

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28A065	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER Carl T Curtis Health Education Center Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Indian Hills Drive Macy, NE 68039	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50106</p> <p>Licensure Reference Number NAC 12-006.04 (F)(i)(5)</p> <p>Based on observation, record review, and interviews, the facility failed to notify the medical provider when a prescribed medication was not given for 6 days for 1 (Resident 7) of 2 sampled residents. The facility had a total census of 21 residents.</p> <p>Findings are:</p> <p>A record review of policy entitled Nursing Standards of Practice Policy for Documentation dated 2020 revealed: If a medication/treatment is not available, document the attempts made to obtain the item. If unsuccessful, contact the Director of Nursing, physician, or pharmacist for assistance.</p> <p>A record review of Resident 7's Census Report revealed Resident 7 was admitted on [DATE].</p> <p>A record review of Resident 7's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 10/7/24 revealed a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 15. A BIMS score of 15 revealed that Resident 7 was cognitively intact. Resident 7's functional abilities revealed Resident 7 could eat independently and required supervision/touching assistance for toileting, bed mobility and transfers. The diagnosis included in the MDS were heart failure, hypertension, cirrhosis, gastro-esophageal reflux, end stage renal disease, diabetes, hyperlipidemia, thyroid disorder, anxiety, respiratory failure, and obstructive sleep apnea.</p> <p>An observation of medication pass at 10/29/24 at 7:55 AM by Medication Aide-E (MA-E) for Resident 7 revealed MA-E was unable to find the Lactulose in the medication cart. All medications except the Lactulose were administered as prescribed.</p> <p>A record review of the Medication Administration Record (MAR) for Resident 7 dated 10/29/24 revealed an order for Lactulose 10 grams per 15 milliliters (ml); take 30 ml twice a day by mouth for cirrhosis of the liver to reduce blood ammonia levels. The MAR further revealed the last documented administration of Lactulose was on 10/24/24 AM dose. The MAR also revealed Lactulose was documented as not available from 10/24/24 through 10/29/24.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with MA-E 10/29/24 at 8:30 AM revealed MA-E ordered the Lactulose on 10/24/24 for Resident 7. MA-E confirmed the Lactulose had not been available since last given 10/24/24 in the morning. MA-E had notified the charge nurse on 10/28/24 and 10/29/24 of the Lactulose not being available.</p> <p>In an interview on 10/29/24 at 12:00 PM with the Registered Nurse (RN-D) regarding Resident 7's Lactulose, revealed RN-D planned to call the pharmacy to find out why the Lactulose had not arrived. RN-D was not aware of any other attempts that have been made to contact the pharmacy. RN-D was not aware if the medical provider had been notified of the medication Lactulose not being given to Resident 7 since the morning of 10/24/2024.</p> <p>A record review on 10/29/24 of Resident 7's Progress notes since 10/24/24 did not reveal any attempts of the pharmacy or medical provider being notified of the Lactulose not being available.</p> <p>In an interview on 10/30/24 at 8:37 AM with RN-D revealed the Lactulose for Resident 7 had arrived last night from the pharmacy. RN-D denied notification of the medical provider of the Lactulose being unavailable since 10/24/24. RN-D confirmed the Lactulose was started again on 10/30/24 in the morning.</p> <p>In an interview on 10/30/24 at 12:03 PM with Nurse Consultant confirmed that the medical provider had not been notified that Resident 7 had not received the prescribed Lactulose since the morning of 10/24/24. NC-A confirmed Resident 7 missed 6 days of the prescribed Lactulose.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50106</p> <p>Licensure Reference Number NAC 12-006.10(D)</p> <p>Based on observation, record review, and interviews, the facility failed to ensure medication was available for 6 days resulting in a significant medication error for 1 (Resident 7) of 2 sampled residents. The facility had a total census of 21 residents.</p> <p>Findings are:</p> <p>A record review of policy entitled Nursing Standards of Practice Policy for Documentation dated 2020 revealed: If a medication/treatment is not available, document the attempts made to obtain the item. If unsuccessful, contact the Director of Nursing, physician, or pharmacist for assistance.</p> <p>A record review of Resident 7's Census Report revealed Resident 7 was admitted on [DATE].</p> <p>A record review of Resident 7's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 10/7/24 revealed a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 15. A BIMS score of 15 revealed that Resident 7 was cognitively intact. Resident 7's functional abilities revealed Resident 7 could eat independently and required supervision/touching assistance for toileting, bed mobility and transfers. The diagnosis included in the MDS were heart failure, hypertension, cirrhosis, gastro-esophageal reflux, end stage renal disease, diabetes, hyperlipidemia, thyroid disorder, anxiety, respiratory failure, and obstructive sleep apnea.</p> <p>An observation of medication pass at 10/29/24 at 7:55 AM by Medication Aide-E (MA-E) for Resident 7 revealed MA-E was unable to find the Lactulose in the medication cart. All medications except the Lactulose were administered as prescribed.</p> <p>A record review of the Medication Administration Record (MAR) for Resident 7 dated 10/29/24 revealed an order for Lactulose 10 grams per 15 milliliters (ml); take 30 ml twice a day by mouth for cirrhosis of the liver to reduce blood ammonia levels. The MAR further revealed the last documented administration of Lactulose was on 10/24/24 AM dose. The MAR also revealed Lactulose was documented as not available from 10/24/24 through 10/29/24.</p> <p>In an interview with MA-E 10/29/24 at 8:30 AM revealed MA-E ordered the Lactulose on 10/24/24 for Resident 7. MA-E confirmed the Lactulose had not been available since last given 10/24/24 in the morning. MA-E had notified the charge nurse on 10/28/24 and 10/29/24 of the Lactulose not being available.</p> <p>In an interview on 10/29/24 at 12:00 PM with the Registered Nurse (RN-D) regarding Resident 7's Lactulose, revealed RN-D planned to call the pharmacy to find out why the Lactulose had not arrived. RN-D was not aware of any other attempts that have been made to contact the pharmacy. RN-D was not aware if the medical provider had been notified of the medication Lactulose not being given to Resident 7 since the morning of 10/24/2024.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review on 10/29/24 of Resident 7's Progress notes since 10/24/24 did not reveal any attempts of the pharmacy or medical provider being notified of the Lactulose not being available.</p> <p>In an interview on 10/30/24 at 12:03 PM with Nurse Consultant confirmed that a significant medication error occurred for Resident 7 due to the medication Lactulose being unavailable for 6 days.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50106</p> <p>Licensure Reference Number 12-006.18(B)</p> <p>Based on observation, record review, and interview, the facility failed to don (put on) and doff (take off) gowns during cares and treatments of a resident with a supra-pubic indwelling catheter (a tube placed in the abdomen to drain urine from the bladder to a bag) per Enhanced Barrier Precaution Protocol for 1 of 1 Residents (Resident 1) observed for the care of the catheter. The facility identified a census of 21 residents.</p> <p>Findings are:</p> <p>Record review of Enhanced Barrier Precautions (EBP) Policy dated 2022 revealed the following:</p> <p>It is the policy of this facility that Enhanced Barrier Precautions, in addition to Standard and Contact Precautions, will be implemented during high-contact resident care activities when caring for resident that have an increased risk for acquiring a Multi-Drug Resistant Organisms (MDRO, bacteria that resist treatment with more than one antibiotic) such as a residents with wounds, indwelling medical devices (supra-pubic indwelling catheter) or residents with infection or colonization with an MDRO.</p> <p>The purpose of EBP is to prevent opportunities for transfer of MDROs to employees' hands and clothing during cares, beyond situations in which staff anticipate exposure to blood or body fluids.</p> <p>High contact resident care activities include:</p> <ul style="list-style-type: none"> -Providing hygiene, -Changing briefs or assisting with toileting, -Device care or use for urinary catheter. <p>Record review of Resident 1's Minimum Data Set (MDS, a federally mandated assessment tool used for care-planning) dated 10/1/2024 revealed an admitted [DATE]. Resident 1 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) with a score of 2 which indicated Resident 1 was severely cognitively impaired. Resident 1 was dependent on staff for toileting, bed mobility, and transfers. Resident 1 had an indwelling suprapubic catheter.</p> <p>An observation on 10/29/24 at 9:30 AM revealed outside of Resident 1's doorway hanging beside the door was an EBP Precautions sign which instructed staff to wear gown and gloves with Resident 1 when providing high contact resident care activities. The personal protective equipment (PPE) was located directly below the EBP sign outside of the room, which included disposable gowns to use.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation on 10/29/24 at 9:42 AM of staff emptying indwelling suprapubic catheter bag revealed upon entering the room Nursing Assistant B (NA-B) and Nursing Assistant C (NA-C) did not don a personal protective gown before entering Resident 1's room. Nursing Assistant-C (NA-C) completed hand hygiene in the bathroom. Nursing Assistant-B completed hand hygiene in the bathroom. Both NA-B and NA-C applied clean gloves. NA-B emptied the urine from the catheter bag into the graduate to measure and then disposed of the urine in the toilet.</p> <p>An observation on 10/29/24 at 10:38 AM, NA-B and NA-C provided supra-pubic catheter care, peri-care, and brief change for Resident 1. Upon entering the room neither NA-B nor NA-C donned a personal protective gown. Both NA-B and NA-C did HH in the bathroom with soap and water for 23 seconds prior to cares. NA-B and NA-C applied gloves after HH was completed. After the completion of cares, both NA-B and NA-C did HH in the BR for 25 seconds.</p> <p>In an interview at 10/29/24 at 10:38 AM with NA-B confirmed a gown should have been worn when providing catheter care, peri-care, and when emptying the supra-pubic indwelling catheter for Resident 1.</p> <p>In an interview at 10/29/24 at 10:38 AM with NA-C confirmed a gown should have been worn when providing catheter, peri-care, and emptying the supra-pubic indwelling catheter for Resident 1.</p> <p>In an interview at 10/29/24 at 10:38 AM with Nurse Consultant-F (NC-F) confirmed a gown should have been worn when providing catheter, peri-care and emptying the supra-pubic indwelling catheter for Resident 1.</p>		

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<p>F 0923</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have enough outside ventilation via a window or mechanical ventilation, or both.</p> <p>17285</p> <p>Licensure Reference Number 175 12-007.04 D</p> <p>Based on observation and interview, the facility failed to ensure that ventilation systems were operational in resident bathrooms in 21 (Rooms 1, 3, 4, 5, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 23, 24, 25) of 21 occupied resident bathrooms. The facility census was 21.</p> <p>Findings are:</p> <p>An observation on 10/30/24 between 8:30 AM to 9:00 AM with the facility Maintenance Director revealed that the ventilation system was not functional and would not draw a 1 ply square of toilet paper to the surface of the ventilation cover in resident bathrooms in resident rooms 1, 3, 4, 5, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 23, 24, and 25.</p> <p>Interview on 10/30/24 at 9:05 AM with the Maintenance Director confirmed that the ventilation system did not draw a 1 square ply of toilet paper in resident bathrooms in resident rooms 1, 3, 4, 5, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 23, 24, and 25. The Maintenance Director confirmed that the ventilation systems had not been checked for draw and that there was no documentation of when the last time the system had been checked to ensure it was operational.</p>