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	12/03/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.18(B)(D) Based on observation, record review and interview; the facility failed to complete hand hygiene at appropriate intervals to prevent potential infection/cross contamination during the provision of cares for Resident 1, 3, 12, 20, 28 and 36. The total sample size was 12 and the facility census was 37. Findings are:A. Review of the facility policy Hand Hygiene with a revision date of 11/20/25 revealed the facility considered Hand Hygiene to be the primary means of preventing the transmission of infection. -Hand hygiene with either soap and water or Alcohol Based Hand Sanitation (ABHR) was to be completed before touching a resident, before a clean procedure or handling an invasive medical device, after contact with potential for body fluid or contaminated surfaces, after touching a resident or the resident's immediate environment, and after removing gloves. B. Review of the facility policy General Standard Precautions with a revision date of 5/2023 revealed the following: -Standard Precautions synthesized the major features of Universal Precautions (Blood and Body Fluid Precautions) (designed to reduce the risk of transmission of bloodborne pathogens) and Body Substance Isolation (designed to reduce the risk of transmission of pathogens from moist body substances) and applied then to all patients receiving care. This applied to blood, body fluids, non-intact skin, and mucous membranes). -It was the facility policy to use good hand hygiene techniques to prevent the transmission of pathogens and hand washing was recommended whenever hands were visibly soiled and the use of ABHR (alcohol-based hand sanitizer was used when the hands were not visibly soiled or had not come in contact the blood or spore forming pathogens. -Gloves were used as an adjunct to, not a substitute for hand hygiene, and gloves were to be changed between patients and when moving from a contaminated to clean procedure on the same patient. C. Review of Resident 28's Minimum Data Set (MDS) (federally mandated comprehensive assessment used to develop resident care plans) dated 9/24/25 revealed the resident required assistance with toileting cares, dressing cares, transfers from chair and toilet and had disorganized thinking continuously. The resident had a diagnosis of Non-Alzheimer Dementia and Anxiety. Review of (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 28's Care Plan revealed that the resident was dependent on staff for transfers, dressing, toilet use and personal hygiene and required maximal assistance with bed mobility. During an observation of provision of cares on 12/2/25 at 9:00 AM revealed Nursing Assistant (NA)-G completed the following cares without washing hands: -NA-G had clean gloves on, transferred Resident 28 from wheelchair to the bathroom with use of a mechanical lift, pulled resident pants and incontinent brief down, sat resident on the toilet (did not remove gloves or wash hands). NA-G then rearranged blankets on the bed and touched face and hair with gloved hand, stood resident up with use of mechanical lift, cleaned perineal area and buttocks, pulled up incontinent brief and pants (did not change gloves or wash hands) and then assisted resident to bed. NA-G removed soiled gloves and exited the room (handwashing was not completed.) D. Review of Resident 12's MDS dated [DATE] revealed the resident had an indwelling catheter and an ostomy, used a wheelchair for mobility, required assistance with toileting cares, dressing cares and transfers from bed and chair. Resident 12 had a diagnosis of Paraplegia (paralysis of the lower half of the body) and had limited range of motion to arms and legs bilaterally. Review of Resident 12's Care Plan revealed that the resident was to receive catheter cares (cleaning of the catheter and insertion site) every 8 hours and that resident wore an ostomy appliance and was to be changed on Tuesday and as needed due to leaking. During an observation of provision of cares on 12/2/25 at 9:25 AM revealed NA-G and NA-H completed the following cares without washing hands: -NA-G and NA-H completed foley catheter cares on Resident 12, removed soiled gloves and then applied clean gloves (no handwashing when gloves changed). NA-G and NA-H then completed colostomy cares (removed the colostomy bag and cleaned around the stoma) due to colostomy bag leaking, removed soiled gloves and then applied clean gloves, applied the new ostomy bag and removed the soiled gloves. (No handwashing was identified between glove change) and NA-G did not wash hands after cares were completed and before exiting the room. E. Review of weekly skin measurement documentation for Resident 1 revealed that Resident 1 had a pressure ulcer to right facial cheek and an open area to right side of the coccyx. Pressure ulcer to the right cheek was washed with wound cleanser and covered with a band-aide for protection. Open area to the right side of the coccyx was washed with wound cleanser and covered with a dressing. During an observation of provision of cares on 12/2/25 at 10:05 AM revealed the following: -Registered Nurse (RN)-I applied clean gloves, removed a band-aide from Resident 1's right facial cheek, cleansed the wound with wound cleanser and applied a new band-aide to the area, then removed soiled gloves and applied hand sanitizer to hands. (Did not change gloves or wash hands between soiled wound dressing being removed and a clean wound dressing being applied.) RN-I applied clean gloves, removed an adhesive dressing from Resident 1's right buttock area, cleansed the area with wound cleanser and applied clean dressing to the area. (Did not change gloves or wash hands between soiled wound dressing being removed and a clean wound dressing being applied.) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. An interview on 12/2/25 at 2:55 PM with the Director of Nursing (DON) confirmed the following: -NA-G should have removed dirty gloves and washed hands after Resident 28 was assisted to/from the bathroom and should have washed hands prior to exiting the room after cares were completed. - NA-G and NA-H should have washed their hands after dirty gloves were removed and before clean gloves were applied when catheter and colostomy cares were completed and before exiting the room when Resident 12's cares were completed. -RN-I should have washed hands and changed gloves between the dirty wound dressing removed and the clean wound dressing applied. G. Review of Resident 20's MDS dated [DATE] revealed the resident had mild cognitive impairment; had diagnoses of Right Pelvis Fracture, Dementia and Anxiety; and required assistance with toileting, dressing and transfers. Review of Resident 20's Care Plan, last reviewed 10/28/25 revealed the resident required assistance with dressing, mobility and transfers and was dependent with dressing the lower half of the body and taking off and putting on footwear. On 12/2/25 at 10:30 AM an observation during the provision of cares for Resident 20 revealed NA-E was putting on gloves when this surveyor entered the resident room. NA-E ambulated the resident to the bathroom. At the toilet, NA-E pulled the residents pants and pull-up down and then the resident sat down on the toilet. NA-E removed their gloves and no hand hygiene was observed to be completed. When the resident was finished, NA-E applied clean gloves (no hand hygiene was observed) and performed perineal cares on the resident. NA-E continued to wear the soiled gloves and pulled the resident's pull-up and pants up. NA-E removed their gloves and no hand hygiene was observed. NA-E ambulated the resident to their recliner and NA-E did perform hand hygiene upon exiting the room. H. Review of Resident 36's MDS dated [DATE] revealed the resident had severe cognitive impairment; was dependent with oral hygiene, toileting, dressing and personal hygiene; and had diagnoses of Heart Disease and Dementia. Review of Resident 36's Care Plan initiated 11/11/25 revealed the resident had impaired cognition and required assistance with bed mobility, transfers, dressing, toileting and hygiene. On 12/2/25 at 1:50 PM an observation of provision of cares revealed NA-E entered Resident 36's room and no hand hygiene was observed to be completed. NA-E put on clean gloves. NA-E transferred the resident to the bathroom and NA-E pulled the resident's pull-up and pants down and assisted the resident to sit on the toilet. NA-E removed their gloves, and no hand hygiene was observed to be completed. When the resident was done, NA-E applied a pair of clean gloves without performing hand hygiene and provided perineal cares on the resident. NA-E continued to wear the same pair of soiled (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gloves and pulled the resident's pull-up and pants up. NA-E, still wearing the same pair of soiled gloves, assisted the resident to ambulate to the wheelchair. NA-E had touched the resident's clothing, the walker and the wheelchair while wearing the same pair of soiled gloves. After the resident sat down, NA-E removed their gloves. No hand hygiene was observed to be completed. The NA-E exited the resident room and no hand hygiene was observed to be completed. I. An interview with the DON on 12/2/25 at 2:45 PM confirmed hand hygiene should be completed after removing gloves and when exiting resident rooms. J. During an observation of toileting/incontinence cares on 12/2/25 at 8:33 AM, NA-E and NE-F entered Resident 3's room and without washing or sanitizing hands put on a clean pair of gloves. Staff transferred the resident into the bathroom with the mechanical sit-to-stand lift. The resident's slacks and disposable incontinent brief were lowered and the resident was observed to be involuntary of feces. Without cleansing the resident's buttocks, the resident was placed onto the toilet. NA-E and NA-F removed soiled gloves but failed to complete hand hygiene before putting on clean gloves. The resident was lifted from the toilet with the mechanical lift and NA-F used multiple pre-moistened cleansing cloths to remove feces from the resident's buttock and the toilet seat. When hygiene cares were completed, NA-F removed soiled gloves but failed to complete hand hygiene before putting on a clean pair of gloves. The resident was assisted out of the bathroom, and into the wheelchair. NA-F adjusted the resident's positioning in the wheelchair, placed foot pedals on the chair, and attached the resident's fall alarm to the resident's clothing before removing gloves and performing hand hygiene. The resident was assisted out of the resident's room to the commons area. During an interview on 12/2/25 at 9:43 AM, NA-E and NA-F confirmed they did not complete hand hygiene when they entered Resident 3's room and before putting on clean gloves. In addition, NA-F confirmed after completing incontinence cares on the resident, NA-E should have performed hand hygiene after removing soiled gloves and before putting on clean gloves.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(E)Based on record review and interview; the facility failed to ensure Resident 2's Post Traumatic Stress Disorder (PTSD-a mental health condition caused by extremely stressful or terrifying events. Symptoms may include flashbacks, nightmares, severe anxiety and uncontrolled thoughts) triggers and interventions to address triggers were identified in the resident care plan. The total sample size was 18 and the facility census was 37. Findings are: Review of Resident 2's Minimum Data Set (MDS- federally mandated assessment used in the development of resident care plans) dated 10/1/25 revealed the resident was admitted [DATE] with diagnoses of anxiety, depression, lung disease, and heart failure. The following was assessed regarding Resident 2:-cognitively intact but had episodes of disorganized thinking. -behaviors which included delusions, resistance with cares and verbal behaviors directed at others. -current medications included an antidepressant, anticonvulsant (used to prevents seizures), and an opioid (used to help manage pain). Review of Resident 2's current Care Plan dated 5/5/25 revealed the resident exhibited verbal behaviors towards the staff and was resistive to cares. The resident was delirious at times and had made comments about being held prisoner at the facility against the resident's will. The resident was impulsive at times. Interventions included the following:-monitor use of Duloxetine (antidepressant medication which can also be used to treat anxiety) 30 milligrams (mg) twice a day.-monitor use of Trazadone (antidepressant medication also used to treat insomnia) 50 mg in the evening. -allow time to verbalize concerns and determine if something was bothering the resident. -help to solve problems as needed. -reorient as needed.-reapproach as needed as will calm self when left alone. Review of a Nursing Progress Note dated 10/1/25 at 9:21 AM revealed the resident was seated in the bathroom. The resident was tearful and indicated a need for help. The resident was stuck and needed help getting up. The resident was tearful and anxious with increased shortness of breath. The resident reported having PTSD and stated the ex-spouse used to lock the resident into the bathroom or a closet. Sometimes being in the bathroom increased the resident's anxiety and the resident would freak out. Review of a Psychiatric Progress Note dated 11/21/25 revealed the resident was seen by the Psychiatric Mental Health Nurse Practitioner (PMHNP) to follow up management of the resident's PTSD, depression, anxiety, insomnia, and nightmare disorder. The resident reported appetite varied, was only sleeping 1-3 hours per night with nightmares most nights, some visual hallucinations, and flashbacks from time to time. A new order was received for Prazosin (medication used to treat high blood pressure and/or to help with PTSD related nightmares) 1 mg at bedtime. To be seen again in 1-2 months. Further review of the resident's current Care Plan revealed no evidence the resident's diagnosis of PTSD was identified with potential triggers and interventions to address the triggers. An interview with the Director of Nursing (DON) on 12/3/25 at 9:53 AM confirmed the resident's current care plan did not list potential triggers for Resident 2's PTSD and no interventions were in place to prevent potential triggers.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09(I)Based on observation, record review, and interview; the facility failed to implement assessed interventions to prevent a potential injury from a hot liquid spill for Resident 32. The facility census was 37 and the sample size was 1.Findings are:A. Review of the facility policy Hot Liquids Assessment and Spill Occurrences with a revision date of 11/2025 revealed all residents were to be assessed for risk of injury from consuming hot liquids, including physical capabilities and contributing factors. Residents were to be identified utilizing a Hot Liquid Risk Assessment tool. The assessment was to be completed on admission, annually, with significant changes and with any hot liquid spill. Residents considered at risk or that had a score of 6-9 on the assessment were to wear one lap cover and one apron (one over their lap and one on their chest) and will have an orange name tag on their dining room table. Risk for hot liquids and interventions used were to be included in the residents' care plan. B. Review of Resident 32's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 10/14/25 revealed the resident was admitted [DATE] with diagnoses of anemia, Alzheimer's disease, and depression. The MDS further revealed the resident had severe cognitive impairment; required setup and clean-up assistance with eating and drinking, and required moderate assistance with personal hygiene.Review of a Hot Liquid Risk screening form completed 6/5/25 revealed a score of 4 which indicated the resident was at low risk for a hot liquid spill. The form indicated the resident was consuming hot liquids, had an intention type tremor (a specific type of tremor that develops as you try to do a purposeful movement), had a diagnosis of dementia with poor decision making abilities and the resident required assistance with eating. The resident was to wear one cover at all times when in the dining room and when consuming hot liquids. Review of a Nursing Progress Note dated 7/7/25 at 3:00 PM revealed the staff were summoned to the dining room and were notified Resident 32 had a hot liquid spill. The resident was attending Bingo and the Activity Director gave the resident a cup of hot water and a snack. The Activity Director failed to place a protective cover on the resident before serving the hot water. The resident had some pinkness to the left side of the resident's neck and down the middle of the resident's chest. No blisters or skin breakdown were observed. Review of a Hot Liquid Risk screening form dated 7/7/25 revealed the resident now scored a 6 indicating the resident's risk for a hot liquid spill had increased. New interventions were developed which included the resident was to wear x2 vinyl clothing protectors in the dining room (one around the neck and one across the resident's lap) and an orange name tag was to be added to the resident's dining room table. Staff were to fill the resident's cup only half full when hot liquids when served. Observations of Resident 32 in the facility dining room revealed the following:-12/2/25 at 7:40 AM, the resident was seated in a wheelchair positioned at the dining room table. The resident was served the breakfast meal which consisted of a bowl of hot cereal, toast with jelly, one strip of bacon and 1/2 of a banana. The resident was observed to have a slight tremor to hands when attempting to eat/drink. In addition, the resident pushed the wheelchair slightly away from the table and had to reach for items as the resident was eating/drinking. Resident 32 was wearing only 1 clothing protector around the resident's neck and did not have the second clothing protector across the resident's lap. -12/2/25 at 12:45 PM the resident was seated in the dining room at the resident's table in a wheelchair. The resident was served a bowl of beef and barley soup. The resident was wearing only one clothing protector which had been placed around the resident's neck. The second clothing protector had not been positioned across the resident's lap. During an interview on 12/2/25 at 12:59 PM the Director of Nursing confirmed the resident did have a hot liquid spill on 7/7/25. The resident had previously been assessed at low risk for a hot liquid spill and had an intervention in place to wear a clothing protector around the resident's neck in the dining room to (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	protect the resident from a potential hot liquid spill. The residents' risk for a hot liquid spill was then reassessed and additional interventions were developed to protect the resident. Resident 32 was always to wear two of the clothing protectors in the dining room. The resident was to wear one around the resident's neck and one was to be placed across the resident's lap.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(vi)Based on record review and interview; the facility to ensure residents received trauma informed care related to diagnosis of Post Traumatic Stress Disorder (PTSD-a mental health condition caused by extremely stressful or terrifying events. Symptoms may include flashbacks, nightmares, severe anxiety and uncontrolled thoughts) and to identify potential triggers as well as resident preferences to prevent and/or mitigate re-traumatization for 1 (Resident 2) of 1 sampled resident. The facility census was 37. Findings include:Review of Resident 2's Minimum Data Set (MDS- federally mandated assessment used in the development of resident care plans) dated 10/1/25 revealed the resident was admitted [DATE] with diagnoses of anxiety, depression, lung disease, and heart failure. The following was assessed regarding Resident 2:-cognitively intact but had episodes of disorganized thinking. -behaviors which included delusions, resistance with cares and verbal behaviors directed at others. -current medications included an antidepressant, anticonvulsant, and an opioid. Review of Resident 2's current Care Plan dated 5/5/25 revealed the resident exhibited verbal behaviors towards the staff and was resistive to cares. The resident was delirious at times and had made comments about being held prisoner at the facility against her will. The resident was impulsive at times. Interventions included the following:-monitor use of Duloxetine (antidepressant medication which can also be used to treat anxiety) 30 milligrams (mg) twice a day.-monitor use of Trazadone (antidepressant medication also used to treat insomnia) 50 mg in the evening. -allow time to verbalize concerns and determine if something was bothering the resident. -help to solve problems as needed. -reorient as needed.-reapproach as needed as will calm self when left alone. Review of Resident 2's Nursing Progress Notes revealed the following:-8/29/25 at 4:09 AM the resident had been crying out for help. The resident was tearful and reported everyone told me yesterday all day that I was dying. -9/22/25 at 1:27 PM the resident made several negative comments about self and called self dumb and/or stupid. -10/1/25 at 9:21 AM the resident was seated in the bathroom. The resident was tearful and indicated a need for help. The resident was stuck and needed help getting up. Remained tearful and anxious with increased shortness of breath. The resident reported having PTSD and stated the ex-spouse used to lock the resident into the bathroom or a closet. Sometimes being in the bathroom increased the resident's anxiety and the resident would freak out. -10/14/25 at 10:10 PM the resident complained of abdominal pain and stated, no one cared for the resident and the resident's spouse wanted to leave the resident in the Nursing Home to die. Review of a Psychiatric Progress Note dated 11/21/25 revealed the resident was seen by the Psychiatric Mental Health Nurse Practitioner (PMHNP) to follow up management of the resident's PTSD, depression, anxiety, insomnia, and nightmare disorder. The resident reported appetite varied, was only sleeping 1-3 hours per night with nightmares most nights, some visual hallucinations, and flashbacks from time to time. A new order was received for Prazosin (medication used to treat high blood pressure and/or to help with PTSD related nightmares) 1 mg at bedtime. To be seen again in 1-2 months. Further review of Resident 2's medical record revealed no evidence the facility had attempted to identify triggers and preferences to eliminate/mitigate triggers related to PTSD. During an interview on 12/3/25 at 9:48 AM, Resident 2 confirmed the resident had a history of PTSD. The resident reported being raped/beaten while in the service and being abused by a previous spouse. The resident's previous spouse would beat the resident and lock in a closet or a bathroom. The resident indicated the facility had not interviewed the resident to determine PTSD triggers and had not asked the resident about potential interventions to address triggers. The resident felt the staff were always in a hurry and did not have time for the resident. An interview with the Director of Nursing (DON) on 12/3/25 at 9:53 AM confirmed the facility had not determined potential triggers for Resident 2's PTSD and no interventions were in place to prevent potential triggers. Interview with the Social Service Director (SSD) on 12/3/25 at 11:27 AM (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed the facility did not have a policy related to Trauma Informed Care. The SSD was not aware if triggers and/or interventions were in place to address Resident 2's PTSD.