

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  285280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2024
NAME OF PROVIDER OR SUPPLIER  The Lighthouse at Lakeside Village		STREET ADDRESS, CITY, STATE, ZIP CODE  17600 Arbor Street Omaha, NE 68130	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17285</b></p> <p>Licensure Reference Number 175 NAC 12-006.09B</p> <p>Based on record review and interview, the facility failed to ensure that the Minimum Data Set (MDS, a mandatory comprehensive assessment tool used for care planning) was accurate and coded to reflect Hospice [End of Life] Services for Resident 1 and no intravenous (IV) fluid use for Resident 10. The sample size reviewed was 13. The facility census at the time of the survey was 31.</p> <p>Findings are:</p> <p>A.</p> <p>Record review of the Clinical Census Report revealed that Resident 1 was admitted to the facility on [DATE]. Resident 1 was admitted to Hospice services on 1/19/22</p> <p>Record review of Resident 1's Comprehensive Care Plan [CCP, a interdisciplinary comprehensive plan that detailed care of the resident] dated 1/8/24 revealed that Resident 1 had an overall decline in health and had a terminal prognosis related to advanced</p> <p>Alzheimer's disease.</p> <p>Record review of Resident 1's MDS dated [DATE] revealed diagnoses that included Non Alzheimer's Dementia. The MDS revealed that Resident 1 was severely cognitively impaired with a Brief Interview for Mental Status [BIMS, a brief screener that aids in detecting cognitive impairment] score of 00 and was dependent on staff for all activity of daily living needs. Section Section O, K1 revealed that Hospice was not marked for Resident 1 on the MDS.</p> <p>Interview on 04/03/24 at 2:00 PM with the Director of Nursing [DON] confirmed that the Resident 1 had been on Hospice for a long time, since January of 2022, and that the MDS was coded incorrectly and Hospice should have been marked while a resident.</p> <p>B.</p> <p>Record review of Resident 10's Clinical Census Report revealed that Resident 10 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident 10's admission MDS dated [DATE] revealed that no BIMS score had been identified for Resident 10. The MDS revealed diagnoses that included Alzheimer's Disease and vascular dementia and that Resident 10 was dependent with all activities of daily living. Section K0520 of the MDS revealed that Resident 10 had received IV fluids as a resident and not as a resident, both of which were marked on the MDS.</p> <p>Interview on 04/03/24 at 10:06 AM with the Assistant Director of Nursing [ADON] confirmed that the MDS was coded incorrectly and that Resident 10 did not receive IV fluids while as a resident in the facility. The ADON stated that Resident 10 did receive IV fluids while in the hospital prior to admission but the fluids had been discontinued at the hospital.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>49164</p> <p>Licensure Reference Number 175 NAC 12-006.10D</p> <p>Based on observation, record review and interview; the facility staff failed to ensure it was free of a medication error rate of 5% or greater. Observations were made of 25 medications administered which revealed 2 errors resulting in an error rate of 8%. The medication errors affect 2 (Resident 8 and 25) of 3 sampled residents. The facility staff identified a census of 31.</p> <p>Findings are:</p> <p>Record Review of Resident 8's Medication Summary printed on 04-03-2024 revealed an order for mucous relief 600 mg by mouth twice a day. Do not crush.</p> <p>An observation on 04-03-2024 at 7:40 AM of Care Partner (CP)-B administering medication for Resident 8 revealed CP-B prepared mucous relief 600 mg by placing the medication into a med pouch, crushing medication and then mixing the medication in applesauce. CP-B took the prepared medication and administered it to Resident 8.</p> <p>An interview with CP-B on 04-03-2024 at 7:55 AM confirmed that CP-B should not have crushed the mucous relief tablet.</p> <p>An interview with Registered Nurse (RN)-E on 04-03-2024 at 1:37 PM confirmed a medication error occurred because the mucous relief 600 mg medication should not have been crushed.</p> <p>Record Review of the facility Policy-Medication Administration dated 03-08-2024 under Crushing of Medication revealed the follow information:</p> <ol style="list-style-type: none"> <li>1. Only medications approved by the manufacturer and pharmacy, and which have a provider order are crushed.</li> <li>2. Each medication to be crushed should have this instruction on the Medication Administration Record.</li> <li>3. If a medication cannot be crushed and the resident cannot take medication whole, alternatives include: <ul style="list-style-type: none"> <li>-Pill can be administered in applesauce or food serving with similar consistency.</li> <li>-Pharmacy can dispense in liquid form.</li> <li>-Order can be requested from provider for different medication with the same class of drugs can be crushed or supplied in liquid form.</li> </ul> </li> </ol> <p>B. Record Review of Resident 25's Medication Summary printed on 04-03-2024 revealed an order for Tylenol 500 mg take 2 tablets by mouth twice a day.</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation on 04-03-2024 at 8:00 AM of CP-B preparing medications for Resident 25 revealed CP-B began preparing medications to be administered and noted that Tylenol 500 mg take 2 tablets by mouth twice a day was unavailable.</p> <p>An interview with CP-B on 04-03-2024 at 12:41 PM revealed RN-E was notified of the Tylenol 500 mg tablets for Resident 25 was unavailable.</p> <p>An interview with the Director of Nursing (DON) on 04-03-2024 at 1:31 PM confirmed that a medication not given is an omission medication error.</p> <p>An interview with RN-A on 04-04-2024 at 11:02 AM confirmed that the facility had Tylenol 500 mg in stock and it was not given on 04-03-2024 at 8:00 AM to Resident 25.</p> <p>Record Review of the facility Policy-Medication Administration dated 03-08-2022 revealed Policy Statement: It is the Care Communities policy to store and administer medications and treatments in a safe and effective manner. The Procedure section revealed the following:</p> <p>Professional standards of medication administration are followed.</p> <ul style="list-style-type: none"> <li>-6 rights of medication administration-right resident, drug, dose, time, route, documentation.</li> <li>-Resident is observed swallowing oral medication.</li> <li>-Documentation is completed before setting up medication for the next resident.</li> </ul>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>49164</p> <p>175 NAC 12-006.17</p> <p>Based on observation, record review and interview the facility failed to ensure linens were not exposed to cross contamination as evidenced by placing washcloths into the sink and failed to perform hand hygiene and glove changes during personal cares for 2 residents (Resident 2 and 20) of 7 sampled residents observed. The facility identified census was 31.</p> <p>Findings are:</p> <p>Record Review of the facility policy Hand Hygiene and Glove Usage dated 03-09-2021 revealed the following:</p> <p>-Policy Statement: It is the policy of the facility that hand hygiene for residents and staff will be performed to avoid the spread of pathogens. The use of gloves is to protect from potential exposure to blood, body fluids and/or other potentially infectious material with providing care. Gloves do not eliminate the need for hand hygiene. Hand Hygiene is required before putting on gloves and after removing gloves.</p> <p>-Under the section identified as Definitions revealed the following:</p> <p>-Hand Hygiene-Clean hands at appropriate times:</p> <p>-Before and after providing care to or handling resident belongings</p> <p>-After removing gloves.</p> <p>-After handling soiled linen or equipment.</p> <p>-Anytime you notice hands are soiled</p> <p>Glove Usage-Should be worn and changed at appropriate times:</p> <p>-Between Residents</p> <p>-When going from one contaminated area to another on a resident.</p> <p>-When going from a contaminated area/task to a clean area/task on a resident.</p> <p>-After completing a dirty task before going to a clean task.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A. An observation on 04-03-2024 at 9:53 AM of Nursing Assistant (NA)-D providing a shower for Resident 20 revealed NA-D had 5 washcloths in the sink soaking in soap and water, NA-D performed hand hygiene with Alcohol Based Hand Rub (ABHR) and applied clean gloves. With gloved hands, NA-D took a washcloth from the sink and washed Resident 20's face, then tossed the washcloth in a plastic bag. NA-D took another washcloth from the sink and washed Resident 20's feet then discarded washcloth in plastic sack. NA-D using a mechanical lift raised Resident 20 in the mechanical lift to be transferred from the toilet to shower chair. NA-D took another washcloth and washed Resident 20's peri area and buttocks and discarded the washcloth in the plastic bag. NA-D with the same soiled gloved hands repositioned resident in shower chair and fastened a seat belt. NA-D with the same soiled gloves took another washcloth out of the sink basin and washed Resident 20's back, arms, chest and abdomen and discarded the wash cloth in a plastic bag.</p> <p>An interview with NA-D on 04-03-2024 at 10:30 AM revealed that NA-D did not remove gloves, perform hand hygiene and apply clean gloves after washing Resident 20's peri area and buttocks and before washing other areas of Resident 20's body. NA-D further confirmed washcloths were placed in the sink for use with Resident 20</p> <p>An interview with RN-E on 04-04-2024 at 7:15 AM confirmed the placement of washcloths into the sink could cause cross contamination.</p> <p>B. An observation on 04-04-2024 at 7:40 AM of Care Partner (CP)-C providing care for Resident 2 revealed CP-C went to the bathroom with gloved hands, picked up Resident 2's denture cup and rinsed the dentures under running water. CP-C applied adhesive to the dentures, went to Resident 2's bedside and inserted the dentures into Resident 2's mouth. CP-C without changing the gloves lowered Resident 2's head of the bed and unfastened Resident 2's brief. CP-C went into the bathroom and obtained a bottle of bath soap and on the way back to the bedside CP-C used Alcohol Based Hand Rub (ABHR) on (gender) gloved hands and then continued to change Resident 2's brief.</p> <p>An interview with CP-C on 04-04-2024 at 8:04 AM confirmed that ABHR was used on gloved hands.</p> <p>An interview with RN-E at 8:10 AM on 04-04-2024 confirmed that ABHR should never be used on gloved hands, the gloves should have been removed and hand hygiene performed on bare hands.</p>