STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood Rehabilitation & Care Center	624 Pinewood Avenue Seward, NE 68434

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 47406 Licensure Reference Number 175 NAC 12-006.09(H)(vi)(3)(g) Based on interviews and record reviews the facility failed to obtain a physician's order for the settings of the Continuous Positive Airway Pressure (CPAP, a treatment that uses mild air pressure to keep your breathing airways open) machine for 1 (Resident 11) of 4 sampled residents. The facility census was 57. Findings are: Record review of Resident 11's Clinical Census dated 1/16/25 revealed admission to facility was 12/16/24. Record review of Resident 11's Medical Diagnoses dated 1/15/25 revealed Obstructive Sleep Apnea. Record review of Resident 11's MDS (Minimum Data Set, a comprehensive assessment of each resident's functional capabilities) dated 12/20/24 revealed: -Section C: BIMS (Brief Interview for Mental Status, a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function) was 9 which indicates moderate cognitive impairment. -Section O Non-invasive Mechanical Ventilator. Record review of Resident 11's Physician's orders dated 1/16/25 revealed: -CPAP on every HS (hour of sleep) for sleep apnea, per home settings, on at HS, off in AM, every morning and at bedtime for Sleep apnea On HS; Off AM Record review of Resident 11's Physician orders, care plan, treatment administration record dated 1/16/25 revealed there were no settings for resident's CPAP. Interview with ADON on 1/21/25 at 9:25 AM revealed that ADON that there was no settings for Resident 11's CPAP. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facilities Your CPAP/Bi-Level Unit undated education revealed no instructions regarding the CPAP settings.

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45641 Licensure Reference Number 175 NAC 12-006.10 Based on observation, interview, and record review, the facility failed to provide rational and justification to extend 1 (Resident 30) of 5 sampled resident's as needed (PRN) Alprazolam (Xanax)(an anti-anxiety medication) beyond 14 days. The facility census was 57. Findings are: A record review of the facility's Psychoactive Medication and Medication Regimen Review Management Standard dated 09/2024 revealed that an indication for use was: the identified, documented clinical rational for administering a medication based upon an assessment of the resident's condition. An unnecessary drug was when a drug was ordered for an excessive duration, or without adequate indications for its use, or without adequate monitoring. A record review of Resident 30's Clinical Census dated 01/16/2025 revealed the resident was admitted to the facility on [DATE]. The resident was discharged to the hospital on 08/23/2024 and returned to the facility on [DATE]. A record review of Resident 30's Medical Diagnosis dated 01/11/2025 revealed the resident had diagnoses of Anxiety Disorder, Pain, Dementia (confusion) without behavioral disturbance, Chronic Obstructive Pulmonary Disease (COPD), and Pneumonia. A record review of Resident 30's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 12/29/2024 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a residents cognitive abilities) of 15 which indicated the resident was cognitively aware. The resident required supervision and assistance with oral hygiene (cleaning), partial/moderate assistance for upper body dressing, and substantial/maximal assistance with toileting, bathing, lower body dressing and footwear. The resident had Anxiety and was on an antianxiety medication. A record review of Resident 30's Care Plan with an admitted [DATE] revealed a focus area of uses psychoactive medications (medications that alter mood and perception) related to Anxiety and an intervention of antianxiety adverse effects - monitor/document/report PRN: drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, light-headedness, impaired thinking and judgement, memory loss, forgetfulness, nausea, stomach upset, and blurred vision. Unexpected side effects: mania (extreme mood swings), hostility, rage, aggressive behavior, and hallucinations. Attempt non-pharmacological interventions prior to administering PRN psychoactive medications. A record review of Resident 30's Order Summary Report dated 01/16/2025 revealed the resident had physician orders for: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Alprazolam Oral Tablet 0.5 milligram (MG) 2 times per day (BID) for Anxiety **Time of administration specifically ordered by PCP (Primary Care Physician or Provider)** Prescriber Written 08/30/2024 Alprazolam Oral Tablet 0.5 MG give 1 tablet by mouth every 8 hours as needed for Anxiety for 6 Months **May take two hours after scheduled dose of administration** Prescriber Written 08/30/2024 and set to end 02/28/2025 A record review of the facility's Physician Visit/Communication Form dated 08/30/2024 revealed the facility notified the physician that Resident 30 and the resident's spouse requested Xanax at 10:00 AM, at bedtime, and PRN. The physician agreed, signed, and dated the form, but did not include rational as to why the resident needed the PRN Xanax for more than the allowed 14 days. A record review of Resident 30's Medication Administration Record and Treatment Administration Record (MAR & TAR) dated November 2024 - January 2025 revealed the facility administered PRN Xanax to the resident on the following dates: 11/21/2024 11/08/2024 11/02/2024 11/01/2024 12/02/2024 - No documented out of character behaviors 12/05/2024 - Documented out of character behaviors 01/11/2025 - No documented out of character behaviors 01/13/2025 - No documented out of character behaviors 01/16/2025 - Documented out of character behaviors A record review of Resident 30's Behavior/Intervention Monthly Flow Record Dated November 2024 did not reveal the resident had documented behaviors on: 11/21/2024 11/08/2024 11/02/2024 A record review of Resident 30's Progress Notes Dated 01/22/2025 did not reveal the resident had documented behaviors on: 11/21/2024 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/08/2024 11/02/2024 12/02/2024 01/11/2025 01/13/2025 An observation on 01/15/2025 at 11:43 AM revealed Resident 30 was sitting in a recliner in the room. Resident was very pleasant and appeared calm and in no distress. An observation on 01/16/2025 at 8:41 AM revealed Resident 30 was sitting in the room straightening the blankets on the bed. Resident appeared calm and in no distress. In an interview on 01/22/2025 at 10:49 AM, the facility's Administrator confirmed the Administrator reviewed Resident 30's progress notes and behavior monitoring, and the physician communication forms related to the PRN Xanax order. The Administrator confirmed the physician did not document rational for ordering Xanax PRN for greater than 14 days and should have. The Administrator confirmed behaviors were not documented to justify the use for the Xanax that was administered on the following dates and there should have been: 11/21/2024 11/08/2024 11/02/2024 12/02/2024 01/11/2025 01/13/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 48271 Licensure Reference Number 175 NAC 12-006.10(D) Based on record review, observations and interviews, the facility failed to ensure 2 residents (Resident 5 and 36) out of 4 sampled residents were free of a significant medication error. The facility census was 57. Findings are: A. A record review of the facility's Oral Drug Administration policy dated 5/20/24 revealed: -Verify the order on the patient's medication administration record by checking it against the practitioners orders. -Check the expiration date on the medication. -Visually inspect the medication for particles, discoloration, or other loss of integrity -Verify that you're administering the medication at the proper time, in the prescribed dose, and by the correct route to reduce the risk of medication errors. An observation on 01/16/25 at 8:07 AM revealed the Registered Nurse (RN) opened the narcotic drawer from the medication cart and taking one Phenobarbital 32.4 mg pill out of the medication pack (A blister pack is a form of tamper-evident packaging where an individual pushes individually sealed tablets through the foil in order to take the medication) and put the Phenobarbital pill in a plastic medication cup. The RN then signed out the Phenobarbital and took the Phenobarbital pill to Licensed Practical Nurse (LPN-A). The LPN-A put the medication cup with the Phenobarbital pill in the medication cart for Resident # 5. LPN-A signed (genders) name besides the RN in the narcotic book for the Phenobarbital. An observation on 1/16/25 at 8:15 with the LPN-A revealed that the LPN-A administered the Phenobarbital to Resident #5 per peg tube (a thin, flexible tube surgically inserted through the abdominal wall and into the stomach as an alternative route for delivering nutrition, fluids, and medications directly into the stomach). An interview on 1/16/25 at 8:30 AM with the RN confirmed that (gender) should not have pulled the Phenobarbital out of the medication pack unless that nurse was going to be giving the medication themselves. RN confirmed that (gender) should not have given the Phenobarbital to the LPN-A . An interview on 1/16/25 at 8:30 AM with the LPN-A confirmed that (gender) did administer the Phenobarbital to Resident # 5. LPN-A confirmed that (gender) did not remove the Phenobarbital from the narcotic drawer. The LPN-A confirmed (gender) did not compare the label with the medication record. The LPN-A confirmed that this is the normal practice with giving Resident # 5 medications. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 01/16/25 at 1:34 PM with Infection Preventionist/Staff Development (IP/SD) confirmed that the expectations during a medication pass is that the nurse who is pulling the medication out of the narcotic box is the nurse who is administrating the medication. The nurse pulling the medications out of a narcotic box should not give the narcotic to another nurse to administer. 47406 B. Record review of Resident 36's Clinical Census admission was 1/7/22. Record review of Resident 36's MDS (Minimum Data Set, a comprehensive assessment of each resident's functional capabilities) dated 12/6/24 revealed: -Section C: BIMS (Brief Interview for Mental Status, a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function) was 11, which indicates moderate cognitive impairment. -Section N: Indicates that the resident is Hypoglycemic (has low blood sugar) . Record review of Resident 36's Diagnosis list dated 1/16/25 revealed Type 2 Diabetes Mellitus without complications. Record review of Resident 36's Physician's orders dated 1/16/25 revealed: - Basaglar KwikPen Subcutaneous Solution Pen-injector 100 Unit/ML (Insulin Glargine) Inject 50 units subcutaneously at bedtime for diabetes. -NovoLOG Injection Solution 100 Unit/ML (Insulin Aspart) Inject 6 units subcutaneously before meals for diabetes, administer with sliding scale-Fiasp Flex pen equivalent. -NovoLOG Injection Solution 100 Unit/ML (Insulin Aspart), Inject as per sliding scale: 151-200 = 4; 201 - 250 = 8; 251 - 300 = 10; 301 - 350 = 12; 351 - 425 = 15; 426 - 500 = 18; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	501 - 650 = 20; 651 - 800 = 22 notify Dr. if blood sugar below 50 and above 400, subcutaneously four times a day for diabetes. Administer with scheduled dose= Fiasp Flex pen equivalent Observation on 1/16/25 at 12:09 PM of Resident 36's insulin administration and obtaining BS (blood sugar) by LPN-B. LPN-B obtained the BS from right forefinger after cleansing with alcohol wipe with results 367. LPN-B prepared 6 units Novolog and 15 units sliding scale Novolog totaling 21 units without priming needle and gave in resident's left lower abdomen after cleansing with alcohol wipe. Interview on 1/16/25 at 12:12 PM with LPN-B revealed that [gender] was taught to prime the insulin pen the first time the pen was opened and did not have to prime after that for any other times used. Interview on 1/21/25 at 11:56 AM with Interim DON revealed that the nurse needed to prime the pre-filled insulin pens prior to setting the dose at each administration to ensure that the correct amount of insulin is administered. Record review of Pre-filled Insulin Pen Competency Policy dated 1/2020 revealed: Important notes: Use a new needle for each injection, making sure it is completely attached to the pen before priming, setting the dose and injecting the insulin. Procedure Step: 10. To prime the pen, make sure the arrow is in the center of the dose window. (If you do not see the arrow in the center of the dose window, push in the injection button fully and turn the dose knob until the arrow is seen in the center of the dose window.) 11. Pull the dose knob out in the direction of the arrow until a 0 is seen. 12. Turn the dose knob clockwise until the number 2 is seen. (If the number dialed is too high, simply turn the dose knob backward until the number 2 is seen.) 13. Hold the pen with the needle pointing straight up, tapping the clear cartridge holder so any air bubbles collect near the top. Push the injection button completely using thumb. Keep pressing and continue to hold the injection button firmly. A stream of insulin should come out of the tip of the needle. (If the stream of insulin does not come out, repeat above steps. If after 6 attempts a stream of insulin does not come out the tip of the needle, change the needle. If still unable to get insulin flowing out of the needle, do not use the pen and contact pharmacy).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45641 Licensure Reference Number 175 NAC 12-006.11(E) Based on observation, interview, and record review, the facility failed to ensure the microwave, refrigerator, and freezer in the Life Enrichment (activities) kitchen were clean. The facility census was 57. Findings are: A record review of the facility's kitchens Deep Cleaning schedule revealed the microwave and refrigerator/freezer should have been cleaned daily. A record review of the facility's requested last 2 months of the Life Enrichment kitchen's Weekly Cleaning logs dated 11/21/2024 - 01/21/2025 did not reveal they had been completed. An observation on 01/14/2025 at 8:10 AM revealed the Life Enrichment kitchen's microwave had multi-colored food splatters and debris throughout and the residential refrigerator/freezer bottoms and drawers contained food drippings and debris. An observation on 01/14/2025 at 1:36 PM with the facility's Registered Dietician (RD) revealed the Life Enrichment kitchen's microwave had multi-colored food splatters and debris throughout and the residential refrigerator/freezer bottoms and drawers contained food drippings and debris. In an interview on 01/22/2025 at 10:29 AM, the facility's Administrator confirmed 10-12 residents consume food from the Life Enrichment kitchen. In an interview on 01/14/2025 at 1:36 PM with the facility's RD confirmed the Life Enrichment kitchen's microwave had multi-colored food splatters and debris throughout and the residential refrigerator/freezer bottoms and drawers contained food drippings and debris and should have been clean.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 45641 Licensure Reference Number 175 NAC 12-006.11(E) Based on observation, interview, and record review, the facility failed to ensure food in the Life Enrichment refrigerator and freezer were labeled with the resident's name and dated. The facility census was 57. Findings are: A record review of the facility's Visitor Food policy revealed that food stored for residents needed to be labeled, dated, and stored safely in designated area per facility policy following the food safety guidelines for personal food. An observation on 01/14/2025 at 8:10 AM revealed the Life Enrichment (activities) kitchen residential refrigerator/freezer contained: 1 plastic container of grapes not labeled, dated, or sealed 1 purple/pink/white cake light covered in plastic wrap not labeled, dated or sealed 1 plastic wrapped white cheese that had a resident's name first name on it, no date 1 sealed package of beef snack sticks that had a resident's first name on it, no date 1 container Coffee Ice Cream with a resident's first name on it, no date 1 container Rocky Road Ice cream had a resident's first name on it, no date 1 container Vanilla Bean ice cream had a resident's first name on it, no date An observation on 01/14/2025 at 1:36 PM with the facility's Registered Dietician (RD) revealed the Life Enrichment kitchen residential refrigerator/freezer contained: 1 plastic container of grapes not labeled, dated, or sealed 1 purple/pink/white cake light covered in plastic wrap not labeled, dated or sealed 1 plastic wrapped white cheese that had a resident's name first name on it, no date 1 sealed package of beef snack sticks that had a resident's first name on it, no date 1 container Coffee Ice Cream with a resident's first name on it, no date 1 container Rocky Road Ice cream had a resident's first name on it, no date (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1 container Vanilla Bean ice cream had a resident's first name on it, no date An observation on 01/16/25 08:37 AM revealed the Life Enrichment (activities) kitchen residential refrigerator/freezer contained: 1 pack of white cheese in a plastic wrap labeled with a resident's first name, no date 1 pack of beef meat sticks labeled with a resident's first name, no date In an interview on 01/14/2025 at 1:36 PM with the facility's RD confirmed the Life Enrichment kitchen residential refrigerator/freezer contained: 1 plastic container of grapes not labeled, dated, or sealed 1 purple/pink/white cake light covered in plastic wrap not labeled, dated or sealed 1 plastic wrapped white cheese that had a resident's name first name on it, no date 1 sealed package of beef snack sticks that had a resident's first name on it, no date 1 container Coffee Ice Cream with a resident's first name on it, no date 1 container Rocky Road Ice cream had a resident's first name on it, no date 1 container Vanilla Bean ice cream had a resident's first name on it, no date The RD confirmed the items should have been sealed, labeled with the resident's name, and dated with the date it was placed in the refrigerator/freezer and was not.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47406 Licensure reference number 175 NAC 12-006.17 Based on observations, record reviews, and interviews, the facility failed to ensure Resident 11's catheter drainage bag was off the floor, ensure staff wore gloves when touching Resident 4's catheter tube, use infection control technique when removing cleansing wipes, provide activities of daily living cares for Resident 4 without performing hand hygiene, and failed to clean Resident 2, 22, and 50's nebulizer kits to prevent potential cross contamination. The facility census was 57. Findings are: A. Record review of Resident 4's Clinical Census dated 1/16/25 revealed resident admitted to the facility on [DATE]. Observation of Resident 4 on 01/15/25 at 9:45 AM revealed slightly cloudy urine in catheter tubing. Record review of Resident 4's MDS (Minimum Data Set, a comprehensive assessment of each resident's functional capabilities) dated 12/20/24 revealed: -Section C: BIMS (Brief Interview for Mental Status, a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function) was 13, which indicated that the resident's cognition is intact. Record review of Resident 4's physician's orders dated 1/16/25 revealed: -Macrobid Oral Capsule 100 mg (milligram), Give 100 mg by mouth two times a day for Urinary Tract Infection until 01/21/2025 - Start Date- 01/14/2025. -Change indwelling catheter monthly and PRN(as needed) inability to drain every day shift starting on the 1st and ending on the 1st every month for wound healing. Medical justification/diagnosis: Nonhealing wound related to constant moisture form incontinence Indwelling catheter: Catheter size 16fr/30cc balloon Irrigate as needed. -Catheter cares two times a day related to Type 2 Diabetes Mellitus with Hyperglycemia. Interview on 1/21/25 at 10:50 AM with LPN-B revealed Resident 4's catheter was placed on 12/31/24 to assist with promoting wound healing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of catheter cares for Resident 4 on 1/21/25 at 8:33 AM by NA-C revealed the following. NA-C had gown and gloves on when surveyor arrived in room. NA-C removed resident's pullup (incontinence product) and placed the catheter drainage bag on the foot of bed. NA-C took a cleansing wipe out of the wipes container using the contaminated glove. NA-C wiped left groin with wipe and turned it over and cleansed the right groin, then threw it away in the trash. NA-C took another wipe out of container using the same glove and cleansed underneath meatus opening and perineal care, then threw the wipe away. NA-C took another wipe using the same glove and wiped around catheter tubing at meatus opening and threw wipe away. NA-C took another wipe from container with same glove and cleansed catheter tube from meatus down about 4 inches and threw the wipe away. NA-C assisted putting a new pullup on. NA-C removed [gender] gloves without performing hand hygiene and assisted resident to sit up on edge of bed and put on pants. NA-C placed a gait belt on resident and transferred the resident into wheelchair using walker. NA-C placed the catheter drainage bag under the wheelchair in the privacy bag while touching the catheter tubing without gloves on. NA-C took gown off and pushed resident into bathroom. NA-C touched [gender] own hair. NA-C did not perform hand hygiene. NA-C handed resident a comb, hearing aids and eyeglasses. NA-C took resident to the dining room for breakfast without performing hand hygiene. Interview with interim DON on 1/21/25 at 11:00 am confirmed that staff should not take a cleansing wipe out of the wipe container using a contaminated glove, pick up catheter tubing without gloves, touch their own hair or do other activities of daily living without hand hygiene, and that staff should wash hands when finished with catheter cares and when removing gloves. Interview with NA-C on 1/21/25 at 11:20 AM confirmed NA-C should not take a cleansing wipe out of the wipe container using a contaminated glove, touch their own hair, do other activities of daily living without hand hygiene, and needed to wash hands when finished with catheter cares and when removing gloves. Record review of facility's Handwashing Competency policy dated 8/2013 revealed: When to wash hands: -After touching a resident or handling their belongings -Whenever hands are soiled -After any contact with body fluids -After handling contaminated items (linens/garbage/briefs, etc.) -Before and after gloving -Whenever indicated Record review of facility's Foley Catheter Care Competency policy revised 7/2009 revealed: Procedure Step: 12. Remove gloves and wash hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Enhanced Barrier Precautions (EBP) policy dated 4/12/24 revealed: Definitions: Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs the use of gown and glove use during high contact resident cares. High contact resident care activities include: -Providing hygiene -Dressing -Transferring -Changing briefs or assisting with toileting -Device care or use for central lines including PIIC lines, urinary catheters, feeding tubes, tracheostomy tubes B. Record review of Resident 11's Clinical Census dated 1/16/25 revealed resident admitted to the facility on [DATE]. Observation on 1/15/25 at 1:07 PM of Resident 11's catheter drainage bag tubing had dark yellow urine with sediment. Record review of Resident 11's MDS (Minimum Data Set, a comprehensive assessment of each resident's functional capabilities) dated 12/20/24 revealed: -Section C: BIMS BIMS (Brief Interview for Mental Status, a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function) was 9 which indicates moderate cognitive impairment. -Section H: urinary catheter. Record review of Resident 11's Physician's orders dated 1/16/25 revealed: - Foley catheter coude- replace Foley monthly, catheter cares every shift, gets changed at urology per wife. Record review of Resident 11's Medical Diagnosis dated 1/16/25 revealed Obstructive and Reflux Uropathy (refers to a condition where urine flow is blocked within the urinary tract). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 1/21/25 at 7:45 AM with NA-C for catheter cares for Resident 11 revealed the following. NA-C had gown and gloves on when surveyor entered room. Resident walked to the bathroom with walker and sat on toilet. NA-C took the catheter bag off the walker and placed it on the bare floor. NA-C did not do hand hygiene or apply new gloves. NA-C took a cleansing wipe from the wipes container and was touching the edges of the container, cleansed the right groin and turned the wipe over and cleansed the left groin. NA-C took another wipe from container with the same glove and cleansed resident's genital area. NA-C took a cleansing wipe from the wipe container touching the edges of the container and cleansed catheter tubing from meatus down tubing approximately 4 inches. NA-C placed the catheter bag onto walker and assisted resident with new pull up. NA-C performed hand hygiene with soap and water for 18 seconds. Interview with interim DON on 1/21/25 at 11:00 AM revealed that staff is to keep the catheter bag off the floor, not use contaminated gloves to take cleansing wipes from the wipes container. Interview with NA-C on 1/21/25 at 11:21 AM confirmed [gender] should have kept the catheter bag off the floor and not use the same gloves to take cleansing wipe from the wipe container. Interview with Administrator on 1/21/25 at 1:55 AM revealed that the facility did not have a Catheter policy. Record review of Foley Catheter Care Competency education dated 7/2009 revealed: 10. Check the drainage tubing and bag to ensure proper positioning and drainage. Record review of Resident Handwashing Competency policy dated 8/2013 revealed: When to wash hands: -After touching a resident or handling their belongings -Whenever hands are soiled -After any contact with body fluids -After handling contaminated items (linens/garbage/briefs, etc.) -Before and after gloving -Whenever indicated Record review of Enhanced Barrier Precautions (EBP) policy dated 4/12/24 revealed: Definitions: Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs the use of gown and glove use during high contact resident cares. High contact resident care activities include: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Providing hygiene -Dressing -Transferring -Changing briefs or assisting with toileting -Device care or use for central lines including PICC (peripherally inserted central catheter) lines, urinary catheters, feeding tubes, tracheostomy tubes (a tube inserted into the windpipe through a surgcally created opening in the neck). 48271 C. A record review of the facility's Nebulizer Therapy (medication delivered to the resident's lungs), small volume policy dated November 17, 2017, revealed after the nebulizer treatment, staff were to rinse the nebulizer with sterile water and allow it to air-dry, or discard it after the treatment. A record review of Resident 50's Order Summary Report dated 01/21/2025 revealed the resident had physician orders for: -Ensure O2 tank is off and has O2 for the morning and (REPLACE if empty!) every evening shift for nursing order. -DuoNeb Solution 0.5-2.5 (3) MG/3ML, 1 vial inhale orally via nebulizer four times a day for shortness of breath, prescriber written 11/13/2024. An observation on 01/15/2025 at 8:18 AM revealed Resident 50's nebulizer kit was laying on the bedside table with a residual amount of medication in it and facial oils on the mask. An observation on 01/15/25 at 08:19 AM revealed Resident 50's oxygen concentrator was on in the bathroom and oxygen tubing was hanging over chair in room. Resident 50 was sitting in the dining room. An observation on 01/16/25 at 10:15 AM revealed Resident 50's nebulizer kit was laying on the bedside table with a residual amount of medication in it and facial oils on the mask. An observation on 01/16/25 at 08:30 AM revealed Resident 50's oxygen concentrator was on in the bathroom and oxygen tubing was hanging over chair in room. Resident 50 was sitting in the dining room. An observation on 1/21/25 at 8:51 AM revealed Resident 50's oxygen concentrator was in the bathroom still running and oxygen tubing was draped over the chair. An observation on 1/21/25 at 8:51 AM revealed that Resident 50's nebulizer kit was laying on the bedside table with a residual amount of medication in it and facial oils on the mask. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 1/21/25 at 11:00 AM with the ADON confirmed that the nebulizer mask had residual medication amount in the medicine cup and the medicine cup should be cleaned after each use and it wasn't cleaned after use. ADON confirmed that the oxygen concentrator should be turned off when not in use and it was not turned off when not in use. ADON confirmed that Resident 50 changes from the oxygen concentrator to the oxygen portable tank themselves and places the oxygen tubing over the chair. 45641 D. A record review of the facility's Nebulizer Therapy (medication delivered to the resident's lungs), small volume policy dated November 17, 2017, revealed after the nebulizer treatment, staff was to rinse the nebulizer with sterile water and allow it to air-dry, or discard it after the treatment. A record review of Resident 2's Order Summary Report dated 01/21/2025 revealed the resident had physician orders for: DuoNeb Solution 0.5-2.5 (3) milligrams (MG)/3 milliliter (ML), (Ipratropium-Albuterol)(a medication used to relax the muscle around the tubes in the lungs) 1 vial inhale orally via nebulizer every 6 hours as needed for cough, shortness of breath, prescriber written 05/28/2024 DuoNeb Solution 0.5-2.5 (3) MG/3ML, 1 vial inhale orally via nebulizer three times a day for cough, shortness of breath, prescriber written 01/08/2025 An observation on 01/15/2025 at 11:53 AM revealed Resident 2's nebulizer kit was laying on the bedside table with a residual amount of medication in it and facial oils on the mask. An observation on 01/21/2025 at 10:43 AM revealed Resident 2's nebulizer kit was laying on top of the nebulizer machine on the bedside table with a residual amount of medication in it and facial oils on the mask. An observation on 01/21/2025 at 11:02 AM with the facility's Assistant Director of Nursing (ADON) revealed Resident 2's nebulizer kit was laying on top of the nebulizer machine on the bedside table with a residual amount of medication in it and facial oils on the mask. In an interview on 01/21/2025 at 11:02 AM, the facility's ADON confirmed Resident 2's nebulizer kit was laying on top of the nebulizer machine on the bedside table with a residual amount of medication in it and facial oils on the mask and it should have been cleaned after the treatment. E. A record review of the facility's Nebulizer, small volume policy dated November 17, 2017, revealed after the nebulizer treatment, staff was to rinse the nebulizer with sterile water and allow it to air-dry, or discard it after the treatment. A record review of Resident 22's Order Summary Report dated 01/21/2025 revealed the resident had physician orders for: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DuoNeb Solution 0.5-2.5 (3) MG/3 ML, 1 vial inhale orally via nebulizer every 6 hours as needed for cough, shortness of breath, prescriber written 05/23/2024 DuoNeb Solution 0.5-2.5 (3) MG/3ML, 1 vial inhale orally via nebulizer two times a day for cough, shortness of breath, mucus, prescriber written 09/27/2024 An observation on 01/15/2024 at 10:01 AM revealed Resident 22's nebulizer kit was laying on the bed with a small amount of medication remaining in the cup and facial oils on the mask. An observation on 01/21/2025 at 10:51 AM revealed Resident 22's nebulizer kit was draped over the oxygen concentrator (a machine used to purify oxygen) with a residual amount of medication in the cup. An observation on 01/21/2025 at 10:57 AM with the ADON revealed Resident 22's nebulizer kit was draped over the oxygen concentrator with a residual amount of medication in the cup. In an interview on 01/21/2025 at 10:57 AM, the ADON confirmed Resident 22's nebulizer kit was draped over the oxygen concentrator with a residual amount of medication in the cup and was not clean. The ADON's expectation was after the nebulizer treatment, the staff would clean, dry, and place the nebulizer kit in a bag.

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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. 47406 Licensure reference number 175 NAC 12.006.04(B)(ii)(1) Based on record reviews and interviews the facility failed to ensure staff had the required 12 hours of in-service training for 2 nursing assistants (2 out of 5 sampled) staff. This had the potential to affect all residents in the facility. The facility census was 57. Findings are: Record review of NA-D's Relias (a company that provides healthcare training/education) training hours revealed 8.59 hours of education for the last year (2024). Record review of NA-E's Relias training hours revealed 11.05 hours of education for the last year (2024). Record review of employee names with their hire date revealed NA-D's hire date was 7/11/13 and NA-E's hire date was 12/17/22. Record review of employee's education training for the past year, found NA-D and NA-E did not have the required 12 hours of education yearly. Interview with the IP/SD (Infection Preventionist/Staffing Development) on 1/21/25 at 2:32 PM revealed the facility's year for nurses' aides 12-hour education is from January 1st to December 31st. Interview with the IP/SD on 1/22/25 at 11:04 AM confirmed that NA-D and NA-E did not have 12-hours of education training completed for 2024.