STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285087	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tiffany Square	3119 West Faidley Avenue Grand Island, NE 68803

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50105 Licensure Reference Number 175NAC 12-006.09(G)(i) Based on record review and interview; the facility failed to ensure that a recapitulation (a concise summary of the resident's stay and course of treatment in the facility) of the resident's stay was completed as required for 1 of 1 residents reviewed (Resident 78). The facility census was 77. Findings are: Record review of the Admission Record dated 10/16/2024 for Resident 78 revealed that Resident 78 admitted into the facility on [DATE]. Resident 78 had a discharge date of [DATE]. Record review of the Care Plan for Resident 78 dated 10/16/2024 revealed that Resident 78 had a goal to return to their own home with their spouse. Record review of the Minimum Data Set (MDS, a mandatory comprehensive assessment tool used for care planning) for Resident 78 dated 07/11/2024 revealed that it was an admission assessment. The MDS revealed that Resident 78 and their spouse participated in the assessment and goal setting. The MDS revealed that Resident 78's overall goal was to discharge to the community. Record review of Progress Notes dated 07/11/2024 through 08/14/2024 revealed Resident 78 and their spouse were actively talking with the facility about discharge plans. Record review of the MDS for Resident 78 dated 08/14/2024 revealed that it was a discharge assessment. The MDS revealed that Resident 78 discharged from the facility on 08/14/2024. Record review of the medical record for Resident 78 revealed that it contained no documented recapitulation of Resident 78's stay. Interview on 10/16/2024 at 11:44 AM with the facility Director of Nursing (DON) revealed that the facility does not have a policy or procedure for resident discharge. The DON revealed that the facility uses the Nursing Discharge Summary assessment to document the recapitulation of stay for discharged residents. The DON reviewed the medical record of Resident 78. The DON confirmed that a Nursing Discharge Summary was not completed for Resident 78. The DON confirmed that a recapitulation of stay was not completed for Resident 78 as required.

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49382 Licensure Reference Number 175NAC 12-006.09(H) Based on observation, record review, and interview; the facility failed to ensure residents medication regimen was free from unnecessary psychotropic medications for 2 (Residents 10, and 32) of 6 sampled residents, and the facility failed to implement a stop date for a PRN (as needed) psychotropic medication for 1 (Resident 12) of 5 sampled residents. The facility census was 77. Findings are: A. Review of a facility policy titled Psychoactive Medication and Medication Regimen Review Management Standard and dated 09/2024 revealed: -Unnecessary Drug is defined as any medication used in excessive dose, excessive duration, with out adequate monitoring, with adequate indications, and in the presence of adverse consequences or any combinations of the reasons stated. -Section 5. Gradual dose reduction or tapering of medications should be reviewed during weekly risk meeting. -Antidepressant medications gradual dose reduction. Tapering may be clinically contraindicated if the resident's target symptoms returned or worsened after the most recent attempt at tapering the dose within the facility. -Documentation requirements for psychoactive medications best practice would be to ensure the documentation is initiated with the appropriate target behavior and side effects listed and review the documentation at the end of the month. The expectation is to review this documentation during the weekly Risk meeting, in conjunction with the care planning process and as needed. Review of an Admission Record revealed the facility admitted Resident 10 on 06/02/2010 with diagnoses of: depression (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with one's daily activities) and anxiety (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly Minimum Data Set (MDS, a mandatory comprehensive assessment tool that measures the health status of nursing home residents and is used for care planning) with an Assessment Reference Dated (ARD) of 08/23/2024 revealed that Resident 10 was unable to complete the Brief Interview for Mental Status (BIMS, a brief screening tool that aids in detecting cognitive impairment). The staff assessment for mental status was conducted and was coded that the resident had both short term and long-term memory problem. The resident was coded as to not have any behaviors during the look back period and staff provided supervision and touching assistance with eating, substantial or maximal assistance with bed mobility, transfers, and toilet use. The resident was dependent on their wheelchair pushed by staff for mobility. The resident was coded as to receive antidepressant medication and no gradual dose reduction was coded as to have occurred or documentation that a gradual dose reduction was clinically contraindicated. Review of Resident 10's Care Plan dated 10/09/2024 revealed no specific or targeted behaviors for Resident 10 and the use of the antidepressant medication. Review of Resident 10's medical health record revealed: -04/10/2024 Resident 10's provider agreed with the pharmacist recommendation to reduce the residents Lexapro medication from 20 milligrams to 10 milligrams. -Resident10's Behavior Intervention Monthly Flow Record for the month of April and May revealed no documentation of the resident having mood or behavior being exhibited during these months. -Resident 10's progress notes revealed no documentation of the resident having alterations in mood or behavior from 04/10/2024 through 05/13/2024. -05/13/2024 the nurse sent a communication to the resident's provider requesting Resident 10's Lexapro be increased back to the 20 milligram dose. The communication did not include any notification of change in mood or behavior since the decrease in the dosing of the Lexapro. -05/14/2024 Resident 10's provider increased the Lexapro back to 20 milligrams. -05/24/2024 Resident 10's Patient Health Questionnaire (PHQ-9, which is an assessment that objectifies and assesses the degree of depression severity) score was 7 indicating mild depression. -08/23/2024 Resident 10's Lexapro medication was decreased from 20 milligrams to 10 milligrams per pharmacy recommendations to the provider. -Resident 10's Behavior Intervention Monthly Flow Record for the months of July and August of 2024 revealed no documentation of the resident having mood or behavior having been exhibited during these months. -Review of Resident 10 progress notes revealed no documentation of the resident having alterations in mood or behavior from 05/14/2024 through 09/22/2024. -09/22/2024 communication from nursing staff sent to Resident 10's provider stating Resident 10 had been more anxious since the decrease in their Lexapro medication and requested to increase the medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-09/24/2024 Resident 10's Lexapro medication was increased back to the 20 milligrams. In an interview on 10/15/2024 at 2:45 PM with Medication Aide D (MA-D), revealed Resident 10s' behaviors are getting confused and crying out for family, not knowing where the resident is and thinking that family had just left the resident and did not know where the resident was. MA-D revealed Resident 10s' behaviors get charted on the paper flow record each shift. MA-D further revealed [gender] would notify the nurse if unable to get the resident to calm down or be able to reassure the resident. In an interview on 10/15/2024 at 3:30 PM with the Director of Nursing (DON) revealed that residents with psychotropic medication changes should be monitored in the weekly risk meeting. The DON confirmed that Resident 10's mood and behaviors were not being monitored in the weekly risk meeting and was unaware of the changes in the resident's antidepressant medication and documentation being present to support the changes in the resident's antidepressant medication. B. Review of an Admission Record revealed the facility admitted Resident 32 on 05/14/2024 with diagnoses of Alzheimer's disease (which is a brain disorder that gradually destroys memory ad thinking skills, and eventually the ability to perform everyday tasks), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with one's daily activities). The comprehensive quarterly MDS with an ARD of 09/06/2024 revealed that Resident 32 had a BIMs score of 11 indicating the resident was moderately cognitively impaired. The resident was coded to not have any mood or behavior problems. The resident needed setup or clean up assistance with eating and substantial or maximal assistance with bed mobility, transfers, and toilet use. The resident was coded to be receiving routine antidepressant medication and no gradual dose reduction was coded as to have occurred or documentation that a gradual dose reduction was clinically contraindicated. Review of Resident 32's Care Plan dated 10/09/2024 revealed no specific or targeted behaviors for Resident 32 and the use of the antidepressant medication. Review of Resident 32's medical health record revealed: -Physician orders for Remeron (Mirtazapine)(an antidepressant medication) 15 milligram tablet once daily dated 05/14/2024. -Physician orders for Zoloft (Sertraline) (an antidepressant medication) 100 milligram tablet once daily dated 07/30/2024. -Progress Notes from 06/01/2024 through 07/30/2024 revealed no documentation of alterations in mood or behavior for Resident 32. -Resident 32 Behavior Intervention Monthly Flow Record for the Month of July 2024 revealed no behaviors documented as being exhibited for the resident. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Review of Resident 32's Informed Consent for use of Psychotropic medications dated 05/15/2024 was completed for the use of the antidepressant medication of Remeron. The document was not signed by the resident or their responsible party. -Review of Resident 32's Informed Consent for use of Psychotropic medications dated 10/10/2024 was completed for the use of the antidepressant medication of Remeron and Zoloft. The document was not signed by the resident or their responsible party. In an interview on 10/15/2024 at 3:30 PM with the DON revealed that residents with psychotropic medication changes should be monitored in the weekly risk meeting. The DON confirmed that Resident 32 mood and behaviors were not being monitored in the weekly risk meeting. The DON confirmed that the Informed Consent for use of Psychotropic Medications were not signed by the resident or responsible parties and that no mood or behavior documentation was present to reflect the addition of the Zoloft medication. 50105 C. Record review of Resident 12's Admission Record dated 10/10/2024 revealed an admitted [DATE]. Resident admission diagnosis on the admission record revealed atrial fibrillation (an abnormal heart rhythm characterized by rapid and irregular beating of the heart) and gastrointestinal hemorrhage (uncontrolled bleeding internally from the mouth to the rectum). Record review of Resident 12's Care Plan (a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) dated 09/11/2024 revealed Resident 12 has no plans for discharge and placement is needed for end-of-life care. Resident 12's Care Plan further revealed a focus on terminal prognosis related to Atrial Fibrillation. The Care Plan revealed the goal to maintain comfort levels, and interventions on encouraging support from family and friends; observe for signs and symptoms of pain, and to work with nursing staff on providing comfort. Continued review of Resident 12's Care Plan revealed a medication regimen including medication with black box warnings (medication with serious safety risks). Interventions listed for the medication regimen with black box warnings revealed to consult with the pharmacist to conduct monthly and PRN (as needed) medication reviews; administer medications per physician order; observe for any complications; and to report concerns to charge nurse and physician as needed. Record review of Resident 12's order summary for medications revealed an order for Lorazepam (a psychotropic medication, (any medication that affects behavior, mood, thoughts, or perception), used for short term relief to treat anxiety disorders (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities)). The medication was prescribed to be provided as needed (PRN) every hour. The medication was prescribed upon admission on 09/11/2024 with no end date. The DON) and Administrator (ADMIN) were interviewed on 10/15/2024 at 2:21 PM about the PRN medication Lorazepam for Resident 12 and if an end date was provided. The DON revealed not knowing and indicated they would follow up. On 10/16/2024 at around 8:45 AM, the DON confirmed there was no previous end date and provided this surveyor with a new hospice order for Resident 12's PRN medication Lorazepam with a new start/end date of 10/15/2024-10/29/2024.

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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. 49382 Licensure Reference Number 175NAC 12-006.10(D) Based on observation, record review, and interview, the facility failed to maintain a Medication Error rate less then 5% with an actual medication error rate of 12% (25 medication administrations were observed with 3 errors occurring) affecting 3 of 11 sampled residents (Residents 13, 30, and 33). The facilty census was 77. Findings are: Review of a document titled Types of Medication Errors and dated 02/12/2024 by the National Library of Medicine revealed a medication error has occurred when specific direction for method or administration of the medication is not followed by the individual taking or administering the medication. Review of a document titled Patient Education: Inhaler Techniques in Adults dated 09/2024 revealed as directions for use to seal the lips around the mouthpiece and keep the tongue under the mouthpiece. Take a slow deep breath at the same time you press down on the medication canister, hold your breath for as long as comfortable then exhale. Wait 20 to 60 seconds before taking another puff of the medicine and repeat the above steps. In an observation of medication administration by Medication Aide C (MA-C) from 10:50 AM to 11:50 AM on 10/15/2024 the following was observed: -MA-C prepared Resident 13's medications at the medication cart in the hallway. MA-C removed a white oblong tablet from a unit dose card labeled with Resident 13 name and Potassium Chloride Extended Release 20 Milliequivalents tablet. Directions were written on the label of the unit dose card to give one tablet by mouth three times a day and to take each dose with a meal and a full glass of water. MA-C placed the medication into a medication cup then poured water into a clear 4 oz glass approximately filling the glass half full. MA-C knocked and entered Resident 13's room then handed the cup with the medications in it and the cup with the water in it to Resident 13. Resident 13 emptied the cup of medications into their mouth then handed the empty cup back to MA-C. Resident 13 then took a drink of the water that MA-C gave to them. The resident drank approximately half of the half full 4 oz glass then handed the cup back to MA-C. MA-C thanked the resident then exited the room and returned to the medication cart and signed out the administration of the medications for this resident. -MA-C prepared Resident 30's medications at the medication cart in the hallway. MA-C removed 4 yellow oblong tablets from a unit dose card labeled with Resident 30's name and Potassium Chloride 10 Milliequivalents tablet. Directions were written on the label of the unit dose card to give 4 tablets twice daily by mouth with a full glass of water. MA-C placed the medication into a medication cup then poured water into a clear 4 oz glass filling the glass approximately 3/4's full. MA-C knocked and entered Resident 30's room then handed the cup with the medications in it and the cup with the water in it to Resident 30. Resident 30 emptied the cup of medications into their mouth then handed the empty cup back to MA-C. Resident 30 then took a drink of the water that MA-C gave to them. The resident drank all of the water except 1/4 of what was in the cup then handed the cup back to MA-C. MA-C then returned to the medication cart and signed out the medications for this resident. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-MA-C prepared Resident 33's medications at the medication cart in the hallway. MA-C removed all the tablet medications from the unit dose cards and place them in the medication cup. MA-C then obtained a gray inhaler from a drawer on the medication cart. The gray inhaler was labeled with Resident 33's name and directions for the resident to inhale 2 puffs into the lungs three times a day. MA-C knocked and entered Resident 33 room. MA-C then handed Resident 33 the cup with the medications in it and a cup with water in it. Resident 33 placed the medications into their mouth then took a drink of water from the cup. The resident then handed the items back to MA-C. MA-C then handed Resident 33 the gray inhaler. Resident 33 removed the cap from the mouth piece of the inhaler opened their mouth, placed their lips around the mouth piece and depressed the inhaler twice releasing two puffs of medication. The resident then performed a deep inhale and handed the inhaler back to MA-C. The resident then thanked MA-C and MA-C exited the room and returned to the medication cart in the hallway and signed out the medication administration to Resident 33. In an interview on 10/15/2024 at 11:50 AM with MA-C, confirmed that the label and the order on the medication administration record for both resident 13 and 30 gave instructions for the residents to drink a full glass of water with the administration of the Potassium Chloride medications. MA-C stated the these residents did not drink a full glass of water with their medication administrations. MA-C confirmed that Resident 33 should have waited one minute between the puffs of the inhaler and not taken the two puffs then inhaled them both at the same time. In an interview on 10/15/2024 at 1:35 PM with the Director of Nursing (DON), confirmed that not following the administration directions like drinking a full glass of water and waiting the allotted time between inhaler puffs were medication errors.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49382 Licensure Reference Number 175NAC 12-006.12(D)(vi) Based on observation, record review, and interview; the facility failed to ensure medications were labeled properly for 1 resident (Resident 229), of 11 sampled residents. The facility census was 77. Findings are: Review of a facility policy titled Medication Ordering and Receiving from Pharmacy: Medication Labels dated 05/2021 revealed under specific directions for use, due to the complexity and length/amount of instructions some medications may be labeled use as directed and refer the person administering the medication to the medication administration record for instruction details. Review of a facility policy titled Medication Storage and Utilization dated 03/2019 revealed multi dose vials which have been opened or accessed should be discarded within 28 days unless the manufacturer specifies a different date for that open vial. In an observation of insulin administration on 10/15/2024 from 8:10 AM to 8:18 AM by Registered Nurse B (RN-B), to Resident 229 the following was observed: A. RN-B removed a box from the top drawer of the medication cart with a label reading Resident 229 name and Insulin Aspart (which is a fast-acting synthetic version of human insulin used to control blood sugar levels), 100 units per milliliter and directions to inject 1-6 units under the skin three times a day with meals and inject 1-5 units at bedtime per sliding scale. Refrigerate until opening, discard 28 days after opening. RN-B revealed that Resident 229 would not get any of the medication due to their blood glucose reading that was obtained prior. RN-B revealed the medication was administered before meals and at bedtime per a sliding scale. Record review of Resident 229 physician order in the electronic medical health record for the month of October 2024 read, Insulin Aspart FlexPen subcutaneous solution Pen injector 100 units per milliliter. Inject as per sliding scale if 151-200 = 1 unit, 201-260= 2 unit, 261-300 = 3 unit, 301-360 = 4 unit, 361-400 = 4 unit, 401-999 6 unit and notify provider. In an interview with RN-B on 10/15/2024 at 08:20 AM, RN-B confirmed that the label on the box of Insulin and the physician order in the electronic medical health record did not match. RN-B confirmed that they should not administer a medication to a resident if the label and the order did not match. The RN confirmed that a clarification was needed prior to Resident 229 receiving any of this medication. B. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN-B removed a box from the top drawer of the medication cart with a label reading Resident 229 name and Lantus 100 unit per milliliter and directions to inject 12 units under the skin every morning with breakfast. To refrigerate until opening and discard 28 days after first use. The RN removed a vial from the box with a sticker attached to the bottle. The sticker read opened date of 09/29 and discard date of 10/29. In an interview with RN-B on 10/15/2024 at 08:20 AM, RN-B confirmed that the medication discard date should be 28 days from the opening date. The RN confirmed that 28 days from 09/29 should be 10/26 and not 10/29 and the vial was miss labeled for the discard date. In an interview on 10/15/2024 at 01:35 PM with the Director of Nursing (DON), the DON confirmed that the order for the insulin on the label and the physician order did not match. The DON stated that the written direction on the label was a shorter way of writing the residents prescribed sliding scale order. The DON confirmed that if a label and order did not match the medication should not be given. The DON confirmed that the facility policy was to use use as directed on the label for complex and lengthy instructions on medications. The DON confirmed that the discard date was to be 28 days from opening and should be written as 10/26 not 10/29.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 41938 Licensure Reference Number 175NAC 12-006.11(A)(i) Based on observation, interview and record review the facility failed to ensure that residents were served the required food portion size per the menu to meet nutritional needs for 50 of 58 residents (Residents 68, 19, 7, 57, 28, 5, 9, 47, 22, 36, 41, 32, 61, 49, 46, 71, 38, 45, 20, 63, 39, 14, 30, 279, 229, 59, 43, 64, 76, 48, 18, 52, 16, 53, 66, 3, 40, 74, 17, 51, 50, 75, 4, 62, 72, 24, 35, 29, 25, and 8). The facility census was 77. Findings are: Record review of the facility Food Preparation and Dining Service Audit dated 4/2022 revealed that standardized recipes are available for all menu items. The audit revealed that portions are served according to the menu unless the resident specifically requests otherwise. Record review of the Dietary Spreadsheet (menu) for 10/10/24 revealed that the lunch meal was Beef Chili. The menu revealed that the regular portion size for the beef chili was 8 ounces. Observation on 10/10/24 at 11:10 AM in the facility kitchen at the steam table revealed that a black handled ladle was in the pan of chili. The ladle was imprinted (labeled) as 6 ounces. Dietary Cook-A (DC-A) used a thermometer to check the temperature of the foods in the pans in the steam table. DC-A revealed the beef chili temperature was 202.2 degrees Fahrenheit. DC-A revealed the temperature of the diced carrots was 194.7 degrees Fahrenheit. DC-A confirmed that the serving spaedle (a ladle-like utensil with slots in the bottom to drain liquid from food) in the diced carrots was a 4 ounce spaedle. DC-A along with this surveyor observed the ladle in the beef chili was imprinted (marked) as a 6 ounce ladle. DC-A confirmed that the ladle in the beef chili in the steam table pan was a 6 ounce ladle for serving the beef chili. Observation on 10/10/24 at 11:25 AM in the facility kitchen revealed that DC-A performed handwashing and prepared to start meal service for facility residents. Record review of the undated list of residents on small portions provided by the facility Registered Dietitian on 10/10/24 revealed that 15 Residents (Residents 21, 33, 60, 1, 26, 31, 56, 12, 44, 34, 67, 37, 42, 2, and 6) requested small portions. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/10/24 at 11:31 AM in the facility kitchen revealed that DC-A picked up the 6 ounce ladle from the pan of chili in the steam table. DC-A used the 6 ounce ladle to scoop beef chili from the pan in the steam table. DC-A poured the 6 ounces of chili from the ladle into a maroon cup for Resident 21 (Resident 21 requested a small portion). DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 33 (Resident 33 requested a small portion). DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 68. DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 19. DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 60 (Resident 60 requested a small portion). DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 7. DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 57. DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 28. DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 5. DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 9. DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 47. DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 22. DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 36. DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 1 (Resident 1 requested a small portion). DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 41. DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a maroon cup for Resident 26 (Resident 26 requested a small portion). DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 32. DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 61. DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 49. DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 46. DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 31 (Resident 31 requested a small portion). DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 71. DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 38. DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 45. DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 20. DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 63. DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 39. The time was now 11:58 AM. DC-A removed a dining bowl of pureed chili from the warmer. DC-A removed the foil from the top of the bowl and poured approximately half of the bowl of pureed chili into another bowl for Resident 14. DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 30. DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 279. DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 229. DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 59. DC-A used the 6 ounce ladle to scoop chili from the pan in the steam table and poured the 6 ounces of chili from the ladle into a bowl for Resident 43. DC-A used

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	285087	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tiffany Square	3119 West Faidley Avenue Grand Island, NE 68803

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/10/24 at 12:35 PM at the facility steam table with the facility Registered Dietitian (RD) confirmed that the ladle in the pan of beef chili was a 6 ounce ladle. Interview on 10/10/24 at 1:32 PM with the Registered Dietitian (RD) confirmed that the regular serving size for the beef chili served for lunch on 10/10/24 was to be 8 ounces per the menu. The RD confirmed that a 6 ounce ladle had been used for serving the beef chili. The RD confirmed that the residents served beef chili did not receive the 8 ounce serving required.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50253 Licensure Reference Number 175NAC 1-005.06(D) Licensure Reference Number 175NAC 1-005.06(F) Based on record review, interview, and observations; the facility failed to ensure staff complete hand hyigene between resident rooms while delivering laundry to prevent the potential for cross contamination for 4 (Residents 71, 16, 53, and 43) of 5 residents observed and the facility failed to ensure that oxygen equipment and supplies were maintained per infection control procedures as required for 1 of 2 residents (Resident 50). The facility census was 77. Findings are: A. Observation on 10/10/2024 at 10:35 AM of Laundry and Housekeeping Supervisor (LHS) who delivered cleaned laundry to the rooms of residents. LHS removed laundry from the laundry cart and carried it into the room of Reisdent 60. LHS exited the room carrying used empty hangers with the bare hands and placed them into the laundry cart. LHS did not perform hand sanitization. LHS entered the room of Resident 71 with cleaned personal clothing items and returned to the laundry cart with empty hangers. LHS hung the potentially contaminated hangers up on the laundry rack next to the cleaned linens. LHS did not perform hand sanitization. LHS then took the cleaned linens for Resident 16, carried these into the room of Resident 16, hung them up in the closet, and returned with used empty hangers. LHS did not perform hand sanitization. LHS removed the cleaned clothing for Resident 53, took those clothes into the resident's room, hung them up in the closet and returned with used empty hangers and hung them next to the cleaned linens. LHS did not perform hand sanitization. LHS removed the cleaned linens and clothing from the laundry cart for Resident 43, took those clothes into the room and hung them up in the closet, returned to the laundry cart with used empty hangers and hung those next to the remaining cleaned laundry on the laundry cart. LHS did not perform hand sanitization. At no time while distributing clothing or returning with potentially contaminated hangers did LHS clean their hands with alcohol-based hand sanitizer or wash hands with soap and water. Observation on 10/10/2024 at 10:45 AM of the laundry cart used by LHS. There was no alcohol-based hand sanitizer on the laundry cart. Interview with LHS on 10/10/2024 at 11:30 AM. LHS stated they did not use alcohol-based hand sanitizer, nor did [gender] wash hands with soap and water between resident rooms while distributing cleaned clothing and personal items and after returning to the cart with potentially contaminated hangers from the rooms. LHS confirmed that all employees are expected to do this to help stop cross contamination and decrease the risk of infections from one resident to another. 50105 B. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident 50's Admission Record revealed Resident 50 admitted on [DATE] with a primary diagnoses of: chronic diastolic (congestive) heart failure (COPD; an impairment of the heart's ability to fill an pump enough blood to meet your body's needs), and chronic obstructive pulmonary disease (a lung disease that limits the airflow into and out of the lungs). Record review of Resident 50's Care Plan (a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) dated 07/01/2024 revealed Resident 50 is at risk for altered respiratory function related to COPD, and a need for oxygen therapy. The care plan indicated the goal for Resident 50 was to display optimal breathing patterns daily. The interventions listed for this care plan revealed: -nursing to assess respiratory status, depth, rate, presence of breath sounds, shortness of breath, and/or cough, -check oxygen saturation as required, -use continuous positive airway pressure ((CPAP) a machine that delivers pressurized air to keep airway open during sleep,) -provide oxygen per the physician order. Record review of Resident 50's Order Summary Report revealed the following orders: -oxygen 2 liters(L)/per nasal canula (a device used to deliver oxygen) as needed for shortness of breath, with an order start date of 06/26/2024 -therapy recommendation: resident will benefit from oxygen during ambulation every day and evening shift for the prevention of oxygen desaturation (inability for oxygen to reach your blood), with an order date of 07/01/2024 -therapy recommendation: resident will benefit from oxygen during ambulation. Document O2 saturation levels with ambulation every day and evening shift for the prevention of oxygen desaturation, with an order date of 10/10/2024 -Change oxygen tubing and holder every evening shift starting on the 2nd and ending on the 2nd every month, with an order date of 08/02/2024 On 10/09/2024 at 10:48 AM, Resident 50 was observed in their room not using oxygen at the time. The oxygen tubing was curled up and lying on the floor. When Resident 50 was asked what the oxygen is for, Resident 50 revealed they need it at times and is available when that time happens. Resident 50 also shared the availability of a portable oxygen container on a walker, used while the resident is up walking to activities, meals, and outings. Upon further observation, the oxygen tubing on the oxygen concentrator revealed a tag notating 08/02. The portable oxygen container revealed its own nasal canula with a tag notating 08/02, hanging off of the container loosely on the walker and touching the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/10/2024 at 10:35 AM Resident 50 was in their room, the portable oxygen container's nasal canula was observed to still have a tag stating 08/02, the oxygen concentrator oxygen nasal canula was changed revealing a date of 10/09 with a black bag present dated 10/24. On 10/15/2024 at 09:01 AM Resident 50 was observed sitting in their room watching television. Upon further observation the portable oxygen container nasal canula was observed to have the same tag 08/02 remain on the tubing. The Director of Nursing (DON) was interviewed on 10/15/2024 at 2:42 PM. The DON stated that the nasal cannula that is connected to the oxygen concentrator and plugged to the wall is to be changed monthly and tagged with a date and initials, as well as the portable oxygen container's nasal canula. The DON further indicated that if the nasal canular had a tag of 08/02 today, this would reveal that the tubing had not been maintained per infection control procedures.