Living (ADLs- basic self-care tasks that people perform to maintain their independence and well-being) Functional Status/Rehabilitation Potential. This focus area detailed that Resident 1 required supervised to extensive assistance with ADLs due to contractures to both hands related to osteoarthritis. Interventions for this focus area instructed staff to observe for decline related to ADLs and to notify physician, allow Resident 1 to do as much for themself as they are able, to provide extensive assistance with dressing as Resident 1 allows, and to notify therapy and physician of any decline. No documented evidence of further interventions related to contractures were noted on the care plan. An interview on 5/6/25 at 12:50 PM with Physical Therapist (PT) revealed the therapy department attempted to utilize splints to contractures years ago, but that Resident 1 refused to use them. The PT was unable to present documented evidence of splint use and refusal. An interview on 5/6/25 at 3:45 PM with the Director of Nursing (DON) confirmed that there were no specific interventions in place to monitor the contractures and prevent them from worsening or developing complications. The DON denied knowing exactly when Resident 1 developed the contractures and confirmed that there should have been specific interventions in place to address them.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 49766 Nebraska Revised Statute 71-6018.02(2)(a) Based on record reviews and interviews, the facility failed to ensure the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week as required. This had the potential to affect all residents who reside within the facility. The facility identified a census of 45. Findings are: A record review of a Payroll-Based Journal Staffing Data Report (PBJ, a system analysis report of staffing metrics, such as excessively low weekend staffing, no RN hours, and failure to have licensed nursing coverage 24 hours/day, that is based off payroll information submitted by the nursing homes) from July 1 - September 30, 2024, revealed the facility had triggered for four or more days within the quarter for no RN hours. The infraction dates were 8/10/2024, 8/11/2024, 8/16/2024, and 9/22/2024. A record review of facility-provided Timecard Reports from 8/10/2024-8/11/2024 revealed no evidence of RN hours on 8/10/2024 or 8/11/2024. A record review of facility-provided Timecard Reports from 9/22/2024 revealed no evidence of RN hours on 9/22/2024. An interview on 5/7/2025 at 12:50 PM with the Nurse Consultant (NC) confirmed the facility did not have RN hours on 8/10/2024, 8/11/2024, or 9/22/2024 but was able to provide evidence of 8-consecutive RN hours on 8/16/2024. A record review of facility-provided Individual Timecards from 2/2/2025-2/8/2025 revealed no evidence of RN hours on 2/8/2025. A record review of facility-provided Individual Timecards from 2/12/2025-2/26/2025 revealed no evidence of RN hours on 2/15/2025 or 2/16/2025. A record review of facility-provided Individual Timecards from 4/1/2025-4/12/2025 revealed no evidence of RN hours on 4/5/2025, 4/6/2025, or 4/12/2025. An interview on 5/8/2025 at 10:00 AM with the Nursing Home Administrator (NHA) revealed the facility's process for ensuring RN hours are to schedule an RN at least 8 consecutive hours every day. If a callout or unanticipated staffing shortage of the RN would occur, the RN would be responsible for attempting to find a replacement, the NHA would also attempt to find coverage. However, the facility had been having difficulty fulfilling RN hours due to vacations and other unexpected staffing turnovers. The NHA confirmed the facility had no evidence of RN hours for at least 8 consecutive hours on 2/8/2025, 2/15/2025, 2/16/2025, 4/5/2025, 4/6/2025, and 4/12/2025.

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 52169 Licensure Reference Number 175 NAC 12-006.09(H) Based on record review and interviews the facility failed to provide rational or clinical indicators of continued use of an antibiotic for one (Resident 14) of one sampled resident. The facility census was 45. Findings are: A record review of Resident 14's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and help nursing home staff identify health problems), dated 02/24/2025 revealed in Section N that the resident was taking an antibiotic. A record review of Resident 14's Care Plan revealed the resident had a supra pubic catheter related to urine retention. Resident 14 had a history of urinary tract infections and the resident was started on a routine antibiotic for prophylaxis on 08/05/2019. A record review of Resident 14's physician's order dated 04/26/2022 revealed an order for cephalexin (an antibiotic) 250 milligrams (MG) with a start date of 05/03/2022, a discontinue date of 03/04/2025, and a restart date of 03/04/2025 with a new diagnosis added of Prophylactic measures, unspecified. There was no stop date on the order. A record review of Resident 14's Progress Note dated 12/26/2024 revealed the Nurse Practitioner was in the facility on rounds and gave a new diagnosis of UTI Prophylactic for the resident's antibiotic and Supra Pubic catheter. A record review of Resident 14's Referral Form note dated 12/24/2024 revealed in the nurses notes/reason for referral, the nurse was asking for a reason for the prophylactic antibiotic. Under the findings and recommendations section in a progress note written by hand was the statement UTI prophylactic. An interview on 05/07/25 at 9:15 AM with the Nurse Practitioner confirmed Resident 14's antibiotic had been ordered for prophylaxis. A record review of the Center for Disease Control's (CDC) document The Core Elements of Antibiotic Stewardship for Nursing Homes APPENDIX A: Policy and Practice Actions to Improve Antibiotic Use revealed Surveys of antibiotic use have shown that (Urinary Tract Infection) UTI prophylaxis accounts for a significant proportion of antibiotic prescriptions. Very few studies support antibiotic use for UTI prophylaxis, especially in older adults, and many studies have shown this antibiotic exposure increases risk of side effects and resistant organisms. Therefore, efforts to educate providers on the potential harm of antibiotics for UTI prophylaxis could reduce unnecessary antibiotic exposure and improve resident outcomes.'

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285271	A. Building B. Wing	05/08/2025

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52169 Licensure Reference Number NAC 175 ,d+[DATE].11(E) Based on record review, interviews, and observations the facility failed to identify and dispose of spoiled fruits and vegetables stored in the walk-in refrigerator. This had the potential to affect all residents who resided within the facility. The facility identified a census of 45. Findings are: A record review of the facility policy Dietary Policy dated [DATE] revealed staff will check for expiration dates when getting food. If food is found to be expired, discard immediately. Do not return expired foods to shelves. There was no evidence of guidance in the policy related to the monitoring and disposal of fresh fruits and vegetables. An observation on [DATE] at 6:15 PM during initial kitchen tour revealed two bags of grapes that had a greenish black fuzzy substance sticking to the grapes with a cloudy light greenish liquid substance throughout the bag. The observation further revealed an open box that contained a bag with one tomato in it. The tomato was noted to have a fuzzy greenish black substance around the stem. An interview on [DATE] at 7:00 PM with the Certified Dietary Manager (CDM) confirmed, these products should never have been in the refrigerator and should have been disposed of immediately. CDM stated that staff check foods that have expiration dates (canned or boxed items) upon removing from storage, but was unable to indicate how they monitor fresh fruits and vegetables.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 49766 Licensure Reference Number 175 NAC 12-006.04(B)(i) Based on record reviews and interviews, the facility failed to implement an effective initial training program to ensure new employees had completed training on topics of resident rights, emergency procedures, abuse/neglect, dementia care and medical emergency directives (for nursing staff) for 3 (Dietary Aide (DA) -G, Nurse Aide (NA) -B, and Medication Aide (MA) -D) of 5 sample employees. This had the potential to affect all residents residing within the facility. The facility identified a census of 45. Findings are: A record review of the facility's undated Facility Assessment Competency Tool, under the section Workforce Training, revealed high priority rating for training on abuse and neglect, emergency preparedness and resident rights and medium priority rating for dementia training. There was no evidence of the importance of training regarding medical emergency directives. A record review of an undated, facility-provided staff list revealed the following: -DA-G was hired on 4/19/2025. -NA-B was hired on 2/19/2025. -MA-D was re-hired on 1/13/2025. A record review of DA-G's personnel record revealed no evidence that initial orientation training had been completed, including on topics of resident rights, emergency procedures, or dementia. A record review of NA-B's personnel record revealed no evidence that initial orientation training had been completed on dementia or medical emergency directives. A record review of MA-D's personnel record revealed no evidence initial orientation training had been completed on dementia or medical emergency directives. An interview on 5/6/2025 at 3:40 PM with Human Resources (HR) confirmed DA-G had no evidence initial orientation training had been completed and no evidence NA-B or MA-D had completed initial orientation training on dementia or medical emergency directives.

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 49766 Licensure Reference Number 175 NAC 12-006.04(B)(ii) Licensure Reference Number 175 NAC 12-006.04(B)(ii)(1) Based on record review and interviews, the facility failed to ensure nurse aides (NA)/ medication aides (MA) had completed ongoing training of at least 12 hours per year on topics appropriate to the employee's job duties, abuse/neglect training, and at least 4 hours of dementia training as required for 5 (MA-H, NA-A, MA-F, MA-E, and NA-I) of 5 sample employees. This had the potential to affect all residents residing within the facility. The facility identified a census of 45. Findings are: A record review of the facility's undated Facility Assessment Competency Tool, under the section Workforce Training, revealed high priority rating for nurse aide education and training on abuse and neglect, and medium priority rating for dementia training. There was no evidence of time requirements for ongoing training. A record review of an undated facility-provided staff list revealed the following: -MA-H was hired on 6/6/2022. -NA-A was hired on 6/26/2022. -MA-F was re-hired on 6/21/2022. -MA-E was re-hired on 10/13/2023. -NA-I was hired on 3/6/2023. A record review of the facility's provided copy of MA-H's Relias Transcript with a date range of 6/6/2023-6/6/2024 revealed MA-H had completed 1.75 hours of ongoing training. There was no evidence that ongoing training on dementia had been completed. A record review of the facility's provided copy of NA-A's Relias Transcript with a date range of 6/6/2023-6/6/2024 revealed a total of 3 hours of ongoing training had been completed. NA-A had completed an additional 0.17 hours of training, but the courses of Setting Up the Steam Table, Proper Freezer Storage, and Dry Storage were unrelated to NA-A's job duties. There was no evidence NA-A had completed ongoing training on dementia. A record review of the facility's provided copy of MA-F's Relias Transcript with a date range of 6/21/2023-6/21/2024 revealed MA-F had completed 4.75 hours of ongoing training with 0.25 hours of training on dementia. There was no evidence MA-F had completed ongoing training on abuse and neglect. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A record review of the facility's provided copy of MA-E's Relias Transcript with a date range of 10/13/2023-10/23/2024 revealed MA-E had completed a total of 8 hours of ongoing training had been completed with 0.25 hours of training on dementia. A record review of the facility's provided copy of NA-I's Relias Transcript with a date range of 3/6/2024-3/6/2025 revealed no evidence NA-I had completed 4 hours of ongoing training on dementia. An interview on 5/7/2025 at 8:30 AM with the Nurse Consultant (NC) confirmed the facility had not met the requirements for ongoing training for the 5 sampled staff.