STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 Licensure Reference Number 175 NAC 12-006.05(21) Based on record review and interviews, the facility failed to treat Resident 1 with dignity and respect when assisting the resident with cares. The sample size was 1 and the facility census was 28. Findings are: A. Review of the facility list of Resident's Rights given to each resident and/or the resident's responsible party at admission, revealed all residents had the right to be treated with respect and dignity. B. Review of Resident 1's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 3/27/24 revealed the resident was admitted [DATE] with diagnoses of non-traumatic brain dysfunction, Alzheimer's, dementia, and depression. The resident's cognition was assessed as severely impaired and the resident required partial to moderate assistance with toileting, dressing and personal hygiene. Review of a facility investigation dated 5/6/24 revealed on 5/5/24 at 11:30 AM, Licensed Practical Nurse (LPN)-P documented in Resident 1's Nursing Progress Notes the resident had slapped Nurse Aide (NA)-Y when staff had attempted to assist the resident to get dressed when the resident was incontinent. LPN-P went down to the resident's room and asked the resident how old are you? LPN-P then told the resident they were acting like a 2-year-old who did not want to mind and the resident could get up on their own or LPN-P and NA-Y would help the resident. The resident did not move and so LPN-P and NA-Y got under the resident's arms and assisted the resident into a seated position on the resident's bed. The resident was resistive but then got up from the bed, ambulated into the bathroom with a walker and later went out to the dining room for the breakfast meal. Interview with the Director of Nursing and the Administrator on 5/21/24 at 5:38 PM confirmed Resident 1 was not treated with respect and dignity by LPN-P on 5/5/24.

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
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 LICENSURE REFERENCE NUMBER 175 NAC 12-006.04C3a(6) Based on record review and interview; the facility failed to notify Resident 11's physician of a weight loss and Resident 24's representative of increased edema, shortness of breath, persistent cough, difficulty ambulating, and new physician orders related to the resident's change in condition. The sample size was 2 and the facility census was 28. Findings are: A. Review of the facility policy Nutrition (Impaired)/Unplanned Weight Loss with a revision date of 9/21, revealed the facility staff were to report to the physician significant weight losses or persistent change from baseline appetite or dietary intakes. B. Review of Resident 11's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 5/9/24 revealed the following: -severe cognitive impairment and decision-making skills, -diagnoses of dementia, depression, and cancer, -required partial to moderate assistance with eating and drinking, -loss of liquids/solids from mouth when eating, with coughing and choking when eating meals or taking medications, -mechanically altered diet, -weight of 187 lbs. (pounds), and -weight loss of 5 % (percent) or more in 1 month or a loss of 10% or more in the last 6 months and not on a physician prescribed weight loss regimen. Review of the resident's current Care Plan dated 8/22/20 revealed the resident was at risk for a nutritional decline related to diagnoses of dementia and gastroesophageal reflux disease (GERD-a condition in which acidic gastric fluid flows backward into the esophagus). In addition, the resident had a history of a stroke and had difficulty with swallowing and with feeding self. The following interventions were identified: -extensive staff assistance with eating, and -mechanical soft (any food which can be blended, mashed, pureed, or chopped to make food soft and easy to eat) diet with pureed meat and honey-thick (honey or a milkshake consistency) liquids. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 11's Weights and Vitals Summary Sheet (form used to document a resident's weight, blood pressure, respiration, temperature, and pulse) revealed the following regarding the resident's weights: -11/24/23 the resident's weight was 199 lbs. -12/19/23 weight was 196 lbs. (down 3 lbs. in 1 month). -1/30/24 weight was 194 lbs. (down 2 lbs. in 1 month). -2/27/24 weight was 188 lbs. (down 6 lbs. in 1 month). -5/17/24 weight was 177 lbs. (the resident was down 22 lbs. or had a loss of 11% in the last 6 months). C. Review of Resident 24's MDS dated [DATE] revealed the resident had severe cognitive impairment with diagnoses of non-traumatic brain dysfunction, dementia, heart failure, depression, anxiety, and psychotic disorder. Review of Resident 24's current Care Plan with a date of 1/11/24 revealed the resident had a diagnosis of congestive heart failure and was at risk for fluid overload and edema. An intervention was identified to monitor/document/report any signs and symptoms which included edema to the legs and feet, shortness of breath upon exertion, dry cough, weakness and/or fatigue. Review of Nursing Progress Notes for Resident 24 revealed the following: -5/7/24 at 12:12 PM the resident had increased edema and swelling to bilateral lower extremities with increased difficulty walking, -5/8/24 at 3:15 PM the resident was having shortness of breath with walking and a persistent cough with continued increase in swelling to lower extremities. The resident's physician was notified with new orders for laboratory testing and a urinalysis, and -5/10/24 at 1:00 PM new orders received to increase the resident's protein intake with shakes and to update the physician on swelling in 1 week. Review of the resident's electronic medical record revealed no evidence the resident's representative was notified of the residents' change in condition and new physician orders. D. Interview on 5/23/24 at 7:21 AM with the Director of Nursing confirmed the following: -the facility does not have a policy related to notification of change for a physician and/or responsible party, -the DON expected the Charge Nurses to notify the resident's physicians and the resident's representatives within 24 hours of a change of condition which would include a fall, skin tears/bruises/open areas/pressure ulcers, a change in physician orders, incidents of potential abuse/neglect, and of a weight loss or gain, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-the facility failed to notify Resident 11's physician of the resident's 22 lb. weight loss from 11/24/23 to 5/17/24, and -the facility failed to notify Resident 24's representative of the resident's increased edema to lower extremities, shortness of breath with exertion, and persistent cough. In addition, the facility failed to notify the representative of new orders from the resident's physician regarding the resident's change in condition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 LICENSURE REFERENCE NUMBER 175 NAC 12-006.05(9) Based on record review and interview; the facility failed to protect Residents 1, 9, 15, 18 and 24's right to be free from staff-to-resident verbal abuse. The sample size was 5 and the facility census was 28. Findings are: A. Review of the facility Abuse Prevention Policy (undated) revealed the policy was a mechanism for the prompt identification, investigation and reporting of any allegation or complaint of abuse, neglect, or exploitation. The policy indicated allegations of potential abuse were to be immediately reported to a supervisor, the facility Administrator or designee and in accordance with the state and federal laws. If there was reasonable suspicion of a crime or if serious bodily injury occurred, then the report was to be made immediately but no later than 2 hours. Allegations were to be promptly investigated and documented. After completion of the in-depth investigation, the facility was to submit a report of all investigation results to the State Agency within 5 working days. B. Review of Resident 24's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 3/27/24 revealed the resident was admitted [DATE] with diagnoses of non-traumatic brain dysfunction, heart failure, dementia, anxiety, depression, and psychotic disorder. The assessment further revealed the resident's cognition and decision-making skills were severely impaired and the resident was dependent or required substantial to maximal staff assistance with toileting, transfers, dressing, hygiene, and bed mobility. Review of a facility investigation dated 1/5/24 revealed an allegation of staff to resident abuse. Nurse Aide (NA)-O reported on 1/2/24, staff had assisted NA-N with placing Resident 24 in bed. Resident 24 was positioned in the sit-to-stand lift (a mechanical lift that allows for transfers from a seated position to a standing position. The lift is designed to support only the upper body of the resident and requires the resident to have some weight-bearing capability) and refused to keep feet on the footplate of the lift. NA-N pushed Resident 24's feet down on the footplate 3 times. NA-O further reported NA-N was rough when pushing down the resident's feet. C. Review of Resident 18's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of dementia, Parkinson's disease, anxiety, and depression. The resident's cognition was severely impaired, and the resident was dependent or required substantial to maximal staff assistance with hygiene, toileting, dressing, bed mobility, and transfers. Review of a facility investigation dated 1/5/24 revealed an allegation of staff-to-resident abuse involving Resident 18 and NA-N. NA-O identified on 1/2/24, NA-O and NA-N had assisted Resident 18 with morning cares. Staff were attempting to transfer the resident out of bed. Resident 18 refused to lean forward and to hold onto the hand grips of the sit-to-stand mechanical lift, so NA-N proceeded to roughly pull the resident's arm forward and the resident then voiced ouch. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. Review of Resident 15's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of a progressive neurological condition, Parkinson's disease, cancer, and non-Alzheimer's dementia. The resident had short- and long-term memory loss with severely impaired decision-making skills and the resident was dependent on staff to assist with all activities of daily living. Review of a facility investigation dated 1/5/24 revealed an allegation of staff-to-resident abuse involving Resident 15 and NA-N. NA-O identified on 1/2/24, NA-O and NA-N had assisted Resident 15 with evening cares. Resident 15 was not leaning forward properly, and staff were having a difficult time positioning the sling for the sit-to-stand lift behind the resident. NA-N pulled the resident forward and NA-N then placed an elbow in the resident's back to keep the resident forward so the sling could be placed behind the resident's back. E. Further review of the investigation involving NA-N and Residents 15, 18 and 24 revealed NA-N was suspended pending the outcome of the investigation. In addition, NA-O was reminded any allegations of potential abuse/neglect should have been reported immediately and not days after the incident. After completion of the investigation, the facility determined the allegations of abuse were not substantiated as NA-N had meant no ill will or harm and NA-N was not aware of own strength. NA-N was to complete online training related to abuse and dealing with residents with dementia and behaviors before NA-N was allowed to return to work. Review of NA-N's training transcript revealed on 1/12/24 NA-N completed the following training modules: -A day in the life of [NAME], a dementia experience, -Advanced Care Skills in late-stage dementia, and -Alzheimer's disease and related disorders; the environment. Review of the nursing staff schedule for January/2024 revealed NA-N worked on 1/13/24 and on 1/14/24 from 6:00 AM to 6:00 PM Further review of NA-N's training record revealed no evidence NA-N had completed any training related to abuse from 1/5/24 to 1/13/24, despite the staff returning to work and providing direct cares for the facility residents. F. Review of Resident 1's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of non-traumatic brain dysfunction, Alzheimer's, dementia, and depression. The resident's cognition was assessed as severely impaired and the resident required partial to moderate staff assistance with toileting, dressing and personal hygiene. Review of a facility investigation dated 1/16/24 revealed an allegation of staff to resident abuse on 1/14/24 with NA-N and Resident 9. NA-X reported NA-N had grabbed Resident 9 by the waist and made the resident sit back down in a wheelchair. NA-N propelled the resident into the dining room and pushed the resident's wheelchair up against a table. NA-N then used their knee to hold the resident and the wheelchair against the table. In addition, Resident 9 had attempted to enter the public restroom and NA-N took the resident's shoulders and then slammed the resident down and into the wheelchair. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the facility investigation revealed on 1/14/24 NA-N submitted their resignation. G. Review of a facility investigation dated 5/6/24 revealed on 5/5/24 at 11:30 AM, Licensed Practical Nurse (LPN)-P documented in Resident 1's Nursing Progress Notes the resident had slapped NA-Y who had attempted to assist the resident to get dressed as the resident had been incontinent. LPN-P went down to the resident's room and asked the resident how old are you? LPN-P told the resident the resident was acting like a 2-year-old who did not want to mind and told the resident they could get up on their own or LPN-P and NA-Y would help the resident. The resident did not move and so LPN-P and NA-Y got under the resident's arms and assisted to a seated position. Resident 1 was resisteive but then got up from the bed, ambulated into the bathroom with a walker and came out to the dining room for the breakfast meal. Further review of the investigation revealed a skin assessment completed on 5/6/24 revealed the resident had bruising on their wrists. LPN-P indicated staff had not touched the resident's wrists, but the resident had been combative during the incident. The Director of Nursing (DON) did not substantiate the abuse allegation against LPN-P as the LPN was often loud and had a matter of fact personality. LPN-P was educated regarding resident rights and was assigned to complete training related to Resident Rights, Dementia and Abuse. Review of the Nursing schedule for 5/2024 revealed LPN-P worked on 5/18/24 from 6:00 AM to 6:00 PM. Review of LPN-P's training transcript revealed from 5/5/24 to 5/18/24 there was no evidence the LPN had completed the required training related to abuse, dementia and resident rights before returning to work. H. Interview with the DON and the Administrator on 5/21/24 at 5:38 PM confirmed the following: -staff to resident allegation of potential abuse dated 1/2/24 with NA-N and Residents 24, 18 and 15. The allegations were not substantiated but NA-N was assigned retraining related to abuse, residents with behaviors and residents with dementia. NA-N was to complete the re-training prior to returning to work. -NA-N failed to complete the Abuse training prior to returning to work and providing direct resident cares on 1/13/24. -1/14/24 staff to resident allegation of potential abuse with Resident 9 and NA-N. -1/14/24 NA-N submitted their resignation. -staff to resident abuse allegation dated 5/5/24 with LPN-P and Resident 1. The allegation was not substantiated but the staff member was assigned retraining related to abuse, dementia and resident's rights. LPN- P was to complete these training's prior to returning to work. LPN-P worked on 5/18/24 as a Charge Nurse and failed to complete the required training prior to working.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0606 Level of Harm - Potential for minimal harm Residents Affected - Many	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 42360 Licensure Reference Number 175 NAC 12-006.04A3b Based on record review and interview; the facility failed to check the Nurse Aide/Med Aide Registry for 4 of 6 sampled staff for findings to protect residents from potential abuse. Findings are: Review of personnel files on 5/23/24 for the following staff revealed no evidence the facility had checked the Nurse Aide/ Medication Aide registry for the following staff. Housekeeping/Laundry staff -V. Licensed Practical Nurse -P. Dietary Aide -T. Domestic Aide -U. During an interview on 5/23/24 at 8:44 AM the Business Office Manager confirmed the facility was not checking the Nurse Aide/Medication Aide Registry for negative finding for all staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42360 Licensure Reference Number 175 NAC 12-006.09C3 Based on interview and record review; the facility failed to complete a Discharge Recapitulation Summary for Resident 29. The sample size was 1 and the facility census was 28. Findings are: Review of the facility policy Discharge Summary and Plan with a revision date of October 2022 revealed the following: -When a resident's discharge was anticipated, a discharge summary and post discharge plan was developed to assist the resident with discharge. -The discharge summary included a recapitulation of the resident's stay at the facility and a final summary of the resident's status at the time of discharge in accordance with established regulations governing release of resident information and as permitted by the resident. The discharge summary included diagnoses, medical history, course of illness/treatment/therapy, laboratory information, physical/mental functional status, ability to perform activities of daily living, sensory impairments, nutritional status, special treatments and procedures, psychosocial status, discharge potential, activity potential, rehab potential, cognitive status, and medication therapy. -As part of the discharge summary, the nurse reconciled all pre-discharge medications with the resident's post discharge medication and documents. Review of Resident 29's Electronic Medical Record (EMR) revealed the resident was admitted to the facility on [DATE] and discharged from the facility on 4/17/24. Review of Resident 29's Medical Record revealed no evidence the facility had completed a Discharge Summary. During an interview on 5/22/24 at 8:34 AM the Director of Nursing (DON) confirmed the facility had not completed a comprehensive Discharge Recapitulation Summary of Resident 29's stay in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 29638 Licensure Reference Number 175 NAC 12-006.09D7 Based on record review and interviews, the facility failed to identify causal factors and to develop and/or revise interventions to prevent ongoing falls for Resident 24. The sample size was 5 and the facility census was 33. Findings are: A. Review of the facility Fall Prevention Program Policy (undated) revealed each resident was to be assessed for fall risk and was to receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. At the time of admission, each resident's risk for falls was to be evaluated. If the resident's score was 45 or higher, they were considered high risk for falls. The following procedure was indicated after a resident fall: -assess the resident, -complete an Incident Report, -complete a post-fall assessment and determine causal factors, -notify the physician and family, -develop or revise interventions as needed and monitor for effectiveness, -review the resident's care plan and update as indicated, and -document all assessments actions. B. Review of Resident 24's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 3/27/24 revealed diagnoses of osteoarthritis, atrial fibrillation, heart failure, non-Alzheimer's dementia, anxiety, and depression. The following was assessed for Resident 24: -short- and long-term memory loss with impaired decision-making skills, -incontinent of bowel and bladder, -required substantial to moderate staff assistance with transfers, bed mobility, toilet use, dressing and personal hygiene, and -2 falls without injury since the previous assessment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Morse Fall Scale dated 1/1/24 at 8:50 AM revealed the resident's score was 65 indicating Resident 24 was at high risk for falls. Review of an Incident Report dated 1/19/24 revealed at 10:30 AM, the resident was in the dining room, dropped something on the floor, leaned over to retrieve and fell forward out of the chair. Further review revealed a fall alarm had been in place. A new intervention was developed to place the resident at the Nurse's Station so staff could provide with increased monitoring. Review of an Incident Report dated 2/3/24 at 3:00 PM revealed staff heard the resident's fall alarm sounding and observed the resident fall out of a chair. The report confirmed the resident's fall alarm was in place at the time of the fall and documented there was nothing which could be done to avoid future/further falls. In addition, no causal factors were identified. Review of an Incident Report dated 3/10/24 revealed at 5:25 AM the resident was observed lying on the floor by the resident's wheelchair at the Nurse's Station. Current fall interventions were not revised, and no new interventions were indicated. Staff were to continue to monitor the resident. Review of an Incident Report dated 3/19/24 revealed at 8:35 PM the resident was found lying on the floor near the Nurse's Station. The resident had been very restless and had required 1 on 1 supervision throughout the shift. Further review of the report revealed the resident's fall alarm had not sounded and no staff had been in the area when the resident fell . Staff were to assure the resident was supervised when restless and the fall alarm was functioning to prevent further falls. Review of an Incident Report dated 3/20/24 at 2:25 PM, revealed the staff observed the resident stand up unassisted in the wheelchair, turn and try to sit in another chair and then fall to the floor. Review of the resident's electronic medical record revealed no evidence a new intervention was developed for fall prevention. Review of an Incident Report dated 4/17/24 revealed at 4:20 AM, the resident was found on the floor with a 1. 5 centimeter (cm) by .1 cm laceration above the resident's left eye. Review of the post-fall assessment revealed staff failed to respond timely to the resident's fall alarm. Staff were provided education regarding timely fall alarm responses. Review of an Incident Report dated 4/26/24 at 8:00 PM revealed Resident 24 was observed on the floor by the Nurse's Station. The resident had attempted to self-transfer and ambulate without the walker. Current interventions were not revised, and no new interventions were listed. Review of an Incident Report dated 4/28/24 at 7:45 PM revealed the resident's fall alarm was sounding and staff found the resident on the floor next to the resident's wheelchair in the dining room. Staff documented the need for a psychiatric consult and use of gripper socks to prevent further falls for the resident. Review of an Incident Report dated 5/4/24 at 2:50 PM revealed the resident was lowered to the floor when staff were attempting to assist the resident to the bathroom. A new intervention indicated the facility should assure use of 2 staff when ambulating and/or transferring the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Incident Report dated 5/20/24 at 2:10 AM revealed the resident tipped the wheelchair over and fell . The resident's fall alarm did not sound when the resident fell . Staff were again educated to make sure the resident's fall alarm was functioning. No further interventions were identified. Interview with the Director of Nursing (DON) on 5/21/24 at 5:43 PM confirmed the resident was at high risk and had a history of multiple falls. Due to the resident's restlessness (scooting up and down in the chair) the fall alarm was rendered dysfunctional at times, but the alarm had been instrumental in preventing falls so the facility continued use to maintain the resident's safety. The DON verified the following: -staff were to develop a new intervention or were to revise current interventions with each resident fall to prevent further falls and potential injuries. -with the resident's falls on 2/3/24, 3/10/24, 3/20/24 and 4/26/24 staff failed to determine causal factors, to develop new interventions or to revise current interventions. -5/20/24 the resident's fall alarm was not working, and staff received re-educated again to assure the alarm was functional. No interventions were put into place to guarantee the alarm continued to function.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 LICENSURE REFERENCE NUMBER 175 NAC 12-006.09D8 Based on observations, record review and interviews; the facility failed to evaluate weight loss, to develop and/or revise interventions to prevent ongoing weight loss and to ensure nutritional interventions were implemented for 2 (Residents 11 and 15) of 5 sampled residents. The facility census was 28. Findings are: A. Review of the facility policy Nutrition (Impaired)/Unplanned Weight Loss with a revision date of 9/21, revealed the nursing staff were to monitor and document the weight and dietary intake of residents in a format which permitted comparison over time. The staff and physician were to define the resident's nutritional status and identify individuals with weight loss and at significant risk for impaired nutrition. In addition, the staff were to report to the physician significant weight losses or persistent change from baseline appetite or dietary intakes. The staff and the physician were to identify interventions based on individual causes and the resident's condition, prognosis and wishes. The resident's response to interventions was to be monitored and then interventions were to be adjusted as needed. B. Review of Resident 11's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 5/9/24 revealed the following: -severe cognitive impairment and decision-making skills, -diagnoses of dementia, depression, and cancer, -required partial to moderate assistance with eating and drinking, -loss of liquids/solids from mouth when eating, with coughing and choking when eating meals or taking medications, -mechanically altered diet, -weight of 187 lbs. (pounds), and -weight loss of 5 % (percent) or more in 1 month or a loss of 10% or more in the last 6 months and not on a physician prescribed weight loss regimen. Review of the resident's current Care Plan dated 8/22/20 revealed the resident was at risk for a nutritional decline related to diagnoses of dementia and gastroesophageal reflux disease (GERD-a condition in which acidic gastric fluid flows backward into the esophagus). In addition, the resident had a history of a stroke and had difficulty with swallowing and with feeding self. The following interventions were identified: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-extensive staff assistance with eating, -mechanical soft (any food which can be blended, mashed, pureed, or chopped to make food soft and easy to eat) diet with pureed meat and honey-thick (honey or a milkshake consistency) liquids, and -avoid lying down for at least 1 hour after eating. Review of a Nutrition Assessment Progress Note by the Registered Dietician (RD) dated 11/18/23 at 12:40 PM revealed the resident was on a mechanical soft diet with honey-thick liquids and indicated the resident's average dietary intakes were normally 65%. Review of Resident 11's Weights and Vitals Summary Sheet (form used to document a resident's weight, blood pressure, respiration, temperature, and pulse) revealed on 11/24/23 the resident's weight was 199 lbs. Review of a Weights and Vitals Summary Sheet revealed the following: -12/19/23 weight was 196 lbs. (down 3 lbs. in 1 month). -1/30/24 weight was 194 lbs. (down 2 lbs. in 1 month). -2/27/24 weight was 188 lbs. (down 6 lbs. in 1 month). Review of Resident 11's electronic medical record from 12/19/23 to 2/27/24 revealed no evidence the facility had assessed the resident's weight loss or that a nutritional intervention was developed and/or implemented to prevent further loss. Review of a Nutrition Assessment Progress Note by the RD dated 5/11/24 at 2:23 PM revealed the resident's current weight was 176 lbs. (down 23 lbs. or a loss of 12% in the last 6 months). A new intervention was identified to start Complete Nutrition Supplement (CNS) 4-8 ounces thickened to honey consistency daily, due to recent weight loss and decreased intakes. Review of a Nutrition/Dietary Progress Note by the Dietary Manager (DM) dated 5/16/24 at 3:48 PM revealed the resident was on a mechanically soft diet with puree meats and liquids thickened to a honey consistency. The note further revealed the resident's current body weight as of 5/3/24 was 187 lbs. down 5 lbs. in 1 month and 11 lbs. in 6 months. Review of a Weights and Vitals Summary Sheet revealed the resident's weight on 5/17/24 was 177 lbs. The resident had a loss of 10 lbs. in 2 weeks and was down 22 lbs. or a loss of 11% in the last 6 months. Review of a Weights and Vitals Summary Sheet dated 5/21/24 revealed Resident 11's weight was 182 lbs. During an observation on 5/21/24 at 5:17 PM, the resident was served the noon meal which consisted of puree roast beef, mashed potatoes with gravy and regular diced carrots. In addition, the resident received honey thickened juice and water. Further observation revealed no evidence the resident was provided the CNS as recommended by the RD. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations in the dining room on 5/22/24 revealed the following: -7:51 AM the resident was served a pancake with a fried egg and thickened orange juice. No CNS was provided for the resident, and -12:13 PM the resident received a serving of puree chicken, regular green beans and cheesy potatoes cut into bite sized pieces. The resident received thickened orange juice and a container of vanilla ice cream. No CNS was provided to the resident with the noon meal. Review of Resident 11's electronic medical record from 5/11/24 to 5/22/24 revealed no documented evidence the resident received the nutritional supplement recommended by the RD on 5/11/24. During an interview on 5/22/24 with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) the following was identified regarding Resident 11's weight loss: -unaware of the resident's weight loss, -discussed weight loss during interdisciplinary meetings but the nursing department and the dietary department frequently had different weights and there was no consistency with identifying weight loss of residents, -did not have any interaction with the RD and was not aware of the RD's recommendation on 5/11/24 for the nutritional supplement, and -no nutritional interventions had been developed and/or implemented by nursing for Resident 11 despite the resident's weight loss. During an interview with the DM on 5/22/24 at 4:06 PM, the DM confirmed the following: -aware of the RD's recommendation for the CNS, -the resident was offered Boost Breeze (nutritional supplement) at 1 meal and the resident seemed to accept, and -even though Resident 11 accepted the Boost Breeze, the dietary department failed to initiate and to continue to provide the nutritional supplement despite the resident's ongoing weight loss. 42679 C. Review of Resident 15's MDS dated [DATE] revealed the resident had a significant change in condition that identified a weight loss of 5% in the last month or loss of 10% or more in the last 6 months. Further review revealed the resident had severe cognitive impairment and was totally dependent on staff for assistance with eating, dressing, bed mobility, transfers, toileting and personal hygiene. Review of Resident 15's Monthly Weight Report with a print date of 5/22/2024 revealed the following documented weights in the past 6 months between 12/2023 and 5/2024: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-December = 174.0 lbs -January = 172.2 lbs -February = 159.8 lbs -March = 153.8 lbs -April = 147 lbs -May = 144.3 lbs Further review revealed the total amount of the resident's weight loss was 29.7 lbs or 17.07% within the past 6 months. Percentages of weight loss greater than 10% in 6 months was to be considered a significant weight loss. Review of Resident 15's Medication Administration Record (MAR) dated 5/1/2024 - 5/31/2024 revealed the resident had a physician's order dated 5/21/2023 for a nutritional supplement/Ensure 8 ounces three times a day as needed if the resident did not eat well at meals. During an interview with the DON on 5/22/2024 at 1:19 PM, the DON confirmed Resident 15 had a significant weight loss and when the resident consumed 50% or less of food at mealtimes staff should provide the resident with the ordered 8 ounces of nutritional supplement. In addition, staff were expected to document the resident's meal intake percentages and the amount of nutritional supplement the resident received when [gender] meal consumption was 50% or less. D. Review of the facility's meal intake documentation from 3/16/2024 to 5/16/2024 revealed the following related to Resident 15's meal intake percentages and the amount of nutritional supplement the resident received: -3/16/2024 & 3/17/2024, breakfast, lunch and supper, resident ate less than 50% and no supplement amount was documented. -3/20/2024, lunch and supper, resident ate less than 50% and no supplement amount was documented. -3/21/2024, supper, resident ate less than 50% and no supplement amount was documented. -3/23/2024, breakfast and lunch, resident ate less than 50% and no supplement amount was documented. -3/24/2024, supper, resident ate less than 50% and no supplement amount was documented. -3/26/24 & 3/28/2024, breakfast, lunch and supper, resident ate less than 50% and no supplement amount was documented. -3/29/2024, supper, resident ate less than 50% and no supplement amount was documented. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-4/4/2024, breakfast and supper, resident ate less than 50% and no supplement amount was documented. -4/8/2024, breakfast, resident ate less than 50% and no supplement amount was documented. -4/15/2024, breakfast, resident ate less than 50% and no supplement amount was documented. -4/17/2024, lunch and supper, resident ate less than 50% and no supplement amount was documented. -4/18/2024, breakfast, resident ate less than 50% and no supplement amount was documented. -4/19/2024, breakfast, lunch and supper, resident ate less than 50% and no supplement amount was documented. -4/20/2024, supper, resident ate less than 50% and no supplement amount was documented. -4/21/2024, lunch, resident ate less than 50% and no supplement amount was documented. -4/25/2024, supper, resident ate less than 50% and no supplement amount was documented. -4/26/2024, lunch and supper, resident ate less than 50% and no supplement amount was documented. -4/27/2024, breakfast, resident ate less than 50% and no supplement amount was documented. -4/29/2024, supper, resident ate less than 50% and no supplement amount was documented. -4/30/2024, breakfast, resident ate less than 50% and no supplement amount was documented. -5/1/2024, supper, resident ate less than 50% and no supplement amount was documented. 5/2/2024, breakfast and supper, resident ate less than 50% and no supplement amount was documented. -5/4/2024, breakfast, resident ate less than 50% and no supplement amount was documented. 5/9/2024, supper, resident ate less than 50% and no supplement amount was documented. During an interview with the DM on 5/23/2024 at 12:15 PM, DM confirmed the resident's weight loss was significant and there was no evidence of documentation regarding the amount of nutritional supplement the resident received on multiple days [gender] meal consumption was 50% or less between 3/16/2024 and 5/16/2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 42360 Licensure Reference Number 175 NAC 12-006.10D Based on observation, interview, and record review; the facility failed to administer medication with an error rate of less than 5 percent (%). This included crushing medications that should not be crushed for residents 20 and 28, giving medications outside of the recommended/schedules times for Residents 1 and 26, and not observing the consumption of the entire dose of a medication for Resident 1. The sample size was 8 and the facility census was 28. Findings are: A. Review of the facility policy Medication Administration with a revision date of 4/1/24 revealed the following: -Medications were administered by licensed nurses or other staff who are legally authorized to do so, as ordered by the physician and in accordance with professional standards of practice, -Medications were administered in accordance with manufacturer specifications including not crushing medications with do not crush orders. B. Review of the facility policy Medication Errors dated 4/1/23 revealed the following: -The facility provided protections for the health, welfare, and rights of each resident by ensuring residents received care and services safely in an environment free of significant medication errors. -A Medication Error meant the observed of identified preparation or administration of medications or biologicals which was not in accordance with the prescribers' orders, manufacturers specifications regarding the preparation and administration of medications or biologicals, or accepted standards and principles which applied to professionals providing services. -The facility ensured a medication error rate of less than 5%. C. Review of Resident 20's Care Plan with a revision date of 1/31/24 revealed the resident had a tube feeding due to nutritional problems and risk for aspiration (when food accidently goes to the lungs during eating/swallowing) and could only have ice chips orally. Staff were to administer medications as order and monitor for effectiveness and potential side effects. Review of Resident 20's Medication Administration Record (MAR) dated May 2024 revealed a scheduled daily medication of Tamsulosin HCL (Medication used to relax muscle and allow urine to flow more easily from the body- this medication should not be crushed or chewed to avoid all of the medication from being absorbed at once causing a potential drop in blood pressure) 0.4mg capsule at bedtime given by Peg-tube (feeding tube). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of Medication Administration on 5/20/23 at 8:31 PM Registered Nurse (RN)-D prepared a dose of Tamsulosin for administration for Resident 20. RN-D opened the capsule of tamsulosin, emptied it into a bag used for crushing medications and crushed the beads of medication, emptied the crushed beads into a medication cup of warm water and administered the medication through Resident 20's feeding tube. D. Review of Resident 28's Care Plan with a revision date of 3/27/24 revealed the resident had a heart disease, atrial fibrillation (irregular heartbeat that increases a resident's chance for having a stroke), potential for nutritional problems, was diabetic, and staff were to administer medications as ordered and monitor for effectiveness and potential side effects. Review of Resident 28's MAR dated May 2024 revealed the resident received Isosorbide Mononitrate ER(Extended Release -medication used to prevent chest pain in patients with certain heart conditions that should be administered whole and should not be crushed as it could release all the drug at once increasing the potential for adverse side effects) daily for treatment of heart failure. During an observation of the provision of medication for Resident 28 on 5/21/24 during the breakfast meal Licensed Practical Nurse (LPN)-E prepared a dose of Isosorbide Mononitrate ER by placing the tablet in a bag used for crushing medication, crushed the pill, mixed it in apple sauce and administered it to Resident 28. E. Review of Resident 1's Care Plan with a revision date of 1/11/24 revealed the resident was confused and forgetful and was not able to make informed decisions. The resident was at risk for nutritional decline and had GERD (gastro-esophageal reflux disease - condition in which food or gastric content can reflux into the esophagus causing heartburn and or esophageal irritation or erosion and should be taken 30 minutes before breakfast on an empty stomach) In addition, staff were to administer the resident's medication and observe for effectiveness. Review of Resident 1's MAR dated May 2024 revealed the resident received Omeprazole (medication used to treat GERD) one tablet daily at 7:30 AM and Wheat Dextrin powder 2 teaspoons dissolved in liquid 3 times daily for fiber supplementation (promotes good bowel health). During an observation of the provision of medications to Resident 1 during the breakfast meal on 5/21/23 LPN-E administered Omeprazole 1 tablet after the resident had consumed 75% of breakfast (should have been given 1/2 hour prior to the meal). In addition, LPN-E then gave the resident Wheat Dextrin 2 tsp mixed in a glass of fluid and walked away not ensuring the resident consumed the entire dose of Wheat Dextrin. F. Review of Resident 26's Care Plan with a revision date of 1/20/24 revealed the resident had physical and cognitive limitations. The resident was at risk for nutritional problems secondary to obesity. Staff were to administer medications as ordered and monitor effectiveness and for side effects. Review of Resident 26's MAR date May 2024 revealed the resident received Pantoprazole 40mg daily for GERD. During an observation of the provision of medication to Resident 26 during the breakfast meal on 5/21/24 LPN-E administered Pantoprazole 1 tablet after the resident had consumed 100% of the meal. Pantoprazole should be given 30-60 minutes before a meal. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G. During the observed medication administration, the surveyor observed 26 opportunities of medications administration from 5/20/23 through 5/21/23 with 5 errors, revealing an error rate of 19.23%. H. During an interview on 5/22/24 at 2:00 PM the Director of Nursing (DON) confirmed Omeprazole and or Pantoprazole should be administered 30-60 minutes prior to meals, and Isosorbide Mononitrate ER and Tamsulosin should not be crushed. In addition, the DON confirmed that during medication administration, the nurse is responsible to ensure residents consume the entire dose of a medication under direct supervision.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42360 Licensure Reference Number 175 NAC ,d+[DATE].12E Based on observation, interview, and record review; the facility failed to ensure medications were always kept locked, outdated medications were not available for administration, and failed to ensure medications placed for destruction were accounted for until destroyed. The facility census was 28. Findings are: Review of the facility policy Medication Storage with a revision date of [DATE] revealed the following: -the facility ensured all medications on the premises was stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security, -all drugs and biologicals were stored in locked compartments, -only authorized personnel had access to the keys to locked compartments, and -unused medications were destroyed in accordance with the Destruction of Unused Drugs Policy. Review of the facility Destruction of Unused Drugs Policy dated [DATE] revealed the following: -All unused, contaminated, or expired prescription drugs would be disposed of in accordance with state laws and regulations. -drugs were destroyed in a manner that rendered them unfit for human consumption and disposed of in compliance with all current State and Federal requirements, -unused, unwanted, and non-returnable medication would be removed from their storage and secured until destroyed. During observation of the medication storage of the facility on [DATE] at 3:50 through 4:05 PM the following concerns were identified: 1).The facility had no accounting or logged amounts of the current medication that had been place for destruction in a locked cupboard at the nurse's station. The following unlogged medications were present in the cupboard. -1 Spiriva inhaler 18mcg doses -2 Colace 100mg tabs (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-6 Mens multivitamin tablets, -6 Aspirin 81mg tablets, -31 Requip tablets, -4 Nicotene 14mg Patches, -10 Nicotene 21mg patches, -3 Pain Relief 500mg tablets, -200 Eliquis 2.5mg tablets, -30 Zofran 4mg tablets, -25 Nitroglycerin 0.4mg tablets, -5 Novolog insulin 100 units, -5 Levemir insulin 100 units, -1 Acetaminophen 650mg tablet, -6 lidocaine 4% pain patches, -171 Lasix 40mg tablets, -Nyst/Hydrac/Zinc cream 120ml tube, -28 Zofran 8mg ablets, -26 doses Breo ,d+[DATE]mg, -,d+[DATE] tube of Voltaren 1% gel, and -2 full bottles of Antacid regular strength. 2).The facility had no accounting of medications scheduled to be returned the pharmacy. The following medications were observed placed in an unlocked cupboard at the nurse's station . -10 Trazadone 50mg tabs, -5 Olanzapine 5mg tabs, -9 Bumetanide 1mg tabs, -8 Anti-diarrheal 2mg tabs, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-8 Tylenol 325mg tabs, -3 Ibuprofen 600mg tabs, and -10 Zoloft 25mg tabs. 3).The following items were identified in the facility locked medication refrigerator: -Tuberculin injectable: open date of [DATE] (should have been destroyed after 30 days) and was still available for use. -COVID 19 ,d+[DATE] Vaccine: Outdate as of [DATE] - 6 doses were still available for use. During an interview on [DATE] at 4:10 PM Licensed Practical Nurse (LPN)-E confirmed that all outdated medication should not be available for administration and placed for destruction. During an interview on [DATE] at 6:00 PM the Director of Nursing (DON) confirmed all facility medications were to be locked and secure at all times while being stored in the facility. Additional interview confirmed the medications scheduled to be returned to the pharmacy had been stored in an unlocked cabinet at the nurses station, and the medications that had been discontinued and stored in a locked cabinet at the nurses station had not be logged to ensure accountability for those medications in the interim between the time they were placed in the cabinet and the time when they would be destroyed. Additional interview confirmed that all outdated medication needed to be placed for destruction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 42360 Licensure Reference Number 175 NAC 12-006.11E Based on observation, interview, and record review; the facility failed to implement and maintain hand hygiene practices, ensure the dishwasher temps were monitored, and failed to implement and maintaining the cleaning or food preparation equipment and surfaces to prevent the potential for food borne illness. This had the potential to affect all facility residents. The facility census was 28. Findings are: Review of the facility policy Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices dated November 2022 revealed the following: -The food and nutrition employees followed appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness, -All employees who handled food were free of communicable diseases, -Employee washed their hands whenever entering or re-entering the kitchen, before coming in contact with any food surfaces, after handling raw meat, poultry, or fish and when switching between working with raw and ready to eat food, after handling soiled equipment or utensils, as often as necessary to prevent cross contamination and to prevent cross contamination when changing tasks, and after engaging in activities that contaminated the hands. -contact between food and ungloved hands was prohibited and gloves were considered single use items and were discarded after completing tasks in which they were used. After gloves were removed hands were washed and the gloves replaced. -The use of disposable gloves was not a substitute for proper hand washing. -Food service employees were trained in the proper use of utensils, gloves, deli paper and spatulas to prevent food borne illness. Review of the facility policy Food Safety Requirements dated 4/1/24 revealed the following: -the facility policy was to procure food items from sources approved or considered satisfactory by Federal, State and Local authorities, -food was stored, prepared, distributed and service in accordance with professional standard for food service safety, -food safety practices followed throughout the food handling process including procurement, storage, preparation, distribution, equipment uses and handling, and employee hygienic practices, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-all equipment used in the handling of food was kept clean and sanitized in a manner to prevent contamination, -staff adhered to safe hygienic practices to prevent food contaminations including the appropriate use of gloves during food handling, and -staff would follow procedures for dishwashing and cleaning fixed cooking equipment. During the initial kitchen tour on 5/20/24 at 6:40 PM the following concerns were identified: -There was no dishwasher temp log to for the staff to record dishwasher temps to ensure the water temps were at the desired levels. -The cupboard door below the steamer was soiled with water stains and swollen and distorted from being wet; this was not a cleanable surface. All the wooden cupboards in the facility were stained and had darkened areas around all the access handles and knobs. -The Ninja cooker which staff reported was used to cook baked potatoes was heavily soiled with grease and food debris. -The Certified Dietary Manager (CDM) was unable to produce evidence the facility had cleaning schedules for food service equipment. During an interview on 5/20/24 at 6:52 PM Dietary Aide (DA)-A confirmed the staff had no awareness of a log for recording dishwasher temperatures, no idea at which temperature the wash or rinse water for the dishwasher should be, or even where to look to check the dishwasher temps. In addition, DA-A reported using the dishwasher every shift worked. During an interview on 5/20/24 at 6:54 PM DA-B confirmed the staff had no awareness of a log for recording dishwasher temperatures, no idea at which temperature the wash or rinse water for the dishwasher should be, or even where to look to check the dishwasher temps. In addition, DA-B reported using the dishwasher every shift worked. During an interview on 5/20/24 6:59 PM the CDM confirmed being unaware staff were not checking the dishwasher wash and rinse temperatures to ensure the required temperatures of 120 degrees were being achieved for proper sanitation and food safety. The CDM also confirmed being unable to produce a log of dishwasher temp checks. During the subsequent kitchen tour on 5/21/24 at 11:30 PM and 12:30 PM the following concerns were identified: -DA-W washed hands, dried them and then turned off the water with the same towels used to dry hands with then donned disposable gloves, and reported to the serving area. -DA-W removed all the lids from the food items on the steam table wearing disposable gloves and began serving the meal. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-DA-W left the serving area to retrieve serving bowls from a cupboard and a serving spoon from a drawer and then returned to the serving area wearing the same gloves and continued to serve food. -With the same gloved hands DA-W reached into a bag of bread and retrieved slices of bread which were topped with meat using a tong and then using the same gloved hands held the bread and cut it in half and reached for the serving ladle and covered the bread and meat with gravy. -With the same gloved hands DA-W used a tong to put beef into a chopper to cut the meat up, touching the meat in the process using the same gloved hands, then put the lid on to chop it, and then returned to serving the meal with the same gloves still in use. -DA-W then retrieved a chicken breast with tongs from the serving area, and while holding the chicken onto a plate with the same gloved hands cut it into smaller pieces and then continued to serve food touching multiple serving spoons with the same gloves. -Again, using the same gloves which had touched both beef and chicken and numerous kitchen surfaces and serving utensils DA-W reached into a bread bag and grabbed 2 slices of bread; topped it with meat using a serving tong and then with the same gloved hands held the bread on a plate and cut the bread and meat in half and topped it with gravy and continued to serve the meal. During an interview on 5/22/24 at 2:00 PM the CDM confirmed staff must perform hand hygiene prior to all food handling, before and after changing gloves. In addition, if gloves are used to touch potentially unclean surfaces such as drawers and or cabinet door pulls the gloves must be changed including hand hygiene prior to touching ready to eat food. Further interview confirmed that not all staff were recording dishwasher temps to ensure the dishwasher was reaching temperatures to ensure the proper sanitation of dishes, and the facility had no evidence or log to show that kitchen equipment and surfaces were being cleaned regularly to prevent potential food borne illness.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42679 Licensure Reference Number 175 NAC 12-006.17 Based on observations, record review and interview; the facility failed to prevent potential spread of infection when staff 1) had not worn the required Personal Protective Equipment (PPE) during care of Resident 20's feeding tube (a flexible plastic tube placed into the stomach or bowel used to provide nutritional needs), 2) failed to implement hand hygiene measures during incontinence care of Resident 15 and while residents were assisted with eating during the meal service, and 3) failed to implement a legionella water management plan to prevent the potential for water-borne illness. The sample size was 17 and the facility census was 28. Findings are: A. Review of the facility policy Enhanced Barrier Precautions (EBP) dated 4/1/24 revealed the following: -EBP referred to an infection control intervention used to reduce transmission of drug-resistant organisms by implementing use of gown and gloves during high contact resident care activities. -Initiation of EBP included obtaining a physician's order for residents with wounds (ie. chronic pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (ie. Central lines, urinary catheters, feeding tubes, and tracheostomy/ventilator tubes.) -Implementation of EBP included isolation gowns and gloves made available immediately near or outside of the resident's room. -Personal Protective Equipment (PPE- gloves, gown, masks, face shield and/or eye protection) for EBP was necessary when high-contact care activities were performed. -High contact resident care activities include dressing, bathing, transferring, hygiene care, changing linens and/or briefs or assisting with toileting, device care use (feeding tubes) and wound care. -Ensured access to hand sanitizer and positioned a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exiting the room. Review of Resident 20's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 4/15/24 revealed the resident was admitted [DATE] with diagnoses of cancer, heart failure, high blood pressure, pneumonia, stroke, Parkinson's, anxiety, depression, and lung disease. The resident was assessed with a feeding tube and received nutritional calories and fluids via feeding tube on a daily basis. During an observation of Resident 20's feeding tube cares on 5/20/24 at 6:40 PM the following was revealed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The resident was seated on a chair and had a feeding tube device located on [gender] stomach. -Registered Nurse (RN)-D prepared to administer the resident's feeding tube solution and wore a pair of disposable gloves. There were no isolation gowns available in the room and RN-D did not have a gown on throughout the procedure. -RN-D opened the cap on the end of the feeding tube and using a 60 Cubic Centimeter (CC) needleless syringe, inserted air into the tube to check for correct placement in the resident's stomach. -RN-D then removed the syringe from the feeding tube and removed the plunger from the inside the syringe. -RN-D re-inserted the 60cc needless syringe into the feeding tube and poured the feeding solution into the tube. RN-D then flushed the feeding tube with water and replaced the cap back on the feeding tube. -RN-D then removed gloves and washed hands prior to exiting the room. During an interview with RN-D on 5/20/24 at 6:40 PM, RN-D confirmed [gender] had no knowledge EBP should have been implemented when providing tube feeding cares for Resident 20. During an interview with the Director of Nurses (DON) on 5/20/24 at 7:45 PM, the DON confirmed the facility had not yet implemented Enhanced Barrier Precautions for Resident 20 or other residents as of this date. During an interview with the administrator on 5/20/24 at 7:50 PM, the administrator confirmed Enhanced Barrier Precautions should have been implemented for Resident 20 and those who residents who met the criteria for EBP. B. Review of the facility policy Hand Hygiene dated 4/1/24 revealed all staff performed proper hand hygiene to prevent the spread of infection to other personnel, residents, and visitors. This applied to all staff working in all locations within the facility. Hand hygiene was indicated and would be performed under the conditions listed in, but not limited to the following: -When hands were visibly soiled, before and after eating, after using the restroom, known exposure to bacteria/pathogens, when reporting to duty, between resident contacts, after handling contaminated objects, before and after performing procedures, before putting on and after taking off Personal Protective Equipment (PPE), before preparing and handling medications, before and after resident care procedures, before and after handling soiled dressings or linens, and when in doubt. -Alcohol based hand rub was the preferred method for cleaning hands in most clinical situations. Washing with soap and water was indicated whenever hands were visibly dirty, before eating, and after using the restroom. C. Review of Resident 15's MDS dated [DATE] revealed the resident was admitted on [DATE] with diagnoses of cancer, dementia, Parkinson's disease and vision problems. The resident was assessed with severe cognitive impairment, was incontinent of bowel and bladder and was totally dependent upon staff for bed mobility, transfers, dressing, eating, toileting and personal hygiene. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observation of cares provided to Resident 15 on 5/21/24 at 3:25 PM the following was revealed: -Nurse Aide (NA)-K and NA-J washed hands and put disposable gloves on upon entering the resident's room. -The resident was lying in the bed and NA-J opened the disposable brief and noted the resident was incontinent of Bowel Movement (BM). The resident was positioned onto [gender] left side and NA-J cleaned the BM from the resident's buttocks using several cleansing wipes. -NA-J then removed the soiled gloves and did not wash or sanitize hands before putting on clean gloves. NA-J then proceeded to clean the resident's front genital area. An interview with NA-J on 5/21/24 at 3:35 PM confirmed [gender] should have washed or sanitized hands after cleaning the BM from the resident's buttocks and between changing gloves. 42360 D. The facility policy Infection Prevention and Control Program dated 4/1/24 revealed the following: -The facility had established and maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and help to prevent the development and transmission of communicable disease and infections as per acceptable standards and guidelines. E. Review of the Legionella Surveillance policy dated 4/1/24 revealed the facility established primary and secondary strategies for the prevention and control of legionella infections (pneumonia type bacterial illness). Primary prevention strategies included diagnostic testing, source investigation, physical controls, and temperature controls. Secondary prevention strategies included full scale environment investigation, decontamination and heightened surveillance and environmental sampling. F. Review of the facility Water Management Program dated 4/1/24 revealed the facility established water management plans to reduce the risk of legionella or other opportunistic pathogens in the facilities water system based on nationally accepted standards. This included staff education, access to water treatment professionals, environmental specialists, and State and Local health officials. A risk assessment considered water system components, medical devices utilized that could spread Legionella bacteria, and identification of their at-risk population. Data would be used to complete a risk assessment including but not limited to water system schematics, Legionella environmental assessment, resident infection surveillance, environmental culture results, observation data, water temperature logs, water quality reports, and community infection surveillance through health department reporting. The facility would conduct an annual review of the water management program, document activities related to water management, and report relevant information to the QAPI (Quality Assurance and Performance Improvement) Committee. G. During an interview on 5/22/24 at 12:41 PM the facility Administrator confirmed they had not identified potential sources for water borne illness or implemented a water management plan to prevent potential water borne illness. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285298	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandhills Care Center	143 N Fullerton Street Ainsworth, NE 69210

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	H. Review of the facility policy Hand Hygiene dated 4/1/24 revealed the following: -all staff performed proper hand hygiene to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. -Hand Hygiene is indicated and will be performed under the conditions listed in, but not limited to a hand hygiene schedule indicating that hand hygiene should be performed when hands were visibly soiled, before and after eating, after using the restroom, known exposure to bacteria/pathogens, when reporting to duty, between resident contacts, after handling contaminated objects, before and after performing procedures, before putting on and after taking off Personal Protective Equipment (PPE), before preparing and handling medications, before and after resident care procedures, before and after handling soiled dressings or linens, and when in doubt. -Alcohol based hand rub was the preferred method for cleaning hands in most clinical situations. Washing with soap and water was indicated whenever hands were visibly dirty, before eating, and after using the restroom. I. During observation of the breakfast meal on 5/21/24 at 7:30 AM the following concerns were identified: -Staff members H and I while assisting residents at the assisted tables in the dining room were moving from resident to resident; handling the residents' cup/glasses and silverware before and after the resident handled them and then would move between residents without utilizing hand hygiene. J. During an interview on 05/22/24 at 11:10 AM the Infection Preventionist (IP) confirmed that staff were to complete hand hygiene between resident contacts in the dining room to prevent potential transmission of disease.