STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285284	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avera Creighton Care Centre	1603 Main Street Creighton, NE 68729

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 51391 Licensure Reference Number 175 NAC 12-006.12(D)(i)(2) Based on observation, record review and interview; the facility failed to account for narcotic medications according to the facility policy. This had the potential to affect Residents 6, 26, 3, 21, 8 and 17. The total sample size was 13 and the facility census was 34. Findings are: Review of the facility policy Long Term Care Controlled Substances with a revision date of 7/24 revealed the following: -all scheduled controlled medications were to be kept in double locked locations on the medication cart with a controlled substance record (form used to document the time a narcotic medication was administered, the number of pills remaining and the staff's initials) to be stored on each cart. -the controlled substance record was to identify a resident's name, room number, their physician, and the medication order including strength and the route used for administration of the medication. Observation of a medication pass on 9/19/24 at 12:05 PM revealed the following: -Registered Nurse (RN)-K administered one tablet of Oxycodone/APAP 7.5/325 (narcotic medication for pain) milligrams (mg) to Resident 17. -RN-K documented the administration of the Oxycodone on the controlled substance record however, the count identified on the record did not match the number of pills remaining in the Oxycodone cassette. -after determining the count was incorrect, RN-K proceeded to document the Oxycodone which had been given that morning at 8:00 AM (4 hours earlier) to ensure the count was now correct. Observation on 9/19/24 at 12:30 PM, revealed Licensed Practical Nurse (LPN)-C administered Tramadol (narcotic medication for pain) 50 mg one half tablet to Resident 6. LPN-C indicated the controlled substance record was not available on the medication cart, and LPN-C further indicated staff would update the controlled substance log later when the medication pass was completed. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 6's controlled substance record on 9/19/24 at 12:53 PM revealed a count of 19 Tramadol. Observation of the resident's medication cassette revealed there were only 18 pills remaining. LPN-C verified the count on the resident's controlled substance record should have been 18. Review of the controlled substance records and observations of the medication carts on 9/19/24 at 1:10 PM for the 100 and the 200 hallways revealed the following: -Resident 21's record for Tramadol 50 mg, revealed a count of 2 pills. Observation of the resident's medication cassette for Tramadol 50 mg revealed only 1 pill remained. RN-K verified the count for the Tramadol 50 mg should be 1, and the dose which had been administered at 11:00 AM had not been signed out. -Resident 8's record for Tramadol 100 mg, revealed a count of 16. However, the medication cassette for the resident's Tramadol only contained 15 pills. RN-K verified the count for the Tramadol should have been 15 as the dose administered at 8:33 AM was not signed out. -Resident 3's record for APAP/Codeine (narcotic medication use for pain control) 300-30 mg revealed a count of 31. Observation of the medication cassette for the APAP/codeine revealed only 30 pills remained. RN-K confirmed the count for APAP/Codeine 300-30 mg should have been 30, as the dose administered at 11:17 AM had not been signed out. -Resident 26's record for Tramadol 50 mg revealed a count of 10. Review of the resident's medication cassette for the Tramadol revealed 9 pills remained. LPN-C verified the count for the Tramadol 50 mg should have been 9 but LPN-C had failed to document the last dose of Tramadol the resident had received. -Resident 6's record for Tramadol 50 mg one half tab, revealed a count of 19, LPN-C verified the count for the Tramadol should have been 18 but the dose administered at 12:30 PM had not been signed out. Interview with the Director of Nursing on 9/19/24 at 1:35 PM verified staff were to sign and update the controlled substance record when narcotic medications were administered to ensure the resident's narcotic counts were correct to avoid discrepancies and/or medication errors.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 Licensure Reference Number 175 NAC 12-006.17 Based on observation, record review, and interview; the facility failed to perform hand hygiene (hand washing using soap and water or an alcohol based hand rub (ABHR) at the required intervals and to utilize the required personal protective equipment (PPE-can include items such as gowns, gloves, masks, goggles and/or face shields) during the provision of room tray meal service to prevent the potential spread of COVID-19. This practice had the potential to affect all facility residents. The total sample size was 17 and the facility census was 34. Findings are: A. Record review of the facility policy Transmission-Based Precautions (Isolation) with a revision date of 10/25/23 revealed residents who had been placed on Airborne Respirator Precautions and Contact Precautions required use of the following PPE before entering the resident's room: -fit tested N95 mask (a respiratory protective device designed to achieve a very close facial fitting and very efficient filtration of airborne particles), -eye protection (face shield or goggles), -gown, and -gloves. B. Record review of the facility policy Standard Precautions, Hand Hygiene with a revision date of 11/21/23 revealed staff were to perform hand hygiene when hands were visibly soiled, between resident contacts, after handling contaminated objects, before applying and removing PPE including gloves, before performing resident care procedures, after handling items potentially contaminated with blood, body fluids, secretions, and excretions and whenever in doubt. The policy further indicated the use of gloves would not replace hand hygiene. If a task required use of gloves, perform hand hygiene prior to putting on gloves and immediately after removing gloves. C. Observation of the noon room-tray meal service on 9/18/24 from 12:29 PM to 12:45 PM revealed the following: -Dietary Aide (DA)-A entered the 100 corridor from the kitchen wearing a surgical mask and propelled a cart which contained 5 room trays and a face shield which was hanging on the side of the cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-DA-A position the cart outside of room [ROOM NUMBER]. A sign on the room door indicated the residents in the room were on Airborne Respirator Precautions and Contact Precautions. DA-A performed hand hygiene and placed on a disposable gown and gloves. Without removing the surgical mask or putting on an N95 mask and/or eye protection, DA-A entered the resident's room with a room tray. -DA-A exited room [ROOM NUMBER] and removed their gloves and gown and performed hand hygiene. -DA-A still without changing or removing the surgical mask, entered resident room [ROOM NUMBER] who was not on any transmission-based precautions. DA-A exited the room and without completing hand hygiene continued to propel the cart in the corridor. -DA-A positioned the cart outside of room [ROOM NUMBER] which had a sign indicating the residents were on Airborne Respirator Precautions and Contact Precautions. DA-A placed on clean gloves and a gown and without changing the surgical mask or using an N95, put on the face shield which had been hanging from the cart. DA-A entered the room with a room tray. -DA-A left the resident's room, removed the face shield and without cleaning it, placed it back on the food cart with the remaining meal trays. DA-A removed gown and gloves and completed hand hygiene and continued wearing the same surgical mask. -DA-A returned to room [ROOM NUMBER] to provide a second meal tray to the residents in the room. DA-A finally removed the surgical mask and placed it directly on the handrail outside of the resident's room then placed on a clean N95 mask. Without further hand hygiene, DA-A placed on a clean gown and gloves. Without use of the face shield or eye protection, DA-A re-entered room [ROOM NUMBER]. -DA-A exited the resident's room, removed the N95, gown and gloves, completed hand hygiene, removed the surgical mask from the handrail and placed it back on their face before leaving the corridor and returning to the kitchen. Observations of the breakfast meal room tray pass on 9/23/24 at 8:04 AM revealed the following: -DA-B entered the 100-corridor wearing an N95 mask and propelled a food cart which contained a face shield hanging from the cart. -DA-B performed hand hygiene and placed on a gown and gloves and entered room [ROOM NUMBER] without wearing the face shield or eye protection. -DA-A exited the room and removed gloves and gown. DA-A failed to complete hand hygiene before putting on a new gown and gloves as well as the face shield and re-entering room [ROOM NUMBER] with a second room tray. Interview with DA-B on 9/19/24 at 9:30 AM revealed the dietary staff had not received any additional or recent training regarding use of PPE with a COVID-19 outbreak. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with the Director of Nursing (DON) on 9/19/24 at 2:57 PM confirmed any staff entering/exiting a room for a resident on Airborne Respirator Precautions and Contact Precautions were to wear an N95 mask, face shield or goggles, a gown, and gloves. Upon exiting a room, staff were to remove eyewear and to clean with a disinfectant wipe, to remove and discard the N95 mask then replace with a new mask and remove gown and gloves. In addition, staff were to complete hand hygiene before putting on and after removing PPE.