STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285306	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hemingford Care Center	605 Donald Avenue Hemingford, NE 69348

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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 0606 Level of Harm - Potential for minimal harm Residents Affected - Many	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 49766 Licensure Reference Number 175 NAC 12-006.04(A)(iii) Based on record reviews and an interview, the facility failed to conduct nurse aide registry checks for adverse findings as required for 4 of 5 sampled employees. This had the potential to affect all 27 residing within the facility. Findings are: A record review of a facility policy Abuse, Neglect, Exploitation and Misappropriation Prevention Program with a revised date of April 2021 indicated the facility would conduct employee background checks including state nurse aide registry checks for any adverse findings. A record review of a facility provided list of staff that included date of hire and position revealed the following: - Cook- A was hired on 8/29/2024. - Licensed Practical Nurse (LPN) - B was hired on 10/24/2024. - Nurse Aide (NA) - C was hired on 10/17/2024. - NA - D was hired on 10/21/2024. A. A record review of Cook-A's personnel file revealed no evidence that a nurse aide registry check had been completed. B. A record review of LPN - B's personnel file revealed no evidence that a nurse aide registry check had been completed. C. (continued on next page)

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

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

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F 0606 Level of Harm - Potential for minimal harm Residents Affected - Many	A record review of NA - C's personnel file revealed no evidence that a nurse aide registry check had been completed. D. A record review of NA-D's personnel file revealed no evidence that a nurse aide registry check had been completed. An interview on 12/3/2024 at 2:02 PM with the Administrator confirmed the facility did not conduct nurse aide registry checks for Cook-A, LPN-B, NA-C, or NA-D.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 51122 License Reference Number 175 NAC 12-006.02(H) Based on interviews and record review, the facility failed to report alleged misappropriation of resident property to a state agency within 24 hours and submit an investigation within 5 working days of the incident as required for 1(Resident 12) of 1 sampled resident. The facility identified a census of 27. Findings are: Record review of a facility policy, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, last revised September 2022, revealed if misappropriation of resident property is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The policy also indicated that immediately was defined as within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Record review of an undated facility document titled, Investigation report, Misappropriation, revealed the following: -On 8/7/24 at 10:30AM, the dialysis center called the facility to report that (Resident 12) had alleged that someone stole 4 million dollars from them. -The notification to the administrator/director of nursing was at 8/7/24 at 10:30AM. -Adult Protective Services (APS) was notified on 8/13/24 at 2:12 PM by the facility. -The facility submitted an investigation report to the state agency on 8/19/2024. An interview on 12/5/24 at 10:32 AM with the Director of Nursing (DON) confirmed that the dialysis facility notified the nursing home that Resident 12 alleged that someone had stolen 4 million dollars. The interview also confirmed the allegation was reported to the state agency on 8/13/24. An interview on 12/05/24 at 10:35 AM with the Nursing Home Administrator (NHA) confirmed they did not notify the State Agency within 24 hours or submit an investigation within 5 working days as required.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 49766 Licensure Reference 175 NAC 12-006.09(D) Based on record reviews and an interview, the facility failed to accurately code active diagnoses, medication use, and Gradual Dose Reduction (GDR) information on the Minimum Data Sets (MDS, a standardized assessment tool that measures health status in nursing home residents) for 2 (Resident 9 and 17) of 3 sampled residents. The facility identified a census of 27. Findings are: A record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual with a date of October 2023 revealed the following: -Code medications for anticoagulants if a resident is taking warfarin, heparin, or low-molecular weight heparin. -Code medications for antiplatelet use if a resident is taking clopidogrel or dipyridamole. -If a GDR has been determined clinically contraindicated, enter the date. -Code active diagnoses if that disease has a direct relationship to resident's current functional, cognitive, mood or behavior status, medical treatments, nursing monitoring, or risk of death. A. A record review of Resident 9's annual MDS with a date of 11/5/2024 indicated Resident 9 was taking an anticoagulant. It also indicated the physician had not documented a GDR as clinically contraindicated. A record review of Resident 9's Order Summary as of 12/5/2024 indicated Resident 9 was taking clopidogrel (an antiplatelet medication) 75 milligrams (mg) daily with a start date of 7/5/2022 and was not taking an anticoagulant. Resident 9 was also taking Zyprexa (an antipsychotic medication) 2.5 mg twice a day. A record review of Resident 9's Medication Risk Benefit Evaluation with a date of 10/31/2024 indicated a GDR of Resident 9's Zyprexa was contraindicated. B. A record review of Resident 17's quarterly MDS with a date of 9/10/2024 indicated under active diagnoses that Resident 17 had septicemia (an infection in the bloodstream). A record review of Resident 17's records revealed no indications of ongoing septicemia since before Resident 17 was admitted . (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 12/5/2024 at 11:20 AM with the MDS - Registered Nurse (RN) confirmed Resident 9 had not been taking an anticoagulant and the MDS should have been coded as Resident 9 taking an antiplatelet. The interview also confirmed Resident 9's clinically contraindicated GDR should have been documented on the MDS. Additionally, the interview confirmed Resident 17 no longer had an active diagnosis of septicemia and it should not have been coded on the MDS.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 49766 Licensure Reference 175 NAC 12-006.09(F)(i) Based on record reviews and interviews, the facility failed to develop a baseline care plan within 48 hours of admission and provide a copy to the resident or resident's representative for 5 (Residents 13, 15, 16, 20, and 22) of 8 sampled residents. The facility identified a census of 27. A record review of a facility policy Care Plans - Baseline with last revised date of March 2022 revealed under the policy statement that a baseline care plan is developed for each resident within 48 hours of admission. The policy also revealed the facility would provide a copy of the summary to the resident and/or resident representative and be documented in the medical record. A. A record review of an Admission Record indicated the facility admitted Resident 13 on 6/14/2024 with diagnoses of adult failure to thrive (decline in older adults that manifests as a downward spiral of health and ability,) seizures, atrial fibrillation (a common heart condition that causes an irregular and rapid beating of the heart,) Diabetes, depression, left femur (thigh bone) fracture, acute kidney failure (a sudden decline in the functioning of the kidneys,) and chronic kidney disease (a long-term condition that occurs when the kidneys are damaged and can't filter blood properly.) A record review of Resident 13's medical chart revealed no evidence that a baseline care plan had been developed, implemented, or provided to the resident or their representative. B. A record review of an Admission Record indicated the facility admitted Resident 15 on 2/21/2024 with diagnoses of Alzheimer's disease, Dementia with agitation, mood disorder, chronic pain, and wandering. A record review of Resident 15's Baseline Care Plan v1.1 - V 1 revealed it was completed and signed 2/24/2024, which was more than 48 hours after Resident 15's admission. A record review of Resident 15's records revealed no evidence that a copy of the baseline care plan had been provided to Resident 15 or their representative. C. A record review of an Admission Record indicated the facility admitted Resident 16 on 6/4/2024 with diagnoses of Dementia, psychosis (a group of symptoms that cause a person to have difficulty distinguishing reality from what is not real,) adjustment disorder (a reaction to a stressful event or change in life that is considered unhealthy or excessive,) and Macular Degeneration (a chronic eye disease that affects central vision.) (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 16's medical chart revealed no evidence that a baseline care plan had been developed, implemented, or provided to the resident or their representative. D. A record review of an Admission Record indicated the facility admitted Resident 20 on 5/1/2024 with diagnoses of dementia with psychotic disturbance, generalized anxiety disorder, Alzheimer's disease, chronic pain, and dysphasia (difficulty swallowing.) A record review of Resident 20's Baseline Care Plan v1.1 - V 1 revealed it was completed and signed on 5/4/2024, which was more than 48 hours after Resident 20's admission. A record review of Resident 20's records revealed no evidence that a copy of the baseline care plan had been provided to Resident 20 or their representative. An interview on 12/5/2024 at 9:15 AM with the Director of Nursing (DON) confirmed Residents 15 and 20 were not developed and implemented within 48 hours or provided to the resident or their representative. The DON also confirmed no baseline care plans were developed for Resident 13 or Resident 16. The DON was unaware that baseline care plans were to be developed and implemented within 48 hours and stated the facility has never provided a copy of the baseline care plan to the resident or their representative. E. A record review of an Admission Record indicated the facility admitted Resident 22 on 7/24/2024 with diagnoses of dementia with behavioral disturbance, depression, hypertension (high blood pressure), Congestive Heart Failure (a chronic condition that occurs when the heart can't pump enough blood to meet the body's needs,) and chronic kidney disease. A record review of Resident 22's records revealed no evidence that a baseline care plan had been developed, implemented, or provided to resident or their representative. An interview on 12/5/2024 at 10:58 AM with the DON confirmed a baseline care plan was not developed, implemented, or provided to the resident or their representative for Resident 22.

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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. 49766 Licensure Reference 175 NAC 12- 006.09(G)(i) Based on record reviews and interview, the facility failed to develop and provide a discharge summary that included a recapitulation (a brief review or summary) of stay for 1 (Resident 79) of 1 sampled resident. The facility identified a census of 27. Findings are: A record review of a facility policy, Discharge Summary and Plan with a revision date of October 2022 revealed the following: - 1. The discharge summary includes a recapitulation of the resident's stay at the facility and a final summary of the resident's status at the time of the discharge. - 12. A copy of the following is provided to the resident and will be filed in the resident's medical record: an evaluation of the resident's discharge needs, the post discharge plan, and the discharge summary. A record review of an Admission Record revealed Resident 79 was discharged from the facility on 10/7/2024. A record review of a Discharger Planning Review v1.1 with a date of 10/7/2024 revealed section Recap of the resident's stay was left blank. An interview on 12/4/2024 at 12:00 PM with the Director of Nursing (DON) confirmed a recapitulation of stay was not completed or provided to the resident.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49766 Licensure Reference 175 NAC 12- 006.09(I) Based on record reviews and interview, the facility failed to protect 4 (Residents 9, 16, 17, and 20) from Resident 15's adverse behaviors. The facility identified a census of 27. Findings are: A record review of a facility policy, Abuse, Neglect, Exploitation and Misappropriation Prevention Program with a revised date of April 2021 indicated the facility would protect residents from abuse including from other residents. A record review of a facility policy, Abuse and Neglect - Clinical Protocol with a revise date of March 2018 indicated the physician and staff will address appropriately causes of problematic resident behavior where possible. A. A record review of an Admission Record indicated the facility admitted Resident 15 on 2/21/2024 with diagnoses of Alzheimer's disease, agitation, mood disorder, wandering, and chronic pain. A record review of Resident 15's Minimum Data Set (MDS, a standardized assessment tool that measures health status in nursing home residents), revealed Resident 15 had a Brief Interview for Mental Status score of 2/15, which indicated Resident 15 had severe cognitive impairment. The MDS also revealed Resident 15 had wandering behaviors 4-6 days of the 7 day look back period and required supervision with walking. A record review of Resident 15's undated Care Plan revealed the following: -Resident 15 was admitted to the memory care unit due to diagnoses of Dementia, Alzheimer's disease, and a mood disorder. -Resident 15 was at risk for elopement due to frequent wandering without purpose, verbal aggression, refusal of care, and physical aggression, requiring increased monitoring. -Resident 15 had the tendency to enter other resident's rooms. -Resident 15 had been involved in resident-to-resident altercations on the following dates: 4/18/2024, 5/5/2024, 6/28/2024, and 7/15/2024. -On 3/6/2024, the following interventions were implemented: approach with ease; distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, or a book; and identify patterns of wandering. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 4/18/2024, interventions to attempt to redirect the resident when they attempt to enter other resident's room, if Resident 15 is constantly following staff around to assist Resident 15 to the bathroom and attempt to figure out any other needs they may have, monitor Resident 15 for signs of being tired and assist to room/bed if agreeable; and monitor resident when in close proximity to Resident 17. -On 6/28/2024, a duplicate intervention to supervise Resident 15 when they were ambulating in the hall and attempt to redirect if Resident 15 attempted to enter another resident's room was added. -On 6/29/2024, an additional duplicate intervention was added to include to attempt to distract Resident 15 from entering other resident's room by gently holding their hand and leading them away. Additionally, to use a calm and soothing voice, use a calm and soothing voice, attempt to engage Resident 15 in conversation, and do not tell Resident 15 they can't do something as this could increase Resident 15's agitation. -On 7/15/2024, a duplicate intervention to not tell Resident 15 they can't do something and to redirect was added. -On 7/16/2024, an intervention of a medication review completed by the pharmacist and 15-minute safety checks was added. The 15-minute safety checks were discontinued on 7/22/2024. No additional interventions were placed. B. A record review of Resident 17's Progress Notes from 4/18/2024 at 8:00 PM revealed the nurse heard loud yelling from Resident 17's room. The nurse found Resident 15 standing directly in front of Resident 17. Resident 17 stated to the nurse to get him out. The nurse was unsuccessful in getting Resident 15 out of Resident 17's room and left to get assistance from the charge nurse. Resident 17 stated that Resident 15 had opened the door to their room and laid down on their bed. When Resident 17 told Resident 15 to get out of his room, Resident 17 felt Resident 15 hit them in the back of them head. Resident 17 was assessed for injuries and none were noted. Resident 17 denied any pain related to the altercation. C. A record review of Resident 9's Progress Notes from 5/5/2024 at 12:49 PM revealed the Medication Aide (MA) on duty overheard yelling to get out of their room coming from Resident 9's room. Resident 15 had entered Resident 9's bathroom and pushed Resident 9 to the ground. Resident 9 sustained a bruise to their outer left wrist from the altercation. D. A record review of Resident 16's Progress Notes from 6/28/2024 at 10:56 PM revealed Resident 15 had entered Resident 16's room and an altercation occurred. Resident 16 reported Resident 15 had hit them in the torso. Resident 16 sustained no injuries due to the altercation. E. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 20's Progress Notes from 7/16/2024 at 12:00 AM revealed Resident 20 had been pushed down to the floor by Resident 15 outside their bedroom door. Resident 20 sustained a skin tear to their right upper arm. An interview on 12/9/2024 at 10:55 AM with the Director of Nursing (DON) confirmed no interventions were placed on the care plan after Resident 15's altercation with another resident on 5/5/2024. The DON also confirmed the intervention from 6/29/2024 for Resident 15's altercation with another resident was a duplicate and no intervention to prevent Resident 15 from entering other resident's room was placed. Additionally, the DON also confirmed that no other non-pharmacological intervention to prevent Resident 15 from wandering into other resident's rooms for Resident 15's resident to resident altercation on 7/16/2024 was placed.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 49766 Licensure Reference 175 NAC 12-006.09(H) Based on record reviews and interview, the facility failed to ensure two prophylactic antibiotics had stop dates and had indications for use for 1 (Resident 2) of 1 sampled resident. The facility identified a census of 27. Findings are: A record review of an undated policy Antibiotic Stewardship - Order for Antibiotics indicated if an antibiotic is indicated, prescribers will provide complete antibiotic orders including the drug name, dose, frequency, duration of treatment (start and stop date or number of days of therapy), route and indication. A record review of Resident 2's Order Summary with an active order date of 12/5/2024 revealed orders for Macrobid (an antibiotic), with directions to give one capsule by mouth in the morning for prophylactic with a start date of 11/14/2024 and did not have a stop date or duration. It also revealed an order for bacitracin-polymyxin ophthalmic ointment, an antibiotic for the eye, with directions to instill one ribbon in the right eye at bedtime for supplement with a start date of 4/13/2024 and did not have a stop date or duration. An interview on 12/5/2024 at 9:20 AM with the Director of Nursing (DON) confirmed Resident 2's antibiotic orders did not have stop dates or durations, and the antibiotic eye drops did not have a valid indication for use.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 51122 Licensure Reference Number 175 NAC 12-006.04(H)(i) Based on an interview and record reviews, the facility failed to employ a Registered Dietitian full-time or have a certified Food Service Director. This had the potential to affect 27 residents who ate from the kitchen. The facility census identified a census of 27. Findings are: Record review of a facility document titled, Hemingford Care Center Facility Assessment - 2024, section 3.2: Staffing Plan, revealed that the facility identified the need for one, Dietician or other clinically qualified nutrition professional to serve as the director of food and nutrition services. An interview with the Kitchen Supervisor (KS) on 12/3/24 at 10:40 AM revealed KS had been the supervisor for several months but had not completed any special certifications and was not a certified FSD. An interview with the Administrator on 12/03/24 at 1:01 PM, revealed that the dietitian had resigned and no longer worked at the facility as of 11/29/24.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 51122 License Reference Number 175 NAC 12-006.11(D) Based on observations, record review, and interviews, the facility failed to maintain the nutritive value of pureed food. This had the potential to affect 2 residents (Residents 5 and 15). The facility identified a census of 27. Findings are: An observation of meal service on 12/3/24 at 11:46 AM revealed the following: -Cook-A measured three foods into three separate blender containers: (a) chicken and dumplings, (b) boiled seasoned peas, and (c) cornbread. -The foods were blended by Cook-A with an electric blender attachment. -Cook-A added unmeasured hot water from a coffee carafe to each container, then re-blended to achieve a pureed consistency for the chicken and the peas, and a slurry for the cornbread. -The three blended foods were each distributed to two separate plates, and a serving of cooked canned sweet potatoes was also put on each plate. A record review of the undated facility recipe, Chicken and Dumplings, revealed no guidance for mechanical soft or pureed diet modifications. No recipe was available for the peas or cornbread. An interview on 12/3/24 at 11:46 AM with Cook-A revealed that the pureed food was prepared for and served to Resident 5 and Resident 15. An interview on 12/03/24 at 12:03 PM with the Kitchen Supervisor revealed they were not aware that adding water to food would decrease the nutritive value. An interview on 12/04/24 at 1:30 PM with the Administrator confirmed there was not an existing facility policy for preparing mechanical soft, pureed, or other mechanically altered texture foods for residents.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51122 Licensure Reference Number 175 NAC 12-006.11(A)(iv) Based on observation, interview, and record review, the facility failed to serve food in the texture ordered by the medical provider for two affected residents (Residents 5 and 15). The facility identified a census of 27. Findings are: A record review of active physician's orders for Resident 5 revealed an order for, regular diet, mechanical soft texture, thin consistency liquids, ordered on 7/30/2024. A record review of active physician's orders for Resident 15 revealed an order for, liberalized diet, mechanical soft texture, regular consistency liquids, ordered on 9/23/2024. An observation of meal service on 12/3/24 at 11:46 AM revealed the following: -Cook-A measured three foods into three separate blender containers: (a) chicken and dumplings, (b) boiled seasoned peas, and (c) cornbread. -The foods were blended by Cook-A with an electric blender attachment. -Cook-A added unmeasured hot water from a coffee carafe to each blender container to achieve a pureed consistency for the chicken and the peas, and a slurry for the cornbread. -The three blended foods were each put on two separate plates. An interview with the Cook-A on 12/3/24 at 11:46 AM confirmed that the pureed food was prepared for and served to Resident 5 and Resident 15, and that those residents had a mechanical soft diet order. Record review of an undated facility document titled, Extensions: Week 2, Day 4, revealed that chicken and dumplings should be served as a ground texture to residents on a mechanical soft diet. Record review of an undated facility document titled, Extensions: Week 1, Day 3, revealed that peas should be served as a pureed texture to residents on a mechanical soft diet. Record review of an undated facility document titled, Extensions: Week 2, Day 3, revealed that cornbread should be served as a slurry texture to residents on a mechanical soft diet. An interview on 12/04/24 at 1:30 PM with the Nursing Home Administrator confirmed there was not an existing facility policy for preparing modified texture foods for residents. The Administrator was unaware the foods were being served at a different consistency than what was ordered by the medical provider. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285306	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER Hemingford Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 605 Donald Avenue Hemingford, NE 69348	

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of a educational document from Memorial [NAME] Cancer Center called, Eating guide for pureed and mechanical soft diets, and dated 2015 defined a mechanical soft diet as, made up of foods that require less chewing than in a regular diet. The same document defined a pureed diet as, made up of foods that require no chewing, such as mashed potatoes and pudding.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285306	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER Hemingford Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 605 Donald Avenue Hemingford, NE 69348	

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51122 Licensure Reference Number 175 NAC 12.006.11(E) Based on observations and interview, the facility failed to store, label, cover, and use or discard food and drink items in a manner that prevented the potential for foodborne illness. This had the potential to affect all 27 residents residing at the facility. Findings are: An observation on 12/2/24 at 8:49 AM during the initial kitchen tour revealed the following: Refrigerated items: -1 open half-full 32-ounce container, manufacturer-labeled garlic in water covered with foil and labeled AR 10/30, OPD 11/5. -1 unlabeled package of ground meat-like substance in tubular casing. -1 1-gallon ziplock bag of loose raw meat-like substance labeled 11/29, 12/3. -1 fiberglass tray with 3 1-gallon size ziplock bags of diced meat sitting in liquid on tray, labeled (a)8/23 [NAME], (b)diced chicken, arrive frozen 11/21 LO 11/28, and (c) diced turkey out 11/29. In the dry storage room, 1opened gallon-sized container [NAME] cooking wine, labeled with open date of 8/18 and Best-if used by [DATE]. Next to the triple-compartment utility sink: 1 dual level commercial coffee maker which had 2 carafes of hot coffee and 1 carafe of hot water, with 2 of the three carafes not covered with lids. On a snack cart, three half-sandwiches in baggies labeled with the following dates: 11/29-12/2; 11/25-11/28; 11/28-12/1. An interview on 12/02/24 at 3:27 PM with the Kitchen Supervisor (KS) revealed they were unaware the coffee carafes should be covered, and not be located next to the sink where dirty dishes are washed. The interview confirmed the items listed should have been sealed, labeled clearly, used, or discarded, and the bagged meats should not have been stored in liquid in a container together.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285306	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hemingford Care Center	605 Donald Avenue Hemingford, NE 69348

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.

51122

License Reference Number 175 NAC 12-006.18

Based on observations, interviews, and record reviews; the facility failed to handle contaminated linens for all residents who were residing within the facility in a way that prevented the potential for cross contamination; and the facility failed to complete hand hygiene between distributing laundry for Residents 11, 21, 130, and 131. The facility identified a census of 27.

Findings are:

A.

An observation on 12/09/24 at 10:10 AM revealed Housekeeping/Laundry-G (HSKP-G) distributing personal laundry to residents on the 100 hall of the facility. HSKP-G exited Resident 21's room and returned a plastic bin to the linen cart. HSKP-G zipped the protective plastic covering closed on the cart, pushed the cart down the hall, then unzipped the plastic covering. HSKP-G removed hanging clothing from the cart, carried it into Resident 11's room, exited the room with empty hangers, retrieved a small plastic bin from the cart, returned to Resident 11's room, then exited the room again, recovered the cart, then moved down the hall. HSKP-G performed the same delivery activities for Resident 130's and 131's rooms. No hand hygiene was observed throughout the continuous observation period.

An interview on 12/09/24 at 10:20 AM with HSKP-G confirmed that they did not perform hand hygiene during the distribution of resident laundry. HSKP-G stated they did not know it was required.

B.

Record review of a facility policy titled, Departmental (Environmental Services) - Laundry and Linen, last revised January 2014, revealed the following: Sorting Soiled Linen: Step 1. Employees sorting or washing linen must wear a gown and gloves.

An interview on 12/9/24 at 10:56 AM with Housekeeping/Laundry-G (HSKP-G), revealed that laundry staff sort soiled linen into four separate bins depending on type of item. HSKP-G stated that when staff sorted soiled laundry, they wear gloves and no other protective clothing.

An observation on 12/9/24 at 10:56 AM revealed a box of disposable exam gloves on top of a commercial washer. No clean or soiled gowns were observed during the tour of the laundry area.

An interview on 12/9/24 at 12:15 PM with the Administrator confirmed that no gowns were used in sorting soiled laundry.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285306	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER: Hemingford Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 605 Donald Avenue, Hemingford, NE 69348	

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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 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 49766 Licensure Reference 175 NAC 12-006.04(B)(i) Based on record review and interviews, the facility failed to ensure 1 (Nurse Aide (NA)-F) of 6 sampled employees had completed initial orientation with training on abuse. This had the potential to affect all 27 residing in the facility. Findings are: A record review of a facility policy Abuse, Neglect, Exploitation and Misappropriation Prevention Program with a revised date of April 2021 indicated the facility's process to prevent abuse, neglect, or exploitation included providing staff orientation that included topics such as abuse prevention, identification and reporting of abuse, stress management, and handing verbally or physical aggressive resident behavior. An interview on 12/10/2024 at 10:00 AM with NA-F revealed NA-F was unable to verbalize any types of abuse or when and whom to report to. NA-F revealed they had been employed with the facility since October 2024, but did not recall having had any initial orientation on abuse. An interview on 12/10/2024 at 11:40 AM with the Administrator revealed the Administrator had no evidence that NA-F had completed abuse training during initial orientation.