STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28E271	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Genoa Community Hospital/Ltc	606 Ewing Avenue Genoa, NE 68640

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 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. 45739 Licensure Reference Number 175 NAC 12-006.02(8) Based on record review and interview; the facility failed to report a fall with significant injury to the state agency within the required time frame for Resident 15. The sample size was 4 and the facility census was 36. Findings are: Review of the facility policy Abuse and Neglect, undated, revealed the following: -when an incident or suspected incident of abuse was reported to the Director of Nursing (DON) or Director of social services or his/her designee they would investigate the incident which included interviews with the resident, staff, family, and any witness, a review of the medical record, and a review of all circumstances surrounding the incident, -any alleged violations would be reported to the state agency and all other agencies as required, and -the results of the investigation would be documented and submitted to the State Agency within five working days. Review of Resident 15's Minimum Data Set (MDS-a federally mandated assessment tool used in care planning) dated 2/28/24 revealed the following: -the resident had severe cognitive impairment, -diagnoses of neurocognitive disorder (a progressive dementia disorder that leads to a decline in thinking, reasoning, and independent functioning), -the resident required moderate assistance with toileting, dressing, and personal hygiene, and -the resident received antipsychotic medication (a type of psychoactive medication which alters the chemicals in the brain to effect changes in behavior, mood, and emotion), antianxiety, antidepressant, and hypnotic (a sleep-inducing medication) medications. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility form Abuse Investigation Report Form for an incident that occurred on 3/8/24 at 5:48 PM involving Resident 15 revealed the resident was found lying on the hallway floor, the resident was lethargic, and had red liquid drainage on the floor surrounding the resident's head which was identified to be from a cut above the right eyebrow. The resident was sent to the emergency room and received ten stitches. The incident had no witnesses. The facility reported the incident on 3/9/24 (no time indicated) which was more than the two-hour required time frame reporting for a significant injury to Adult Protective Services (APS). Interview with the DON and the Administrator on 5/13/24 at 2:58 PM confirmed the injury was not witnessed, the resident had an injury that required emergency treatment and APS was not notified within 2 hours.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42679 Licensure Reference Number 175 NAC 12-006.05(5) Based on record review and interview, the facility failed to provide a written notice of transfer to 1 resident (Resident 24) or the resident's legal representative upon transfer to the hospital. The facility census was 36. Findings are: Review of the undated facility policy Notice of A Transfer and/or Discharge revealed the facility would provide a 30 day written notice of transfer or discharge to a resident and/or the resident's representative, except when an immediate transfer or discharge is required by the resident's urgent medical needs. The following information will be provided: -the reason for the transfer or discharge; -effective date of transfer or discharge; -the location the resident is transferred to; -the name, address, and telephone number of the state long-term care ombudsman; -the name address, and telephone number of each individual or agency responsible for the protection of mentally ill or developmentally disabled; and -the name, address, and telephone number of the state health department agency that handles appeals of transfer and discharge notices. Review of Resident 24's Nursing Progress Note dated 5/3/24 revealed the resident was transferred to the local hospital emergency room (ER) for manic (showing wild, apparently deranged, excitement and energy) behaviors that were unable to be controlled. The resident was then transferred and admitted to Faith Regional Behavioral Health Unit for psychosis and mania later on the same day. Review of the Resident 24's medical record on 5/14/24 revealed no evidence a written notice of transfer was provided to the resident or the resident's legal representative after the resident was transferred to the local ER. An interview with the administrator on 5/14/24 at 10:45 AM confirmed Resident 24 was transferred to the localER on [DATE] and the facility had not provided a written notice of transfer to the resident or the resident's representative.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident’s representative in writing how long the nursing home will hold the resident’s bed in cases of transfer to a hospital or therapeutic leave. 42679 Licensure Reference Number 175 NAC 12-006.05(1) Based on record review and interview, the facility failed to provide Resident 24 or the resident's representative, written bed hold information when the resident was transferred to the hospital emergency room (ER). The sample size was 1 and the facility census was 36. Findings are: Review of the undated facility policy Holding Bed Space revealed the facility will inform residents and/or resident representatives of the bed-hold policy upon admission and prior to a transfer for hospitalization or therapeutic leave. The Bed Hold Policy Notification and Acknowledgement will be completed at the time the bed hold is needed. Review of Resident 24's Nursing Progress Note dated 5/3/24 revealed the resident was transferred to the local hospital emergency room (ER) for manic (showing wild, apparently deranged, excitement and energy) behaviors that were unable to be controlled. The resident was then transferred and admitted to Faith Regional Behavioral Health Unit for psychosis and mania on the same day. Review of the Resident 24's medical record on 5/14/24 revealed no evidence a written bed hold notice was provided to the resident or the resident's legal representative when the resident was transferred to the hospital. An interview with the administrator on 5/14/24 at 10:45 AM confirmed Resident 24 was transferred to the local hospital on 5/3/24 and the facility had not provided a written bed hold notification to the resident or the resident's representative upon hospitalization .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 45739 Licensure Reference Number 175 NAC 12-006.09D Based on record review and interview; the facility failed to ensure there was an approved diagnosis for the use of an antipsychotic medication (a type of psychoactive medication which alters chemicals in the brain to effect changes in behavior, mood, and emotions) for Resident 33. The sample size was 5 and the facility census was 36. Findings are: Review of the facility policy Psychotropic Medication Usage, undated, revealed the following: -psychotropic drugs included antipsychotics, -attending physicians would certify that a psychotropic medication was necessary to treat a specific condition/behavior, and -the consulting pharmacist would report any irregularities to the Medical Doctor or Director of Nursing (DON) which included not having an adequate indication for use. Review of Resident 33's Minimum Data Set (MDS-a federally mandated assessment tool used in care planning) dated 4/22/24 revealed the following: -the resident had severe cognitive impairment, -had diagnoses of heart failure, anxiety, and depression, and -required moderate assistance with toileting, dressing the lower half of the body, putting on and taking off footwear and personal hygiene. Review of Resident 33's Care Plan last reviewed 4/30/24 revealed the following: -the resident had behavior problems due to a history of Alzheimer's Dementia, anxiety, hallucinations, schizophrenia, and schizoaffective disorder, and -the resident had impaired cognitive function and impaired thought processes. Review of Resident 33's Order Review Sheet revealed the resident had an order for Haloperidol (an antipsychotic medication) 1 milligram (mg) 1 tablet (tab) orally by mouth twice daily for Alzheimer's Disease ordered 4/26/24 , and Haloperidol 5mg give 1 tab by mouth every evening with supper for Alzheimer's Disease ordered 4/26/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration Records (MARs) revealed in April 2024 the resident received 16 doses of Haloperidol 1mg, and 8 doses of 5mg Haloperidol. In May 2024 the resident received 1mg Haloperidol 26 times, and 5mg Haloperidol 12 times. Interview on 5/13/24 at 2:58 PM with the DON confirmed the resident's diagnosis for the use of Haloperidol was Alzheimer's Disease. Further interview confirmed Alzheimer's Disease was not an acceptable diagnosis for the antipsychotic medication.

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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. 42679 Licensure Reference Number 175 NAC 12-006.11E Based on observation, record review and interview; the facility failed to ensure 1) food was stored under sanitary conditions and 2) outdated food was not available for consumption to prevent the potential development of food borne illness. This had the potential to affect all residents. The facility census was 36. Findings are: Review of the undated facility policy Food Storage revealed all food will be stored off the floor and leftover food is clearly labeled and dated. In addition, leftover food is to be used within 3 days of the date prepared or discarded. Observation during the initial kitchen tour on 5/8/24 at 8:40 AM revealed the following: -Walk-in cooler had 2 large trays of macaroni salad in Styrofoam bowls with plastic wrap covering the trays. There was no label or date on the trays. -Walk-in cooler had a large bowl of orange colored Jello labeled with a date of 4/15/24 (23 days ago). -Walk-in freezer had 3 stacks of food in packages sitting directly on the floor of the freezer. An interview with the Dietary Manager on 5/8/24 at 8:40 AM confirmed the leftover macaroni salad in the walk-in cooler was not labeled or dated and should have been discarded previously. The Dietary Manager also confirmed the 3 stacks of food packages stored in the walk-in freezer should not have been stored directly on the floor.