STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28E303	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock County Hospital Long Term Care	100 East South Street Bassett, NE 68714

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. Licensure Reference Number 175 NAC 12-006.11(E)Based on observation, record review and interview; the facility failed to handle food in a manner that prevented potential food borne illness. This had the potential to affect all facility residents. The census was 18. Findings are: Review of the facility policy Proper use of Gloves with a revision date of 7/2013 revealed the purpose was to prevent disease and food borne illness. This included the following procedures: -Washing hands before gloving and when changing to a new pair of gloves. -Putting on new gloves before handling ready-to-eat foods such as sandwiches, and when handling fresh produce.-Prolonged use of a single pair of gloves could result in excess perspiration, which could be ideal for bacterial growth.-Disposable gloves were for one-time use.During observation of food service occurring from the portable steam table in the dining room on 9/9/25 from 11:55 AM through 12:15 PM the following was observed. -Dietary Aid B washed hands, put on gloves, took a food order from a resident while touching the back of the resident's chair and then returned to the food service cart with the same gloves, opened a drawer on the portable steam table, opened a bag of buns and then with the same gloves grabbed a bun, opened it, filled it with meat and served the meal to the resident. -Cook C exited the kitchen wearing gloves, took a resident's food order, touching both the table and the resident's back, then returned to the steam table, opened a drawer containing buns, opened the buns and with the same gloved hands retrieved a bun from the bag, opened the bun, placed meat on the bun and served it to the resident. After doing this [NAME] C returned to the kitchen wearing the gloves. The cook then returned to the dining room with gloves off holding a bag of chips. Without completing hand hygiene Cook-C put on a clean pair of gloves and returned to the food service steam table and again opened a drawer, retrieved a bun from the drawer and then with the same gloved hands opened the bun, put meat on the bun and then served the resident. During an interview on 9/9/25 at 2:58 PM the Dietary Manager confirmed staff should not have touched ready-to-eat food buns with the same gloved hands that are used while touching other surfaces such as the drawers on the food cart, chair backs, and table surfaces. In addition, any time staff change gloves they should wash their hands. During an interview on 9/10/25 at 3:38 PM the facility Administrator confirmed staff should not handle ready-to-eat food items with disposable gloves unless those gloves had not touched other potentially contaminated surfaces.

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
	28E303	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock County Hospital Long Term Care	100 East South Street Bassett, NE 68714

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09A Based on record review and interview; the facility failed to ensure a new Pre-admission Screening and Resident Review (PASARR) screen was completed related to a mental health diagnosis for Resident 3. The sample size was 1 and the facility census was 18. Findings are:Review of the facility policy Pre-admission Screening and Resident Review and admission dated 10/2024 revealed the following:-the review process was designed to identify individuals with Serious Mental Illness (SMI), Intellectual or Developmental Disabilities (IDD), or both, and to ensure they received the necessary specialized services and appropriate placement in accordance with federal and state guidelines,-the facility established a standard process that facilitated comprehensive screening, assessment, and decision-making to determine the eligibility and appropriate level of care for individuals seeking admission to a nursing home,-the discharging hospital or nursing home conducted an initial screening for all individuals seeking admission to determine reasonable suspicion of SMI, IDD, or both,-if the initial screening indicated a reasonable suspicion of SMI, IDD, or both, the evaluation was conducted by a qualified mental health professional or health care provider to determine if further evaluation would be required, and-if further screening confirmed the presence of SMI, IDD, or both determinations regarding the individual's condition, functional abilities, and support needs were considered to determine appropriate levels of care and specialized services and if admission to a Long-Term Care facility was appropriate. Review of Resident 3's Minimum Data Set (MDS-a federally mandated assessment tool used in care planning) dated 8/19/25 revealed the resident was admitted on [DATE]. The resident was cognitively intact; didn't exhibit behaviors; required assistance with dressing and toileting; diagnoses included: Non-Alzheimer's Dementia, Parkinson's Disease, Depression, Chronic Lung Disease, and Post Traumatic Stress Disorder (PTSD- a mental health condition that is caused by an extremely stressful or terrifying event); was receiving Antianxiety and Antidepressant medications; and did not have a Level II PASARR evaluation. Review of the Resident 3's Care Plan last revised on 8/21/25 revealed the resident received a medication for Major Depressive Disorder, the facility was to arrange a psychological consult dated 7/31/25, and there was no documentation that the resident had a Level II PASARR evaluation completed. Review of the facility form PASARR for Resident 3 dated 10/3/22 revealed no mental health diagnosis was known or suspected and the results of the Level I screen revealed there were no signs of a serious mental illness, intellectual disability or related found during the Level I screen and no further clinical review or onsite evaluation was needed. Review of the facility form Diagnosis for Resident 3 revealed the resident had diagnoses of PTSD dated 11/6/24 and Major Depressive Disorder dated 9/27/24. Review of the facility form Order Summary Report dated 9/10/25 with Resident 3's active orders revealed an order for Venlafaxine (an antidepressant) with a diagnosis of Major Depressive Disorder. Interview on 9/10/25 at 2:45 PM with the Social Services Director confirmed Resident 3 had diagnoses of PTSD and Major Depressive Disorder. Further interview confirmed a new PASARR should have been completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28E303	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock County Hospital Long Term Care	100 East South Street Bassett, NE 68714

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09 Based on interview and record review; the facility failed to ensure Resident 3 received trauma informed care related to a diagnosis of Post Traumatic Stress Disorder (PTSD) and to identify triggers and implement approaches to mitigate potential triggers. The sample size was 1 and the facility census was 18. Findings are:Review of the facility policy Trauma Informed Care dated 4/2025 revealed the following:-it was the policy of the facility to ensure residents who were trauma survivors received culturally competent, trauma informed care in accordance with professional standards of practice,-trauma was defined as an event or series of events or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening, that had lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual well-being,-trauma informed care was defined as organizational structure and treatment framework that involved understanding, recognizing, and responding to the effects of all types of trauma, -each resident was screened for a history of trauma upon admission and if that screening indicated the resident had a history of trauma or trauma-related symptoms, a physician's order would be obtained for the resident to be evaluated by a mental health professional, and-the facility accounted for resident experiences, preferences, and cultural differences in order to eliminate or mitigate triggers that caused re-traumatization of the resident. Review of Resident 3's Minimum Data Set (MDS-a federally mandated assessment tool used in Care Planning) dated 8/19/25 revealed the resident was admitted on [DATE], was cognitively intact; didn't exhibit behaviors; required assistance with dressing and toileting; and diagnoses included: Non-Alzheimer's Dementia, Parkinson's Disease, Depression, Chronic Lung Disease, and Post Traumatic Stress Disorder (PTSD-a mental condition that is caused by an extremely stressful or terrifying event). Review of Resident 3's Care Plan last revised 8/21/25 revealed no documentation that the residents diagnosis of PTSD was addressed. Review of the facility form Diagnosis Report revealed Resident 3 had a diagnosis of PTSD dated 11/6/24. Review of the facility forms Social Service Monthly Behavior Flow Sheet regarding Resident 3 for 12/2024 through 7/2025 revealed the PTSD diagnosis was not included. Interview on 9/11/25 at 10:00 AM with the Director of Nursing confirmed the PTSD diagnosis was not included on the behaviors sheets, a trauma informed care assessment had not been completed and PTSD was not identified with triggers and interventions on Resident 3's care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28E303	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock County Hospital Long Term Care	100 East South Street Bassett, NE 68714

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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.18 Based on record review and interview; the facility failed to implement infection control practices to prevent the potential spread of Covid-19 infection related to testing a symptomatic resident (Resident 4) for COVID-19. The sample size was 2 and the census was 18. Findings are: A. Review of the facility Infectious Patient, Communicable Disease, Pandemic Plan with a revised date of 1/2025 revealed the purpose of the policy was to include plans and actions to respond to the threat of Covid-19 and to prevent transmission. Staff and residents were to be tested for Covid-19 if onset of symptoms develop. B. Review of Resident 4's Nursing Progress Notes revealed the following:-5/21/25 at 7:52 PM the resident had a runny nose and a cough at times. There was no evidence the resident was tested for COVID-19. -5/22/25 at 4:57 AM the resident reported feels like crud with a temperature of 99.1 degrees Fahrenheit. -5/22/25 at 7:04 PM the Director of Nursing (DON) was called, and the resident was placed in isolation. -522/25 at 7:30 PM the resident's oxygen saturation (the measure of oxygen in the red blood cells, with normal levels ranging from 95 percent (%) to 100 %) level was 86%. -5/22/25 at 10:21 PM the resident had a cough and felt congested. Review of the resident's medical record revealed no indication the resident was tested for COVID-19. -5/25/25 at 8:04 AM the resident had a cough and congestion with complaint of not feeling well. -5/25/25 at 10:31 AM the resident had a cough and wheezing. -5/25/25 at 5:20 PM the resident's temperature was 100 degrees Fahrenheit. -5/25/25 at 6:28 PM the resident had wheezing and crackles to lungs with a temperature of 101.3 degrees Fahrenheit. The resident's Primary Care Practitioner (PCP) was notified, and the resident was started on Azithromycin (antibiotic that fights bacteria and treats various infections) 500 milligrams (mg) daily for 5 days and Prednisone (medication which can be used to treat upper respiratory tract infection symptoms) 40 mg daily for 3 days. Review of the resident's medical record revealed no evidence the resident had been tested for COVID-19 despite the resident's ongoing symptoms. During an interview on 9/10/25 at 10:13 AM, the DON confirmed the following regarding Resident 4:-5/22/25 the resident had a cough, elevated temperature, nasal drainage, and lowered oxygen saturation level.-the resident continued to have symptoms which included an elevated temperature, congestion, cough, nasal drainage, and wheezes to lungs through 5/25/25 when the resident was started on an antibiotic.-no evidence the resident was ever tested for COVID-19 from 5/22/25 to 5/25/25 despite the resident's ongoing symptoms. An interview with the Infection Preventionist on 9/10/25 at 2:08 PM confirmed Resident 4 had symptoms of an upper respiratory infection and should have been COVID tested on [DATE]. In addition, the resident continued to be symptomatic through 5/25/25 with no COVID-19 testing.