STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285294	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Care Centers-Ord, LLC	220 South 26th Street Ord, NE 68862

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49382 Licensure Reference Number 175NAC ,d+[DATE].19 Based on observation and interviews; the facility failed to maintain flooring that was stain free, ceiling tiles that are stain free, lighting fixtures that are bug and/or pest free, and thresholds that are free of trip hazards for 4 (Halls 300, 400, 500, and 700) of 5 sampled hallways. The facility census was 33. Findings are: In an observation completed on [DATE] from 7:25 PM to 8:20 PM the following was observed: A. In the 300 Hall in front of the door labeled Dining the carpet in front of the door is black and shiny in color from the threshold of the doorway extending 5 to 6 inches into the hallway where it fades to a gray color and then into the brown cream coloring of the carpeting squares. In the 300 Hall the carpeting between room [ROOM NUMBER] and 311 a large dark colored ring extending from the wall to the middle of the hallway. In the commons area in front of the nurse's station gray black circular discolored areas. B. In the 400 Hall on the exit side of the fire doors the ceiling tiles stained black, red fading into brown circles with the stained discolored area protruding down from the flat surface of the other ceiling tiles. The area is 3 ceiling tiles long and 2 ceiling tiles wide. In the 400 Hall first light fixture in the ceiling entering the hall is a black multi legged deceased bug approximately the size of a quarter. In the 400 Hall in front of room [ROOM NUMBER] a large dark gray black colored circular area extending from the threshold of the entry to the room approximately 4 inches into the hallway. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In the 400 Hall the thresholds of Rooms 400, 402, 403, 406, 408, and 409 the carpet is loose, and the laminate flooring is loose from the underlayment beneath creating a trip hazard for residents. C. In the 500 Hall on the exit side of the fire doors the ceiling tiles are stained orange fading into a red brown color. The area is 2 ceiling tiles long and 4 ceiling tiles wide. In front of room [ROOM NUMBER] the ceiling tiles are yellow brown in color extending from the entrance to the room across 3 sections of ceiling tile. D. In the 700 Hall rooms [ROOM NUMBERS] the flooring of the threshold is carpet going to tile. The carpet is loose in the inner corner coming up from being secured to the floor. The tile is chipped and cracked exposing the sub floor underneath creating an uneven area where black, thick brown substance has collected and built up. In an interview on [DATE] at 9:56 AM with the Maintenance Manager (MM) the MM confirmed that the ceiling tiles were warped and stained and needed replaced. The MM stated that a water leak had been repaired but the ceiling tiles had not been replaced yet. The MM stated that the carpets are cleaned twice a year by an outside company and the facility does not perform any carpet cleaning in between these cleanings. The MM confirmed that the carpet throughout the facility had different degrees of staining present and needed cleaned more frequently. The MM confirmed the bug present in the 400-hall light fixture and that the carpeting and tile were cracked and coming loose on the thresholds of some of the doorways of the resident rooms.

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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** 49382 Licensure Reference Number 175NAC 12-006.09 Based on observation, record review, and interviews; the facility failed to ensure the provider was notified of abnormal laboratory results affecting 1 Resident (Resident 21) of 5 sampled residents, and failed to notify a physican of blood pressures that were out of range per the physcian order for 2 Residents (Resident 24 and Resident 4) of 3 sampled residents. The facility census was 33. Findings are: A. Review of an Admission Record revealed the facility admitted Resident 21 on 12/01/2022 with diagnoses that included type two diabetes (which is when the body has trouble controlling blood sugar and using it for energy). Review of Resident 21 Physician Orders revealed an order for the facility to obtain a Hemoglobin A1C (HbA1C, a blood test that measures the average amount of glucose(sugar) in the blood over the past three months) every 3 months to be performed on the 5th of the month with a start date of 03/05/2024. Review of Resident 21's medical health record revealed a laboratory value for a HbA1C of 9.10 with a collection date of 06/07/2024. The normal reference range for this laboratory value was documented as 4. 80-6.00. The result of 9.10 was indicated on the document as an abnormal value listed as High. The document provided no indication of provider review or acknowledgment of the abnormal laboratory value. Review or Resident 21's progress notes for the month of June 2024 revealed no documentation of the provider being notified of the abnormal HbA1C level or the provider reviewing the abnormal HbA1C level. In an interview completed on 08/21/2024 at 3:45 PM with the facility Medical Records (MEDR), the MEDR confirmed there was no documentation indicating the provider had been notified of the abnormal HbA1C lab value. In an interview completed on 08/21/2024 at 4:43 PM with the facility Director of Nursing (DNS), the DNS confirmed that Resident 21's HbA1C was an abnormal laboratory value, and the provider should have been notified of the abnormal value and reviewed the abnormal laboratory value indicating further directions for treatment or not to the facility. The DNS confirmed that this was not present in the resident's medical health record. 50105 B. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 24's Admission Record dated 08/19/2024 revealed the resident admitted on [DATE]. The admission record also reveals an admission and primary diagnosis of Parkinson's Disease (a progressive brain disorder that affects the nervous system and causes unintended or uncontrollable movements). Record review of Resident 24's Care Plan (a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) dated 08/18/2024 revealed the resident takes and anti-Parkinson medication. The care plan goals and interventions revealed: -The resident will be free of any discomfort or adverse side effects of anti-Parkinson therapy, -will remain free of signs and symptoms (s/s), -administer medications per physician orders, -monitor/document/report as needed (PRN) adverse reactions of anti-Parkinson therapy: increased risk of low BP on rising and falls; significant confusion, restlessness, delirium, difficulty walking/moving, nausea, dizziness, hallucinations, and agitation. Record review of Resident 24's physician orders revealed the following orders: -Carbidopa-Levodopa oral tablet 25-250 milligram (MG) give 1 tablet by mouth 3 times a day related to Parkinson's Disease: order date 02/15/2024. -Notify doctor if systolic blood pressure is greater than (>)150 or less than (<)100, heart rate >110 or <50, respiratory rate >24 or <12, oxygen saturation <90%. temperature > 100.5 Fahrenheit (F) or <95.8 F: order date 03/07/2024. Record review of Resident 24's Blood Pressure Summary report revealed the systolic blood pressure >150 or less than <100 were found on dates: -08/14/2024: 99/54 -08/05/2024: 99/54 -07/22/2024: 99/60 -04/22/2024: 89/45 Record review of Progress Notes and medical records of physician notification of blood pressure summaries or notification of systolic blood pressure >150 or less than <100 revealed no documentation that the physician was notified. C. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 4's Admission Record dated 08/20/2024 revealed the resident admitted on [DATE]. The admission record also reveals an admission and primary diagnosis of an injury of the cervical spinal cord, quadriplegia (a symptom of paralysis that affects a person's limbs and body from the neck down) and hypertensive heart disease (heart problems that occurred due to high blood pressure). Record review of Resident 4's Care Plan revealed the high-risk medications the resident takes are a hypertension (a condition where the pressure in your blood vessels is consistently too high) medication, and an anticoagulant (a blood thinner medication used to prevent the formation of blood clots) medication. An intervention listed for taking the medications are to notify the physician if systolic blood pressure is greater than (>)150 or less than (<)100. Record review of Resident 4's physician orders revealed the following orders: -Notify the physician if: systolic blood pressure is >150 or less than <100: order date 03/13/2024. Record review of Resident 4's Blood Pressure Summary report revealed the systolic blood pressure >150 or less than <100 found on dates: -08/20/2024: 98/54 -07/25/2024: 99/54 -07/11/2024: 94/55 -07/04/2024: 94/58 -05/30/2024: 97/70 -04/11/2024: 90/58 -03/28/2024: 96/69 -03/27/2024: 93/53 -03/26/2024: 98/68 -03/16/2024: 96/58 -03/15/2024: 88/54 -03/13/2024: 98/54 Record review of Progress Notes and medical records of physician notification of blood pressure summaries or notification of systolic blood pressure >150 or less than <100, revealed no documentation that the physician was notified. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Registered Nurse-E (RN-E) on 08/21/2024 at 4:21 PM revealed when an out-of-range vital sign is noted, and an order to notify is present, the physician's office is either called, or a fax to the physician's office is sent. Once that is completed a progress note is completed. The DNS was interviewed on 08/21/2024 at 4:40 PM confirmed there was no documentation that a physican was notified of Resident 24 and Resident 4's blood pressures out side of paramters on the listed dates. The DNS also revealed the expectation of the nurse or the charge nurse on duty is to contact the physician's office on the out-of-range vital signs. The information is then documented in the progress notes.

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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** 41938 Licensure Reference Number 175NAC 12-006.(I) Licensure Reference Number 175NAC 12-006.(I)(i)(3) Based on observation, record review, and interviews; the facility failed to implement fall prevention interventions to prevent falls for 1 resident (Resident 25) and failed to ensure the mattress was secured to the bedframe to prevent the potential for entrapment or falls for 1 resident (Resident 25). The facility census was 33. Findings are: A. Record review of the facility policy Fall Prevention and Fall Leaf Program dated 2/2020 revealed that the purpose is to ensure fall risks are identified and interventions are implemented in an effort to prevent falls, as possible, and to maintain a safe environment for each resident of the facility. The section titled Falls revealed that if a resident incurred a fall, a Fall Incident and Investigation report is completed. The Fall Incident and Investigation report will be reviewed at the next Department Clinical Meeting for interdisciplinary review of the fall, interventions, and determination of need for additional interventions or revision of current interventions. Record review of the Admission Record dated 8/19/24 for Resident 25 revealed that Resident 25 admitted into the facility on [DATE] wiht diagnoses of: anxiety, unsteadiness on feet, muscle weakness, and history of falling. Observation on 8/19/24 at 4:13 PM in the hall between the atrium and the sunshine room revealed that Resident 28 pushed Resident 25 in a wheelchair. Resident 25 held onto a walker to the right side of the wheelchair. Resident 25 steered the walker alongside the wheelchair with their right hand. Resident 28 continued to push Resident 25 in the wheelchair through the sunshine room. Nurse Aide-A (NA-A) approached Residents 28 and 25. NA-A took the walker from Resident 25 and took the walker to the resident's room. Resident 28 continued to push Resident 25 in the wheelchair towards the resident room. Record review of the Progress Note dated 3/20/24 at 3:38 AM for Resident 25 revealed that at 3:00 AM Resident 25 called out to their spouse/roommate (Resident 28) for help. The unidentified nurse arrived at the resident room and found Resident 25 and Resident 28 on the floor. Resident 25 was bleeding from the left front of their head. Emergency Medical Technicians arrived at 3:30 AM and left Resident 25 at 4:00 AM. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Progress Note dated 8/19/24 at 8:35 PM for Resident 25 revealed that Resident 25 was found lying on the floor with their spouse/roommate (Resident 28) in the resident's room. Resident 25 could not recall why they fell . Resident 28 stated that Resident 28 tried to get Resident 25 to the toilet. During transfer, Resident 28 lost their balance, and both fell to the floor. Resident 25 complaint of a headache and soreness to the back of the head. Resident 25 got more confused and started telling staff that they were running into a wall. 911 was called. Emergency Medical Services transported Resident 25 to the emergency room at 9:15 PM. Record review of the Care Plan for Resident 25 dated 8/21/24 revealed a care focus for falls. The care plan revealed that on 3/20/24 Resident 25 called for their spouse/roommate (Resident 28) to help in the bathroom. Resident 25 fell with Resident 28 to the floor. 8/19/24 Resident 28 attempted to transfer Resident 25 to the bathroom. Resident 28 lost their balance and both Resident 28 and Resident 25 fell to the floor. Intervention for the fall on 3/20/24 revealed only that Resident 25 was sent to the emergency room and returned the same day with no acute fractures. No fall intervention to prevent future falls was developed for the 3/20/24 fall. Intervention added to the care plan on 8/19/24 for the fall on 8/19/24 revealed that staff are to place Resident 25 in a chair at meals, and staff to assist Resident 25 back to the room from meals and do cares right then so the spouse/roommate (Resident 28) is not tempted to transfer Resident 25. The intervention was dated 8/19/24. Observation on 8/21/24 at 7:33 AM in the facility dining room revealed that Resident 25 sat in a wheelchair at the dining room table. Observation on 8/21/24 at 8:07 AM in the facility dining room revealed that Resident 25 remained in the wheelchair at the dining room table feeding themselves breakfast. Observation on 8/21/24 at 8:30 AM in the facility dining room revealed that Resident 25 sat in the wheelchair at the dining room table. Observation on 8/21/24 at 8:33 AM at the nurse's station revealed that Resident 28 pushed Resident 25 in the wheelchair from the dining room through the sunshine room to the resident's room. Resident 28 pushed the wheelchair into the bathroom in the resident's room. Resident 25 stood from the wheelchair and Resident 28 backed the wheelchair out of the bathroom. An alarm was beeping at a low volume. The facility Infection Coordinator (IC) came to the room at a fast pace. IC entered the room and closed the door at 8:35 AM. Observation on 8/21/24 at 11:33 AM at the room of Resident 25 revealed that Medication Aide-H (MA-H) transferred Resident 25 from the resident's room in a wheelchair. MA-H transferred Resident 25 into the dining room and positioned Resident 25 in the wheelchair up to the dining room table. Resident 25 thanked MA-H and then asked where their spouse (Resident 28) was. MA-H told Resident 25 that they were coming. MA-H exited the dining room. Resident 28 entered the dining room at 11:34 AM and sat down in a chair at the table. Resident 28 sat to the right of Resident 25. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 8/21/24 at 1:56 PM with Medication Aide-G (MA-G) confirmed that Resident 25 is at increased risk of falls. MA-G revealed that interventions to prevent falls are used to keep residents safe from falls. MA-G revealed that the charge nurse or the stand up meeting team develops new or revised fall prevention interventions after a resident has a fall. MA-G revealed that new or revised interventions are communicated to staff through the computer. MA-G revealed that when the staff log onto the computer the dashboard page displays with new messages including new fall interventions. MA-G revealed that staff usually just glance at it and move on to chart cares. MA-G revealed that staff don't have time to read it. MA-G offered to show this surveyor what the page looks like on the computer. MA-G logged onto a computer. The dashboard page was displayed. The dashboard contained no information regarding the fall of Resident 25 and contained no updated fall prevention measures. Observation on 8/21/24 at 4:50 PM in the facility dining room revealed that Resident 25 sat in a wheelchair at the table. Interview on 8/22/24 at 7:28 PM with the facility Director of Nursing Services (DNS) confirmed that new or revised interventions are expected to be developed for fall prevention after a resident has a fall. The DNS confirmed that staff are expected to follow fall interventions to try to prevent resident falls and injuries. Observation on 8/22/24 at 7:38 AM in the facility dining room revealed that Resident 25 sat at the dining room table in a wheelchair. Resident 28 was seated in a chair to the right of Resident 25. Interview on 8/22/24 at 7:55 AM with Director of Nursing Services (DNS) confirmed observation at the facility dining room that Resident 25 was seated in a wheelchair at the dining room table eating breakfast. The DNS confirmed that Resident 25 is to be placed in a regular chair at the table for the new fall prevention intervention after the resident fall on 8/19/24. The DNS confirmed that the new intervention had not been implemented. B. Record review of the facility Admission Agreement dated 10/2019 revealed that the facility must not charge a resident for room/bed maintenance services. The section titled Safe Environment revealed that the resident has a right to a safe, homelike environment. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes independence and does not pose a safety risk. Record review of the Admission Record dated 8/19/24 for Resident 25 revealed that Resident 25 admitted into the facility on [DATE] with diagnoses of: anxiety, unsteadiness on feet, altered mental status, and history of falling. Record review of the Minimum Data Set (MDS, a mandatory comprehensive assessment tool used for care planning) dated 8/8/24 for Resident 25 revealed that Resident 25 is independent with rolling from their back to their right and their left when lying in bed. The MDS revealed that Resident 25 had a Brief Interview for Mental Status (BIMS, a brief screening tool that aids in detecting cognitive impairment) score of 7 (a score of 0-7 indicates severe cognitive impairment). Observation on 8/18/24 at 7:40 PM in the room of Resident 25 revealed that Resident 25 was in bed. Resident 25 was lying on their back. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 8/19/24 at 8:29 AM in the room of Resident 25 revealed that the mattress on the bed of Resident 25 was not secured to the bedframe. The mattress slid over approximately 14 inches from the bedframe from side to side. This created a gap for potential entrapment on the side of the bed against the wall. This created a fall hazard on the side of the bed away from the wall. Interview on 8/21/24 at 1:34 PM with facility Maintenance Manager (MM) revealed that the facility does not check to see if resident mattresses are secured to the bedframe. MM confirmed that the mattress on the bed of Resident 25 was not secured to the bedframe. MM was unaware of devices to secure mattresses to the frame. MM confirmed that MM was not aware that the mattress had to be secured to the bedframe.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 49382 Licensure Reference Number 175NAC 12-006.09(H) Based on observation, record review, and interviews; the facility failed to manage pain for 2 Residents (Resident 18 and Resident 21) of 2 sampled residents. The facility census was 33. Findings are: Review of a facility policy titled Pain Management dated 02/2020 revealed in order to help a resident attain or maintain their highest practicable level of well-being and to prevent or manage pain the facility manages or prevents pain consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. If the resident's pain is not controlled by the current treatment regimen, the practitioner should be notified. Review of a document titled Determining mild, moderate, and serve pain equivalency across pain intensity tools in nursing home residents by the Journal of Rehabilitation Research and Development dated 11/02/2007 revealed responses to pain rating of 1 through 4 on a 0 though 10 scale indicated mild pain, responses of 5 though 6 for moderate pain, and 7 though 10 for severe pain. A. A review of an Admission Record dated 08/18/2024 revealed the facility admitted Resident 18 on 04/10/2024 with diagnoses that of preprhial vascular disease (which is a chronic disorder that causes blood vessels to narrow reducing blood flow to the organs they supply), restless leg syndrome (which is a disorder that causes uncontrollable urge to move the legs and is often accompanied by an unpleasant sensation), polyneuropathy (which the simultaneous malfunction of many peripheral nerves throughout the body), fibromyalgia (which a chronic disorder that causes widespread pain and tenderness in the body), rheumatoid arthritis (which is a chronic disease that causes inflammation and pin in the joints), and pressure related wound (which is a wound caused by pressure) of the buttock. The Quarterly Minimum Data Set (MDS, a mandatory comprehensive assessment tool that measures the health status of nursing home residents and is used for care planning) with the Assessment Reference Date (ARD), of 07/11/2024 revealed Resident 18 had a Brief Interview for Mental Status (BIMS, a brief screening tool that aids in detecting cognitive impairment) score of 13 indicating the resident was cognitively intact. The resident received both routine and as needed pain medication during the last 5 days prior to the ARD. The resident stated they frequently had pain that interfered with sleep, therapy activities, and day to day activities. The resident rated the pain on a descriptor scale as Moderate. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 18's Comprehensive Care plan (a written interdisciplinary comprehensive plan to meet the resident's needs that are identified in the resident's comprehensive assessment), dated 08/19/2024, revealed a focus of Pain with a tolerable pain level stated as Mild. The goal was listed as the resident will have pain at a tolerable level for them of Mild. An intervention was listed if the resident was receiving frequent as needed pain medication for breakthrough pain, to visit with the provider about getting a different medication or stronger medication to get the residents pain to a tolerable level. In an interview with Resident 18 on 08/19/2024 at 9:35 AM, Resident 18 stated they are often uncomfortable and in pain. Resident 18 stated [gender] is to get up for one hour and get into their recliner two times a day but often refuses to do this due to level of pain. Resident 18 stated staff will administer an as needed pain medication when the resident requests it but by the time the medication takes effect it is to late to get up and into the recliner so just stays in bed. Review of Resident 18's Medication Administration Record for the Month of August 2024 revealed the resident was monitored for pain every shift. 20 of the 37 pain ratings obtained from the resident were of a pain level of 5 or higher on a 1 to 10 scale indicating pain at a moderate to severe level of pain. Review of Resident 18's Medication Administration Record for the Month of August 2024 revealed Resident 18 received as needed Acetaminophen (a mild pain medication) 5 times for pain ratings of 6 or greater on a 1 to 10 scale. Review of Resident 18's Medication Administration Record for the Month of August 2024 revealed Resident 18 received as needed Oxycodone (a narcotic strong pain medication) 17 times for pain ratings of 8 or greater on a 1 to 10 scale. In an interview conducted on 08/21/2024 at 11:00 AM with Registered Nurse E (RN-E), RN-E confirmed that Resident 18 often refused to get up out of bed due to pain. RN-E denies offering Resident 18 pain medication prior to offering to get the resident out of bed stated the medication is administered when the resident requests it. RN-E stated the resident's provider had not been notified about the frequent use of the as needed pain medication to maintain the residents comfort level for adjustments in the resident's routine pain medication for better coverage and less breakthrough pain for Resident 18. In an interview conducted on 08/21/2024 at 12:20 PM with the Director of Nursing (DNS), the DNS confirmed that Resident 18 pain was not controlled, and the provider should be notified for a change in the resident's routine pain medication to decrease break through pain. B. A review of an Admission Record dated 08/18/2024 revealed the facility admitted Resident 21 on 12/01/2022 with diagnoses of multiple myeloma (which is a type of bone marrow cancer), chronic gout (which is repeated episodes of pain and inflammation of joints), and neuralgia and neuritis (which is server sharp often shock like pain that follows the path of a nerve with inflammation of the nerve). (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly MDS with the ARD, of 07/18/2024 revealed Resident 21 had a BIMS score of 15 indicating the resident was cognitively intact. The resident received both routine and as needed pain medication during the last 5 days prior to the ARD. The resident stated they frequently had pain that interfered with sleep and day to day activities. The resident rated the pain on a descriptor scale as Moderate. Review of Resident 21's Comprehensive Care plan, dated 08/19/2024, revealed a focus of Pain with a tolerable pain level stated as Mild. The goal was listed as the resident will have pain at a tolerable level for them of Mild. An intervention was listed to observe for effectiveness of pain mediation and to keep the provider informed. In an interview conducted on 08/19/2024 at 1:30 PM with Resident 21 revealed [gender] often suffered from pain during the early morning hours and would have to request to be gotten out of bed early in the morning to be able to change position to try and alleviate some of the discomfort they were experiencing. The resident stated they received pain medication when they requested it and on a routine basis but felt like their pain was never at a tolerable level. Review of Resident 21's Medication Administration Record for the Month of August 2024 revealed the resident was monitored for pain every shift. 30 of the 37 pain ratings obtained from the resident were of a pain level of 5 or higher on a 1 to 10 scale indicating pain at a moderate to severe level of pain. Review of Resident 21's Medication Administration Record for the Month of August 2024 revealed Resident 21 received as needed Acetaminophen (a mild pain medication) once for pain ratings of 10 on a 1 to 10 scale. Review of Resident 21's Medication Administration Record for the Month of August 2024 revealed Resident 21 received as needed Tramadol (a narcotic pain medication) 7 times for pain ratings of 7 or greater on a 1 to 10 scale. In an interview conducted on 08/21/2024 at 11:15 AM with Registered Nurse E (RN-E), RN-E confirmed that Resident 21 often awoke in the early morning hours and requested as needed pain medication and to get up out of bed to alleviate pain and discomfort. RN-E confirmed that the residents last dose of scheduled analgesics was administered at bed time and the provider had not been contacted about the frequent as needed pain medication use to adjust time of dosing of medication. In an interview conducted on 08/21/2024 at 12:25 PM with the Director of Nursing (DNS), the DNS confirmed that Resident 21's pain was not controlled, and the provider should be notified for a change in the resident's routine pain medication in efforts to decrease break through pain.

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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** 41938 Licensure Reference Number 175NAC 12-006.09(H) Based on record review and interview; the facility failed to ensure that PRN (as needed) psychotropic medications (any medication that affects behavior, mood, thoughts, or perception) were limited to 14 days as required for 1 resident (Resident 135) of 5 residents reviewed. The facility census was 33. Findings are: Record review of the facility policy titled Use of Psychotropic Drugs dated 2/2020 revealed that residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition. PRN orders for psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration (such as 14 days). If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she shall document their rationale in the resident's medical record and indicate the duration for the PRN use. Record review of the Admission Record dated 8/19/24 for Resident 135 revealed that Resident 135 admitted into the facility on [DATE]. Record review of the Order Summary (a listing of all physician's orders for a resident) dated 8/19/24 for Resident 135 revealed that Resident 135 had an order for Lorazepam 0.5 milligrams (a psychotropic medication used to treat anxiety) every 12 hours as needed for anxiety or agitation. The Lorazepam order had a start date of 8/5/24. The order had no end date as required. Record review of the medication administration record (MAR, a legal record of the medications administered to a patient at a facility by a health care professional) dated 8/20/24 for Resident 135 revealed that Resident 135 received the as needed Lorazepam on 8/4/24, 8/5/24, 8/12/24, 8/14/24 and 8/20/24 (the 15th day after the original order). Record review of the Pharmacy Note for Resident 135 dated 8/17/24 at 8:25 AM revealed that the consultant pharmacist completed a medication review for Resident 135. The Consultant Pharmacist noted that Resident 135 had an order for a PRN psychotropic medication that did not have a 14 day stop date. Interview on 8/21/24 at 8:14 AM with the facility Infection Control Coordinator (IC) confirmed that orders for psychotropic medications are limited to 14 days unless re-evaluated for necessity and re-ordered by the physician. IC revealed that IC was unaware of the note from the Consultant Pharmacist for the PRN 14 day Lorazepam for Resident 135. IC then located an email from the consultant pharmacist and printed the recommendation note. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Note to Attending Physician/Prescriber dated 8/17/24 for Resident 135 revealed that PRN orders for psychotropic medications are limited to 14 days. If therapy is desired past a 14 day period, a patient specific rationale and duration must be documented in the resident's medical record by the attending physician or prescribing practitioner. The PRN Lorazepam 0.25 milligrams will be automatically discontinued after 14 days of the original order date; or request to continue the PRN order for less than 1 year with clinical rationale. Interview on 8/21/824 at 8:22 AM with the facility IC confirmed that the Note to Attending Physician/Prescriber dated 8/17/24 for Resident 135's Lorazepam PRN limited to 14 days had not been sent to Resident 135's physician for review and should have been sent.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49382 Licensure Reference Number 175NAC 12-006.12(D)(vi) Based on observation, record review, and interview; the facility failed to ensure medications were labeled clearly and accurately for 2 Residents (Resident 18 and Resident 29) of 5 sampled residents. The facility census was 33. Findings are: Review of a facility policy titled Labeling of Medications and Biologicals dated 02/2020 revealed All medications and biologicals used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of medications. Medication labels bust be always legible. Any medication label that is soiled, incomplete, illegible, worn, or makeshift must be returned and replaced by the issuing pharmacy. A. Review of an Admission Record dated 08/19/2024 revealed the facility admitted Resident 18 on 04/10/2024 with diagnoses of type two diabetes mellitus, (which is when the body has trouble controlling blood sugar and using it for energy). Review of Resident 18's Treatment Administration Record for the month of August 2024 revealed Resident 18 received Humalog Insulin (which is a medication that helps to regulate blood sugar levels), injections per a sliding scale (which is a varied dose based on blood sugar levels) schedule before meals and at bedtime. In an observation of medication administration completed on 08/20/2024 at 7:35 AM, Registered Nurse F (RN-F) was observed to prepare to administer an injection to Resident 18 using an insulin pen. The label attached to the insulin pen was observed to have black smeared ink over one side of the label making the residents name and directions for sliding scale administration illegible. In an interview completed on 08/202/2024 at 7:35 AM with RN-F, RN-F confirmed that the label on the insulin pen was illegible and the full directions for administering Resident 18 insulin was not visible on the label. In an interview completed on 08/21/2024 at 1:35 PM with the Director of Nursing (DNS), the DNS confirmed that the label on Resident 18 insulin pen was illegible and needed to be replaced by the pharmacy. B. Review of an Admission Record dated 08/19/2024 revealed the facility admitted Resident 29 on 10/25/2023 with diagnoses of hypertensive heart disease (which is high blood pressure). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 29 Medication Administration Record for the month of August 2024 revealed Resident 29 had physician orders to receive Potassium Chloride (which is a mineral supplement) ER (Extended Release), 20 Milliequivalents (MEQ) tablet one time every day. In an observation of medication administration completed on 08/20/2024 at 7:45 AM, RN-F was observed preparing Resident 29 medications. RN-F removed an oblong cream granular in appearance tablet from a medication card labeled with Resident 29 name and Potassium Chloride 20 MEQ tablet. RN-F placed the tablet in a clear medication cup with other medications and took the cup to Resident 29. Resident 29 using the medication cup and a drink of water swallowed all the medications in the cup. RN-F then returned to the medication cart. In an interview with RN-F completed on 08/20/2024 at 7:50 AM, RN-F confirmed the label on the medication card read Resident 29 name and Potassium Chloride 20 MEQ and the order in Resident 29 Medication Administration Record read Potassium Chloride ER 20 MEQ. RN-F confirmed that the label on the medication package and the order in the Medication Administration Record did not match. In an interview with the DNS completed on 08/21/2024 at 1:35 PM, the DNS confirmed that the label on Resident 29 Potassium Chloride medication and the order in the Medication Administration Record did not match. The DNS confirmed the order needed verified and clarified with the provider and the pharmacy.

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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. 50105 Licensure Reference Number: 175 NAC 12-006.11(E) Based on observations, record review, and interviews; the facility failed to store food under sanitary conditions as evidenced by rodent droppings in and around the food storage areas. This had the potential to affect all facility residents. Facility census was 32. Findings are: Source: Nebraska Food Code, effective date 07/21/2016 revealed section: 3-305.11: Food Storage: A. Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: -In a clean, dry location; -Where it is not exposed to splash, dust, or other contamination; and -At least 15 cm (6 inches) above the floor. A review of the facility policy titled; Dietary Sanitation Policy Statement revealed: All kitchens, kitchen areas, and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies, and other insects. Observation on 08/19/2024 at 8:35 AM revelaed the Food Services Supervisor (FSS) directed surveyor towards the back of the facility where a kitchen was presented with a dry storage on the east of the kitchen, dishwashing machine, stoves, and ovens. The dry storage had items labeled, and stored off of the floor. Underneath the dry storage was a 4-inch gap between the shelving and the floor, where visible were individual food packs of cookies, condiments and 4 wooden snap mouse traps. The FSS then lead the surveyor towards the main storage area that contained a refrigerator, 5 stand alone freezers and 2 large dry food storage wire shelving units that held dry food items, and another large shelving unit that held canned food items. The floors of the area were observed to have dried pasta, corn kernels and a buildup of dark soiling. Also observed were mouse droppings littered all over the floor with a concentration of droppings in specified areas of the storage room. There is a two-door entryway for deliveries where sticky mouse traps were present by the door and a cluster of mouse droppings. On 08/19/2024 at 2:12 PM Cook-I is observed to be retrieving food items from the food storage area of dry goods and refrigerated items. The items are placed on a rolling cart and brought to the kitchen where food is prepared. After the food is prepared, the food is kept hot in the oven. Once food is ready to be served, the food is then moved to the serving kitchen/dining room, where the food is then placed into a steam table and served to the residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The FSS was interviewed on 08/19/2024 at 2:26 PM. The FSS revealed they were aware of the mouse droppings and stated they did not have the live mouse traps available to the kitchen. The FSS also revealed more cleaning needs to be done.

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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** 49382 Licensure Reference Number 175NAC 1-005.06(E) Licensure Reference Number 175NAC 12-006.18(B) Based on record review and interview the facility failed to complete and review pre-employment health histories for 4 of 4 sampled staff. Based on observation, record review, and interview the facility failed to perform hand sanitization during medication administration to 3 or 5 sampled residents (Resident 17, 28, and 18), sanitize blood glucose glucometer after use for 1 of 1 sampled resident (Resident 18), and failed to follow Enhanced Barrier Precautions (gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a multi-drug resistant organism and residents at increased risk) to prevent the potential spread of multidrug-resistant infection for 2 residents (Residents 11 and 8). The facility census was 33. Findings are: A. Review of a facility supplied documents titled Employee Heath History Screen revealed the following: -Document for Housekeeper J (HSK-J) not completed in its entirety. No primary physician past medical history or allergies listed. The form is signed by HSK-J and dated 06/18/2024. There is no signature or date of the form being reviewed by other facility staff. -Document for Medication Aide K (MA-K) not completed in its entirety. No immunization record present. The form is signed by MA-K and dated 06/19/2024. There is no signature or date of the form being reviewed by other facility staff. -Document for Dietary Aide L (DA-L) completed, signed by DA-L and dated 07/30/2024. There is no signature or date of the form being reviewed by other facility staff. -Document for Maintenance Manager (MM) not completed in its entirety. No employee name listed on the form no position title emergency contact primary physician or immunization history completed. The form is signed by MM and dated 05/24/2023. There is no signature or date of the form being reviewed by other facility staff. In an interview on 08/21/2024 at 10:35 AM with the facility Business Office Manager (BOM), the BOM confirmed they are the individual responsible for ensuring all new hire documentation is completed and present in the employees file. The BOM confirmed that the Employee Health History Screen forms for HSK-J, MA-K, and MM were not completed entirely. The BOM confirmed that the forms were not reviewed to ensure that the individuals were free of communicable diseases prior to working with or in the direct vicinity of residents. B. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility policy titled Hand Hygiene and dated 2021 revealed hand hygiene is indicated and will be performed under the conditions listed in but not limited to the hand hygiene table. The Hand Hygiene Table lists hand hygiene is to be performed between resident contacts, after handling contaminated objects, before applying and after removing personal protective equipment including gloves, before preparing or handling medications. In an observation of medication administration by Registered Nurse F (RN-F), completed on 08/20/2024 from 7:20 AM to 8:20 AM the following was observed: RN-F knocked and entered Resident 17's room. RN-F gave the medications to Resident 17 in a clear plastic cup and Resident 17 then took the medications and swallowed them, and handed the clear up back to RN-F. RN-F thanked the resident and exited the room returning to the medication cart located in the hall outside of the room. RN-F threw the clear plastic cup in the trash can on the cart and placed the syringe in a clear plastic sleeve in the medication cart. RN-F then signed out the medication administration in the computer and removed the next residents' medications from the medication cart. RN-F did not complete hand sanitization/hygiene between administering Resident 17's medications and preparing the next residents' medications. Then RN-F prepared Resident 28's medications at the medication cart in the hallway located outside of Resident 28's room. RN-F knocked and entered the resident's room and handed the resident a cup containing clear liquid and a clear medication cup containing multiple medications. The resident emptied the cup containing the medications in their mouth and handed the cup back to RN-F. RN-F then returned to the medication cart in the hall signed out the medications administered in the computer. RN-F then locked the medication cart and proceeded down the hall to the nurse's station where another medication cart was located. The RN unlocked this cart and obtained a clear blue plastic pencil box from the cart. The RN did not complete hand sanitization/hygiene after administering Resident 28's medications and going to the other medication cart to get the clear blue plastic pencil box. Next RN-F entered Resident 18's room and obtained a paper towel and placed it on the resident's bed side stand. RN-F then set down a clear blue plastic pencil box on the paper towel. RN-F then applied gloves to both hands and performed the procedure of obtaining resident 18's blood sugar. After completion of the procedure RN-F removed their gloves from their hands and placed the items used back into the clear blue plastic pencil box. RN-F then picked up the box exited the resident's room and returned the box to the medication cart located at the nurse's station. RN-F did not complete hand sanitization/hygiene after removing their gloves post procedure. In an interview on 08/20/2024 at 8:25 AM completed with RN-F, RN-F confirmed hand sanitization/hygiene should have been completed after administering Resident 17 and Resident 28's medications. RN-F confirmed that hand sanitization/hygiene should have been completed after [gender] removed their gloves. C. Review of a facility policy titled Blood Glucose Monitoring dated 2021 revealed the nurse or med aide will abide by the infection control practices of cleaning and disinfection of the glucometer as per the manufacturer's instructions. Review of a document titled Assure Platinum Reference Manual and dated 03/2014 revealed the glucometer should be cleaned and disinfected after each use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a document titled General guidelines for use Super Sani-Cloth and dated 2021 revealed to allow the treated surface to remain wet for two minutes then let air dry. In an observation completed on 08/20/2024 at 7:45 AM RN-F used a glucometer to obtain Resident 18's blood sugar at the bedside. RN-F then placed the glucometer into a clear blue plastic pencil box and returned to the medication cart located down the hall by the nurse's station. RN-F placed the clear blue plastic box on the medication cart and obtained a disposable wipe from a container labeled Super Sani-Cloth located on top of the medication cart. RN-F wiped the glucometer with the disposable wipe for approximately 30 seconds. RN-F disposed of the wipe in the trash can and then placed the glucometer back into the clear blue plastic pencil box and placed it into the medication cart. In an interview on 08/20/2024 at 8:25 AM with RN-F, RN-F stated [gender] did not know the contact time or how long the surface had to remain wet for proper cleaning technique of the glucometer per the disposable wipes manufacturer recommendations. Review of the label on the container labeled Super Sani-Cloth revealed a time of 2 minutes the item being cleansed with the cloth should remain wet. RN-F confirmed this instruction was written on the label. In an interview on 08/21/2024 at 1:35 PM with the facility Director of Nursing (DNS), the DNS confirmed that the glucometer is to remain wet for 2 minutes for proper cleaning technique when using the Super Sani-Cloth disposable wipes. 41938 D. Record review of the facility policy titled Enhanced Barrier Precautions dated 4/1/24 revealed that it is the policy of the facility to implement enhanced barrier precautions for the prevention of the transmission of multidrug-resistant organisms. The definition for Enhanced Barrier Precautions (EBP) revealed that EBP is an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. The policy revealed that all staff receive training on enhanced barrier precautions and are expected to comply with all designated precautions. High contact resident care activities include: Dressing, Bathing, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, Wound care: any skin opening requiring a dressing. Enhanced barrier precautions should be followed outside the resident's room when performing transfers and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of an indwelling medical device. Record review of the Admission Record dated 8/19/24 for Resident 11 revealed that Resident 11 admitted into the facility on [DATE]. Record review of the Care Plan dated 8/19/24 for Resident 11 revealed that Resident 11 had a surgery for fracture of the left elbow. Resident 11 had an incision on the left arm to be observed for signs and symptoms of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Treatment Administration Record (TAR, a legal record of the administration of scheduled treatments or performance of other scheduled medical tasks for a resident by a health care professional such as a licensed nurse) dated 8/20/24 for Resident 11 revealed that Resident 11 had an order for dry dressing with ace wrap changed daily. Monitor incision site for signs and symptoms of infection. Observation on 8/19/24 at 8:59 AM in the room of Resident 11 revealed that Nurse Aide-A (NA-A) transferred Resident 11 into the room in a wheelchair. Resident 11 had an ace wrap around their left elbow. A sign on the wall between the bathroom door and closet in the resident's room revealed ENHANCED BARRIER PRECAUTIONS. Everyone must clean their hands, including before entering and when leaving the room. Providers and Staff must also wear gloves and a gown for the following high contact resident care activities: Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting. Device Care or use: Central Line, Urinary catheter, feeding tube, tracheostomy. Wound Care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person. A holder with gowns and gloves hung from the back of the room door. NA-A did not put on a gown or gloves. NA-A applied a gait belt (a belt device placed around a resident's abdominal area used to aid in the safe movement of a resident with mobility problems) around the abdomen of Resident 11 with the bare hands. NA-A's arms were in contact with the arms of Resident 11 as the gait belt was applied. NA-A assisted Resident 11 to stand from the wheelchair. Resident 11 held onto a walker. NA-A assisted Resident 11 to step towards the recliner as NA-A held onto the gait belt with their right hand and held onto the left arm of Resident 11 with the left hand. Resident 11 complained that NA-A was putting pressure leaning on Resident 11's left arm during the transfer. Resident 11 complained that their left arm is sore. Observation on 8/19/24 at 9:34 AM in the room of Resident 11 revealed that Physical Therapy Assistant (PTA) entered the room of Resident 11. PTA did not put on a gown or gloves. PTA put shoes on Resident 11 with the bare hands. PTA put a gait belt around the abdomen of Resident 11 and assisted Resident 11 to stand from the recliner. PTA rubbed against Resident 11 as Resident 11 stood up with the assistance. Resident 11 held onto the walker. PTA held onto the gait belt and walked with Resident 11 from the resident room to the therapy gym. Observation on 8/20/24 at 9:04 AM in the room of Resident 11 revealed that Nurse Aide-B (NA-B) did not put on a gown or gloves. Resident 11 sat in the wheelchair. NA-B placed a gait belt around the abdomen of Resident 11 with the bare hands. NA-B's bare arms rubbed against the arms and torso of Resident 11 as the gait belt was applied. NA-B held onto the gait belt and the resident's left arm pit as Resident 11 was assisted to stand. Resident 11 used the walker to transfer to the recliner. Resident 11 was assisted into the recliner as NA-B held onto the resident. Resident 11 tilted the recliner back and elevated their feet. Interview on 8/20/24 at 2:35 PM with NA-B revealed that this surveyor asked NA-B what the sign Enhanced Barrier Precautions meant. NA-B reviewed the sign and stated that it was for bathing the resident and for residents with catheters that staff have to wear gown and gloves. NA-B was unaware that gown and gloves were required for any high contact care including transfers for residents on Enhanced Barrier Precautions. (continued on next page)

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	285294	A. Building B. Wing	08/22/2024

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Arbor Care Centers-Ord, LLC	220 South 26th Street Ord, NE 68862

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 8/20/24 at 11:06 AM in the therapy gym revealed that Physical Therapist (PT) reached across the back of Resident 11 with the left hand and held onto the back of the gait belt. PT's arm was holding against the back of Resident 11. PT placed their right hand on the upper arm of Resident 11 with the right hand. PT assisted Resident 11 to sit in a chair. PT did not wear a gown or gloves. Observation on 8/20/24 at 11:09 AM in the therapy gym revealed that PTA sat down next to Resident 11. PTA told Resident 11 that the oxygen nasal cannula (a small, flexible tube that contains two open prongs intended to sit just inside your nostrils to provide supplemental oxygen therapy to people who have lower oxygen levels) needed to be adjusted. PTA grabbed the nasal cannula on the left and right of Resident 11's nose with the bare hands and adjusted the prongs into the nostrils of Resident 11. PTA tightened the cannula to hold it in place. Observation on 8/20/24 at 12:44 PM revealed that Nurse Aide-B (NA-B) transferred Resident 11 in the wheelchair from the dining room into the resident's room. NA-B did not put on a gown or gloves. NA-B pushed the wheelchair into the bathroom. NA-B put on gloves and placed a gait belt around the abdomen of Resident 11. NA-B assisted Resident 11 to stand up from the wheelchair using the gait belt. Resident 11 grabbed onto the grab bar on the wall to assist with standing. NA-B pulled down the pants of Resident 11 and then pulled down Resident 11's brief. NA-B assisted Resident 11 to sit down on the toilet. NA-B removed and discarded the gloves. NA-B asked Resident 11 to use the call light to let staff know when the resident was finished in the bathroom. NA-B exited the resident's room. Observation on 8/20/24 at 12:54 PM at the room of Resident 11 revealed that Medication Aide-C (MA-C) entered the room of Resident 11. MA-C did not perform hand sanitization. MA-C did not put on a gown or gloves. MA-C entered the resident's bathroom and asked Resident 11 if they were finished. Resident 11 responded yes. MA-C put on gloves and used a wipe to wipe the bowel movement (BM) from the resident's anal area. MA-C obtained a second wipe and wiped the resident's anal area. MA-C obtained a third wipe and wiped the resident's anal area. MA-C removed and discarded the gloves. MA-C did not perform hand sanitization. MA-C used the bare hands to assist Resident 11 to a standing position in front of the toilet. MA-C used the bare hands to pull up Resident 11's brief and pants. MA-C assisted Resident 11 to sit in the wheelchair. MA-C transferred Resident 11 out of the bathroom to near the recliner. MA-C moved the recliner as requested by Resident 11. MA-C used the bare hands to move the over bed table on the left side of the recliner towards the rear of the recliner as requested by Resident 11. MA-C positioned the wheelchair in front of the recliner. MA-C used the bare right hand to hold onto the gait belt in back of Resident 11 while draping the left arm underneath the left arm of Resident 11. MA-C held onto the front of the gait belt with the bare left hand and assisted Resident 11 to stand from the wheelchair. MA-C's uniform was touching Resident 11 as MA-C pivoted Resident 11 into the recliner. MA-C placed their bare hands on their sides touching their uniform. MA-C used the bare hands to pick up the nasal cannula from the bed and placed the nasal cannula on the face of Resident 11. MA-C used the bare hands to operate the control on the recliner to elevate Resident 11's feet and tilt the back of the chair backwards. MA-C used the bare hands to place a pillow behind Resident 11. MA-C used the bare hands to place a pillow underneath the left arm of Resident 11. MA-C entered the bathroom and performed hand washing. Resident 11 stated that the pain in their left arm was a 6 on a scale of 0-10. Resident 11 stated that they were supposed to place an ice pack to help with the pain. MA-C told Resident 11 they would get an ice pack. MA-C exited the room of Resident 11. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 8/20/24 at 1:06 PM in the room of Resident 11 revealed that MA-C returned to the room with an ice pack. MA-C did not put on a gown or gloves. MA-C used the bare hands and lifted the left arm of Resident 11 and placed the ice pack under the left elbow and forearm of the resident. An ace wrap was in place on the left elbow of Resident 11. MA-C exited the resident room. Interview on 8/20/24 at 4:30 PM with Medication Aide-C (MA-C) revealed that the Enhanced Barrier Precautions means you have to gown up and wear gloves if doing anything with a resident's wounds. MA-C was not aware that gown and gloves were required for transferring and toileting residents on Enhanced Barrier Precautions. Observation on 8/21/24 at 9:57 AM in the room of Resident 11 revealed that Registered Nurse-E (RN-E) performed hand sanitization and entered the resident room after reviewing the order for the incision on Resident 11's left elbow. The incision along the bottom of the left elbow had 6 steri strips (strips of tape put across an incision for wound closure) over it. The area around the incision was a light brown along the length of the incision. The incision contained a scabbed area below the elbow measuring approximately 3 centimeters (cm) long and 1 cm wide and a scabbed area above the elbow measuring approximately 2 cm long and 1cm wide. Resident 11's left arm had a moderate amount of swelling into the fingers and was light reddish in color. Interview on 8/22/24 at 7:28 AM with the facility Director of Nursing Services (DNS) confirmed that residents on Enhanced Barrier Precautions (EBP) are to have an EBP poster sign posted to identify the resident is on EBP. The DNS confirmed that staff are expected to follow the Enhanced Barrier Precautions and wear gown and gloves for resident transfers, toileting, and wound care. The DNS revealed that the facility training to ensure staff are educated needs revised. E. Record review of the Admission Record for Resident 8 dated 8/19/24 revealed that Resident 8 admitted into the facility on [DATE]. Resident 8 had a chronic ulcer (open wound) of the left lower leg. Record review of the Care Plan dated 8/19/24 for Resident 8 revealed that staff are to observe open areas for signs and symptoms of infection. See Treatment Administration Record (TAR) for treatments. The care plan contained a care focus for Enhanced Barrier Precautions. The Care Plan revealed that Resident 8 has an open pressure wound (A localized wound of the skin and/or underlying tissue, usually over a bony area. A bedsore.) and vascular wounds (wounds on your skin that develop because of problems with blood circulation) receiving treatments. Put on gown and gloves for cares at all times in the resident's room. In room care: Provide EBP care during dressing, bathing, transferring, providing hygiene care, changing bed linens, changing briefs or assisting with toileting. Observation on 8/20/24 at 2:35 PM at the room of Resident 8 revealed that a sign on the outside of the door to the room of Resident 8 read ENHANCED BARRIER PRECAUTIONS. Everyone must clean their hands, including before entering and when leaving the room. Providers and Staff must also wear gloves and a gown for the following high contact resident care activities: Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting. Device Care or use: Central Line, Urinary catheter, feeding tube, tracheostomy. Wound Care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 8/20/24 at 2:35 PM with Nurse Aide-B (NA-B) revealed that this surveyor asked NA-B what the sign Enhanced Barrier Precautions on the door of Resident 8 meant. NA-B reviewed the sign and stated that it was for bathing the resident and for residents with catheters. NA-B stated that NA-B was unsure if it was even applicable to Resident 8 anymore. NA-B revealed that Resident 8 may have had an infection at one time. Observation on 8/21/24 at 7:37 AM in the room of Resident 8 revealed that Medication Aide-D (MA-D) and Nurse Aide-A (NA-A) were in the bathroom with Resident 8. Resident 8 was in the wheelchair. MA-D put on gloves and stood in front of the wheelchair beside the toilet. MA-D did not wear a gown. NA-A stood behind the wheelchair just inside the bathroom doorway. NA-A did not wear a gown or gloves. NA-A placed a gait belt around the lower abdomen of Resident 8. MA-D and NA-A each held onto the gait belt with one hand and supported the resident's arms with their other hand. MA-D and NA-A assisted Resident 8 to stand up from the wheelchair. MA-D removed the resident's brief. Resident 8 was assisted to sit on the toilet. Observation on 8/21/24 at 9:22 AM at the room of Resident 8 revealed that Registered Nurse -E (RN-E) reviewed the dressing change order. RN-E performed hand sanitization and put on gown, gloves, and face shield. RN-E revealed that Resident 8 had received a bath so the wound on the top of the foot was open to air. An open wound on the top of Resident 8's left foot measured approximately 8 cm long, 5 cm wide, and 0. 5 cm deep. The wound bed was bright red and approximately 70% covered with a thick dark yellow-brown exudate (wound drainage). RN-E completed the wound treatment and applied the silicone foam border dressing over the wound. Observation on 8/21/24 at 10:25 AM in the room of Resident 8 revealed that Resident 8 was in bed lying on their left side. RN-E reviewed the dressing change order for the pressure ulcer on the resident's coccyx (the bony lower portion of the spine). RN-E performed hand sanitization and put on a gown, gloves, and face shield. RN-E pulled down the resident's pants and brief to just below the buttocks. An open wound was visible on the resident's coccyx. The wound measured approximately 3 cm long and 2.5 cm wide and was light red in color. An approximately 1 cm long, 0.5 cm wide, and 1 cm deep open area inside the wound near the top of the wound area was present. RN-E completed the wound treatment and applied a silicone foam dressing over the wound. Interview on 8/22/24 at 7:28 AM with the facility Director of Nursing Services (DNS) confirmed that residents on Enhanced Barrier Precautions (EBP) are to have an EBP poster sign posted to identify the resident is on EBP. The DNS confirmed that staff are expected to follow the Enhanced Barrier Precautions and wear gown and gloves for resident transfers, toileting, and wound care. The DNS revealed that the facility training to ensure staff are educated needs revised.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49382 Licensure Reference Number 175NAC 12-007.04(D) Based on observation, and interview; the facility failed to ensure the bathroom ventilation system could pull up a square of single ply tissue in 3 rooms, (room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]), of 16 sampled rooms. The facility census was 33. Findings are: In an observation completed on 08/22/2024 at 9:30 AM it was observed that the vent located in the ceiling of the bathroom of room [ROOM NUMBER] could not pull up a single ply of tissue. In an observation completed on 08/22/2024 at 9:31 AM it was observed that the vent located in the ceiling of the bathroom of room [ROOM NUMBER] could not pull up a single ply of tissue. In an observation completed on 08/22/2024 at 9:32 AM it was observed that the vent located in the ceiling of the bathroom of room [ROOM NUMBER] could not pull up a single ply of tissue. In an interview completed on 08/22/2024 at 9:56 AM with the Maintenance Manager (MM), confirmed that the vents located in the ceilings of the bathrooms in room [ROOM NUMBER], 307, and 311 could not pull up a single ply of tissue. The MM confirmed that the vents should be able to pull up a single ply of tissue and that the ventilation system was not working properly.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 50105 Licensure Reference Number: 175 NAC 1-009.01(C) Based on observations, record review and interviews, the facility failed to maintain an effective pest control program as evidenced by rodent droppings in and around the food storage areas. This had the potential to affect all facility residents. Facility census was 32. Findings are: A review of an undated facility policy titled Pest Control, indicates the facility shall maintain an effective pest control program. The policy further implements that the facility will maintain an on-going pest control program to ensure that the building is kept free of insects and rodents. Observation on 08/19/2024 at 8:35 AM the Food Services Supervisor (FSS) directed the surveyor towards the back of the facility towards a kitchen with a dry storage on the east side of the kitchen. Under the dry storage was a 4-inch gap, that had food items and 4 wooden snap mouse traps. The FSS then lead the suerveyor towards the main storage area that contained a refrigerator, 5 stand alone freezers, 2 large dry food storage wire shelving units that held dry food items, and another large shelving unit that held canned food items. The floors of the area were observed to have dried pasta, corn kernels and a buildup of dark soiling present. Also observed were mouse droppings littered all over the floor with a concentration of droppings in specified areas of the storage room. There is a two-door entryway for deliveries where sticky mouse traps caught with dead bugs were present by the doors and a cluster of additional mouse droppings. The FSS was interviewed on 08/19/2024 at 2:26 PM. The FSS revealed they were aware of the mouse droppings and stated they did not have the live mouse traps available to the kitchen as they typically did in other areas of the facility. The FSS stated they cleaned it up, however more cleaning needs to be done. An interview with the Facility Administrator (FA) on 08/19/2024 at 5:05 PM revealed they were unaware of the rodent droppings in the dry food storage area.