STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28E257	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gordon Countryside Care	500 East 10th Street Gordon, NE 69343

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. 49263 Licensure Reference Number 175 NAC 12-006.09(I) Based on observations, record review, and interviews; the facility failed to ensure 1 (Resident 18) of 2 sampled residents' oxygen concentrator was turned off when not in use and unattended. The facility census was 26. The Findings Are: A record review of facility policy Oxygen Administration with revision date of October 2010 revealed that the facility would instruct the resident, their family, visitors, and roommate (if any) of the oxygen safety precautions. The policy also stated that the facility would provide the resident with a written copy of the Oxygen Safety Handout. A record review of undated facility provided document Using Oxygen Safely, revealed instruction to Turn off your oxygen when you're not using it. A record review of Resident 18's Minimum Data Set (MDS), a federally mandated comprehensive assessment tool used for care planning, dated 7/2/2024, revealed that the resident had diagnoses of non-Alzheimer's dementia, pulmonary hypertension due to lung diseases and hypoxia (An absence of enough oxygen in the tissues to sustain bodily functions), and dependence on supplemental oxygen. A record review of Resident 18's physician's orders revealed an order for continuous oxygen therapy at 3 Liters Per Minute (LPM) via nasal cannula. An observation on 7/29/24 at 10:31 AM revealed Resident 18 was not in their room. Resident 18's oxygen concentrator was turned on and running at 3 LPM. An interview on 7/29/24 at 10:33 AM with Registered Nurse (RN)-E confirmed that Resident 18 was not in their room, they had been attending a facility activity since 10:00 AM, and that Resident 18's oxygen concentrator had been left turned on and unattended in the resident's room. An observation on 7/30/24 at 3:20 PM revealed Resident 18 was not in their room. Resident 18's oxygen concentrator was turned on and running at 3 LPM. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 7/30/24 at 3:24 PM with the Director of Nursing (DON) confirmed that Resident 18 had been out of their room at a facility activity since 2:00 PM, and that Resident 18's oxygen concentrator had been left turned on and that the oxygen concentrator should have been turned off while the resident was out of their room.

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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. 49263 Based on record review and interview, the facility failed to ensure 1 (Resident 8) of 2 sampled residents was free from unnecessary medications related to a) the long-term use of an antibiotic medication which did not specify a duration and b) the use of an antibiotic which had no supporting documentation for clinical use based on laboratory results. The facility census was 26. The Findings Are: A record review of facility policy Antibiotic Stewardship Program with revision date of 3/4/24 revealed that all prescriptions for antibiotics would specify the dose, duration, and indication for use. The policy also stated that the facility would monitor resident response to antibiotics, and laboratory results when available, to determine if the antibiotic was still indicated or adjustments should be made. A. A record review of Resident 8's facility admission orders dated 10/25/23, revealed Resident 8 was admitted to the facility with an order for nitrofurantoin (an antibiotic used to treat urinary tract infections (UTI)) 100 milligrams (MG) at bedtime for UTI prevention. A record review conducted on 7/30/24 of Resident 8's current physician's orders revealed an order for Nitrofurantoin 100 MG to be given on time a day for UTI prophylaxis. The order had a start date of 10/25/23 and did not have a stop date or an intended duration. A record review of Resident 8's scanned physician visit documents, revealed Resident 8 was seen by their physician on the following dates with no references made to the continued use, or duration for, Resident 8's Nitrofurantoin order: -12/20/2023 -1/17/2024 -3/29/2024 -5/21/2024 -7/17/2024 B. A record review of Resident 8's progress note dated 5/17/2024 revealed that Resident 8 was having increased confusion and a decreased appetite. The progress note also stated that a urinalysis (UA) had been obtained and sent to the lab, the resident's urine was amber cloudy, that the doctor was aware, and that the resident had denied pain with urination. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of a urinalysis collected for Resident 8 on 5/17/24 revealed a final culture result was received on 5/19/24 which showed there was 50,000-100,000 cfu/ml of Mixed Flora- More than 3 organisms isolated. The report also stated, please review specimen collection procedure and consider resubmitting if clinically indicated. Further record review of Resident 8's urinalysis collected on 5/17/24 revealed a handwritten note on the document stating to start the resident on cephalexin (an antibiotic medication used to treat infections) 500 MG three times a day (TID) for 7 days. The document did not have an antibiotic susceptibility report, which is normally included in a final culture report and details which antibiotics will work to eliminate the infection. A record review of Resident 8's physician's orders revealed an order for cephalexin 500 MG TID for 7 days for UTI with a start date of 5/17/24 and an end date of 5/24/24. The resident also continued to take their nitrofurantoin antibiotic during this time period. A record review of the website asap.nebraskamed.com revealed the Revised McGeer Criteria for Infection Surveillance Checklist which stated that for a voided urine sample, there was to be at least 100,000 cfu/ml of no more than two species of organisms when determining if a person had a urinary tract infection. The McGeer Criteria did not list confusion, decreased appetite, or cloudy urine as signs or symptoms of UTI. A record review of the website pubmed.ncbi.nlm.gov revealed in an article titled The significance of urine culture with mixed flora that urine cultures that contained more than one organism were usually considered contaminated. An interview on 7/31/24 at 8:35 AM with Registered Nurse (RN)-F revealed that RN-F had not specifically discussed Resident 8's antibiotic use with their primary provider in an effort to reduce the unnecessary use of antibiotics. RN-F confirmed that the facility utilized McGeer's Criteria when determining whether a resident had an infection.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49766 Licensure Reference 175 NAC 12-002.10 Based on observations, interviews, and record reviews; the facility failed to ensure medications were administered at the right time for 2 (Residents 1 and 15) of 6 sampled residents and to ensure the medication error rate was less than 5%. The medication error rate was 5.4% (37 medications administered with 2 medication errors.) The facility census was 26. Findings are: A record review of a facility policy Administering Medications with a revision date of April 2019 indicated medications are to be administered within one hour of their prescribed time unless otherwise specified and the individual administering the medication is to check the label to verify the right time before administering the medication. A record review of Resident 15's Medication Administration Record with a date of July 2024 indicated an order for Basaglar insulin (a medication used to treat hyperglycemia) to be administered at 9:00 AM with no special instructions related to the administration time. An observation on 7/30/2024 at 7:29 AM revealed Registered Nurse (RN)-A administered the Basaglar insulin to Resident 15. An interview on 7/30/2024 at 7:32 AM with RN-A confirmed RN-A was aware of the administration time of 9:00 AM, but due to Resident 15 being up early, was going to override that. A record review of Resident 1's Medication Administration Record indicated an order for levothyroxine (a medication used to treat thyroid disorder). A record review of Resident 1's levothyroxine label revealed instructions that included to take on an empty stomach. An observation on 7/30/2024 at 8:07 AM revealed Resident 1 had been sitting in the dining room with a plate of food in front of them. Resident 1 had already consumed approximately 25% of the food that was on the plate. Medication Aide (MA) - B attempted to administer the levothyroxine to Resident 1 but was unsuccessful due to Resident 1's refusal. MA-B then asked the Director of Nursing (DON) to attempt to administer the medication to Resident 1. The DON was successful at getting Resident 1 to take the levothyroxine. An interview on 7/30/2024 at 11:35 AM with MA-B revealed MA-B did not notice the instructions that stated to give on an empty stomach for Resident 1's levothyroxine.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49766 Licensure Reference 175 NAC 12- 006.11(E) Based on observations, interviews, and record reviews; the facility failed to ensure foods were disposed or consumed prior to best-by and use by dates, store foods at least six inches off the floor as required, and to implement hand hygiene practices as required to prevent the potential for cross contamination and foodborne illness. This had the potential to affect all 26 residents who resided within the facility. Findings are: A. A record review of a facility policy Food Storage with a last reviewed date of January 2021, indicated date marking should be visible on foods to indicate the date by which ready to eat foods should be consumed or discarded and that all foods will be consumed by their safe use by dates or discarded. An initial kitchen tour observation on 7/29/2024 at 9:50 AM revealed the following: -In the dry food storage area: -An opened bag of French-Fried Onions that had been opened, but no open date or use by date. -Five cans of Whole Oysters with best if used by dates of 5/31/2024. -One loaf of [NAME] Texas Toast with a best by date of 7/24/2024. -In the walk-in refrigerator: -A container of Deviled Egg Potato Salad with a use by date of 7/16/2024. -A container of Macaroni Salad with a use by date of 7/26/2024. -A jug of Fat Free Milk that was 3/4 empty with a best by date of 7/23/2024. -A container of Original Strawberry Yoplait Yogurt with a best by date of 7/19/2024. -In the reach-in refrigerator: -A bottle of Strawberry Syrup with a best by date of 5/2024. An interview on 7/29/2024 at 10:05 AM with the Certified Dietary Manager (CDM) confirmed the items observed during the initial kitchen tour should have been dated with an open and use by date and consumed or disposed of by the use by or best by dates. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	B. A record review of a facility policy Food Storage with a last reviewed date of January 2021, indicated that food should be stored a minimum of six inches above the floor. An initial kitchen tour observation on 7/29/2024 at 9:50 AM revealed four cardboard boxes of food being stored on the floor of the freezer. An interview on 7/29/2024 at 10:05 AM with the CDM confirmed that all food should be stored at least six inches off the floor. C. A record review of a facility policy Standards, Review and Frequency LTC (Long Term Care) Nutrition Regulations Being Met with a last reviewed date of January 2021, revealed the following: - Employees must wash their hands - before coming in contact with any food surfaces, when switching between working with raw food and working with ready-to-eat food, after handling soiled equipment or utensils, during food preparation as necessary to remove soil and contamination and to prevent cross contamination when changing tasks, after engaging in other activities that contaminate hands. - Contact between food and bare (ungloved hands is prohibited). - Gloves are considered single-use items and must be discarded after completing the task for which they are used. The use of disposable gloves does not substitute for proper handwashing. - Further review of the policy revealed the policy did not include information regarding the length of time required to wash hands with soap and water or the procedure for handwashing to avoid contamination of items in the kitchen. A record review of the 2017 Nebraska Food Code, under section 2-301.12 indicated food employees shall clean their hands for at least 20 seconds. It also included procedures that stated to avoid re-contaminating hands, food employees shall use a disposable paper towels or similar clean barriers when touching surfaces such as manually operated faucet handles on a handwashing sink. A continuous observation on 7/30/2024 from 9:09 AM to 11:15 AM during meal preparation completed by the CDM revealed the following: -The CDM had thrown lettuce in the trashcan, touching the rim of the trash can with their hand, then touched the refrigerator door twice, then obtained clean supplies including a bowl, cutting board, and knife without first performing hand hygiene to prevent cross contamination. -The CDM turned on the water faucet with their soiled hands, washed their hands with soap and water for 20 seconds as required, then turned off the soiled faucet with their bare hand, and then applied gloves. -The CDM had applied gloves but then touched potentially soiled boxes of lettuce, contaminating their gloves, then touched the lettuce with their gloved hands and peeled the lettuce. -The CDM had removed their gloves then obtained a clean cutting board and scale without first performing hand hygiene as required. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The CDM turned on the water faucet with their soiled hands, washed their hands with soap and water for 20 seconds as required, then turned off the soiled faucet with their bare hand. The CDM then checked on a cake they were baking in the oven, inserted a toothpick into the cake using their bare hand and touched the cake with their bare contaminated hands. -The CDM applied clean gloves after they touched the cake without first performing hand hygiene. -The CDM then touched the food scale's power button with their gloved hand, then picked up a tomato to prepare for the salad. -The CDM then removed their gloves, turned on the potentially soiled water faucet, completed hand hygiene for 15 seconds, and then turned off the faucet with their clean hands, contaminating their hands. The CDM then applied clean gloves and began chopping a tomato to prepare for the salad. -The CDM removed their gloves, then began to wash their hands with soap and water for 15 seconds, the CDM then returned to chopping the tomatoes without. -After chopping the tomatoes, the CDM applied new gloves, sanitized the preparation table with a rag then removed their gloves. The CDM then opened a drawer and obtained a knife, vegetable peeler, and new cutting board without first performing hand hygiene. -The CDM then turned on the potentially soiled water faucet, washed their hands with soap and water for 15 seconds, shut off the faucet with their clean hands, contaminating their clean hands. The CDM then began to chop and peel a cucumber. -The CDM again turned on the potentially soiled water faucet, washed their hands for 15 seconds, shut off the faucet with their clean hands, contaminating their clean hands. The CDM then applied clean gloves and prepared pizza dough, pressing the dough into the pans. -The CDM then rolled the trashcan near the can opener, using a paper towel to touch the trashcan. However, the CDM's hand still did touch the trashcan. The CDM did not complete hand hygiene after touching the trashcan with their bare hand. The CDM then began to spread pizza sauce on top of the pizza dough with a spatula and had touched their two knuckles of their right hand into the pizza sauce as they spread the sauce onto the dough. -The CDM then turned on the potentially soiled water faucet, washed their hands with soap and water for 17 seconds, shut off the faucet with their clean hands, contaminating their clean hands. The CDM then obtained ground beef and put into a pan to fry. -The CDM then turned on the potentially soiled water faucet washed their hands with soap and water for 15 seconds, shut off the faucet with their clean hands, contaminating their clean hands. The CDM then began to chop an onion with their bare hands. An interview on 7/30/2024 at 10:25 AM with the CDM revealed that the CDM believed they only needed to glove their hands when food items were not going to be cooked, such as the salad. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview on 7/30/2024 at 11:30 AM with the CDM confirmed hand hygiene should be completed in between tasks, when hands are dirty, immediately before and after gloves, and after contamination of their hands. The CDM confirmed hands are contaminated when touching meats, doors, drawers, and other dirty items. The interview also revealed the CDM believed hands should be washed for 15 seconds.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49766 Licensure Reference 175 NAC 12- 006.18(B) Based on observations, interview, and record review; the facility failed to disinfect multi-use equipment during medication administration for 3 (Residents 1, 16, and 23) of 3 sampled residents and implement infection control practices during wound to prevent the potential for cross-contamination for 1 (Resident 23) of 1 sampled resident. Findings are: A. A record review of a facility policy Cleaning of Patient Care Equipment with a last reviewed date of 7/20/2021 indicated patient care equipment should be cleaned after each use. A continuous observation on 7/30/2024 from 7:37 AM to 8:04 AM revealed Medication Aide (MA)-B had taken a pair of tweezers from the side of the medication cart from a graduated cylinder to pull a piece of plastic from Resident 23's medication cup, touching Resident 23's medication in the cup with the tweezers. MA-B did not disinfect the tweezer prior to use or after use. At 7:39 AM, MA-B had taken the pair of tweezers back out of the side of the medication cart to pull a piece of plastic from Resident 16's medication cup, touching Resident 16's medications in the cup with the tweezers. MA-B did not disinfect the tweezers prior to use or after use. At 8:04 AM MA-B had taken the pair of tweezers from the side of the medication cart to pull out Resident 1's pantoprazole from the medication cup, touching the other medications with the tweezers. MA-B did not disinfect the tweezer prior to use or after use. An interview on 7/30/2024 at 11:35 AM with MA-B confirmed the tweezers should be cleaned or sanitized after each use. B. A record review of the facility's undated policy Wound Care revealed instructions to place a barrier before starting, wash and dry hands thoroughly, and that a gown was only necessary if there was potential to soil the employee's skin. The policy did not include information on how long to wash hands for or that a gown was necessary for Enhanced Barrier Precautions during wound care. A record review of the Center for Disease Control (CDC)'s Implementation of Personal Protective Equipment Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) with a date of 4/2/2024 indicated Enhanced Barrier Precautions, including donning a gown and gloves, should be implemented during all wound care or skin opening that requires a dressing. A record review of the CDC's Clean Hands with a date of February 16, 2024, indicated hands should be scrubbed with soap and water for at least 20 seconds. An observation on 7/31/2024 at 10:10 AM of Registered Nurse (RN)-A performing wound care for Resident 23 revealed the following: -Upon entrance, RN-A washed their hands for 15 seconds. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-RN-A applied gloves, then removed keys from around their neck. -RN-A donned their gown, touching their hair with their own gloved hands. -RN-A touched the trashcan with their own gloved hands. -RN-A opened and reclosed Resident 23's drawer when obtaining additional supplies with their gloved hands. -RN-A removed their gloves, then washed their hands with soap and water for 13 seconds. An interview on 7/31/2024 at 11:00 AM with RN-A revealed RN-A was unaware of the amount of time required when washing hands with soap and water. The interview also confirmed RN-A contaminated their gloves during the wound care procedure.