STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285297	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookestone View	850 Laurel Parkway Drive Broken Bow, NE 68822

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52169 LICENSURE REFERENCE NUMBER 175-12.006.09(H)(iv)(2) Based on observations, interviews and record review, the facility failed to provide toileting interventions for one (Resident 11) of two sampled residents, which had the potential to cause skin breakdown and bladder infection. The facility identified a census of 56. Findings are: Record review of Resident 11's Census Data revealed the resident was readmitted to the facility on [DATE]. Record review of Resident 11's Face Sheet revealed the resident admitted to the facility with the following diagnosis: Unspecified dementia, unspecified severity, with behavioral disturbance, polyosteoarthritis, Parkinson's Disease and muscle weakness. Record review of Resident 11's annual Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 12/05/2024 revealed under Section C the Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score: 13-15: cognitively intact, 8-12: moderately impaired, 0-7: severe impairment, the resident had a score of 5, indicating severe cognitive impairment. Section H0200 shows a zero for toileting plan. Section GG indicated the resident was dependent for toileting and maximum assistance for transfers and bed mobility. Record review of Resident 11's Care Plan last revised 12/25/2024 revealed no toileting plan under Activities of Daily Living (ADL) problem, and toilet before meals listed under the Fall problem. The Problem for bladder incontinence related to Dementia, Impaired mobility did not reveal any toileting plan. Record review of Resident 11's Bladder Assessment form dated 12/05/2024 indicated the resident needed a toileting schedule before and after meals, at bedtime and for activities. No evidence of a 3-day bowel and bladder hourly elimination diary noted in chart. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Bowel and Bladder Management Standard policy last revised 4/18/2017 revealed under Identification and Assessment, C. a bladder assessment is done on admission, quarterly, annually and with significant change for residents, and when there is a change in continence. Assessment is completed after 3 days of hourly elimination diary is completed but not later than 8 days after admission. An observation on 2/24/2025 at 1:07 PM of Resident 11 revealed resident in room sitting up in wheelchair facing the closed door with a tray table in front of the resident while the resident attempted to feed self the noon meal. Resident in isolation in room for Covid 19 infection. An observation on 2/25/2025 at 7:15 AM of Resident 11 revealed resident in the restroom with staff being assisted with morning cares for the day. An observation on 2/25/2025 at 9:05 AM of Resident 11 revealed resident sitting in wheelchair facing closed door with a tray table in front of the resident with remainder of resident's breakfast sitting on tray table and the resident holding the call light. An observation on 2/25/2025 at 10:14 AM of Resident 11 revealed resident continued to be sitting in wheelchair in front of closed door with breakfast tray sitting on the tray table in front of the resident. An observation on 2/25/2025 at 10:45 AM of Resident 11 revealed resident continued to be sitting in wheelchair in front of closed door, staff member removing room tray. An observation on 2/25/2025 from 11:25 AM to 11:40 AM revealed Nurse Aide (NA)-A transferring Resident 11 with a gait belt from the wheelchair to the toilet. Resident 11's sweatpants were visibly soaked with urine to below the knees and the wheelchair cushion was also noted to be wet with urine, and the incontinent pull up was saturated with tan colored urine. Resident verbalized that pants and wheelchair were wet. NA-A removed soiled sweatpants and pull up while the resident was sitting on the toilet. NA-A assisted the resident to stand and obtained 4 peri wipes and placed them together. NA-A then cleansed the resident by doing 4 swipes from the lower center of the buttocks crease to top of the buttocks crease using the same wipes folding once, and the wipes had visible feces on them. No incontinent cares provided to peri area, hips, thighs, or outer buttocks. NA-A removed the soiled gloves, and without the benefit of hand hygiene, NA-A put a clean pull up and pants on the resident. NA-A then assisted the resident to sit down in the wheelchair on the wet cushion without cleaning the cushion. An interview with NA-A on 2/25/2025 at 11:30 AM confirmed that Resident 11 is not on a toileting plan and that the resident was saturated with urine and the NA did not think about cleansing the buttocks, hips and back of legs. NA-A also confirmed that no hand hygiene had been completed at any time during the cares, nor new gloves applied. Record review of Monitoring Frequent checks form dated 2/25/2025 that was placed outside Resident 11's door due to being in isolation with documentation being required every 15 minutes to indicate the resident's activity during that time, documentation revealed resident was toileted at 7:30 AM and 11:30 AM. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing (DON) on 2/26/2025 at 10:27 AM confirmed that Resident 11 does have bladder incontinence, dementia and impaired mobility so there should be some type of toileting plan. When discussing the Monitoring Frequent checks form with the DON, the DON confirmed that Resident 11 should have been toileted between 7:30 and 11:30 AM. The DON also confirmed that NA-A did not follow expectations for incontinence cares or cleansing of the wheelchair cushion. An interview with the MDS nurse on 2/26/25 at 1:45 PM confirmed that Resident 11 would benefit from a toileting plan and that the Bladder Assessment form completed by nursing on 12/05/2024 should have prompted a toileting schedule. The MDS nurse also confirmed that according to the electronic charting system for the nurse aides, Resident 11 is only toileted at 4 AM, 7 AM, 11 AM, 5 PM and 7 PM, with no toileting documented between these times, and confirmed that is not enough.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52171 LICENSURE REFERENCE NUMBER 175 12-006.09(H)(iii)(1) Based on observations, interviews, and record review, the facility failed to put interventions in place to prevent a pressure ulcer for one (Resident 20) of three sampled residents. The facility identified a census of 56. Record review of Resident 20's Census Data revealed resident admitted [DATE]. Record review of Resident 20's Face Sheet admitted with the following diagnosis: Pain in right hip, pain in right knee, Type 2 Diabetes Mellitus (DM II), Primary Hypertension (HTN), chronic kidney disease (CKD), Muscle weakness, Difficulty in walking, Chronic Pain, Lead Induced Gout. Record review of Resident 20's admission Minimum Data Set (MDS) (A federally mandated assessment that captures the resident physical and mental capabilities and care needs) dated 01/02/2025 revealed the following: Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment: score:13-15: cognitively intact, 8-12: moderately impaired, 0-7: severe impairment) a score of 15 indicating Resident 20 was cognitively intact. Section GG revealed resident is dependent with transfers and toileting, touch assistance with bed mobility and set up for eating. Section GG0115 revealed Impairment on one side of the upper and lower extremity. Sections M0100 determination of pressure ulcer injury risk marked No. Braden marked Yes M0150 risk for pressure ulcer marked as a Yes. M0210 unhealed pressure ulcers/injuries marked as a No. M1040 other ulcers, wounds and skin problems marked Yes. M1200 Skin and ulcer/injury treatments marked as a Yes with pressure reducing device for chair and bed. Sections K0520 Nutritional approaches marked Therapeutic diet (specialized diet varies for low salt, diabetic, low cholesterol). Record review of Resident 20's Baseline Care Plan dated 12/27/2024 revealed the following: Braden score of 18 indicating at risk for skin breakdown, pressure relieving cushion in the wheelchair and mattress to the bed. Offer assist with repositioning during nursing rounds and PM (an abbreviation for post meridiem, which means afternoon). Skin assessment routinely. Assist of one for transfers/walking with walker. Physical and Occupational therapies to evaluate and treat. Bed at knee height. Offer assist with toileting during AM/HS (morning/evening) cares, before/after meals, during nursing rounds and PRN (when needed). Record review of Resident 20's Progress Note dated 02/03/2025 at 3:45 PM revealed the following: Reported by staff that resident had a possible pressure area to L) heel. Upon assessment noted area to L) (left) lateral heel that is an oval in shape. Area is dark pink to light purple in color and does not blanche, area staged as a deep tissue injury (DTI is damage to the tissues beneath the skin that can occur due to sustained pressure). Area measures 2.1 cm (centimeter) x 1.3 cm, no OA (pressumed abreviation for Open Area) noted and res. denies pain at time of assessment. Treatment initiated to paint with betadine BID until healed. Prevlon boots (a medical device that helps relieve pressure on the heels) also to be initiated while in bed. Call made to notify son, message left. PCP (Primary Care Physician) notified per fax. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 20's Care Plan updated on 02/03/2025 skin or wound integrity with new Focus for the following: Actual impairment to skin integrity of left lateral (side) heel related to Diabetes, Edema (swelling), with Suspected deep tissue injury. Goal to prevent new skin problems through the next review of 04/03/2025 and second goal is Skin will be free from complications or worsening condition through the next review of 04/03/2025. Interventions are to do a Braden scale (Risk assessment tool used to identify patients at risk of developing pressure ulcers) quarterly and PRN, Dietician to evaluate resident nutrition as needed, float heels using pillows or off-loading boots PRN, Paint left heel wound with betadine twice daily until healed, Weekly and PRN skin monitoring by professional nurse. Record review of Resident 20's Braden Scale for Predicting Pressure Sore Risk-V2 Effective date of 12/27/2024 revealed a score of 18 which is a Category of AT Risk. Record review of Resident 20's Braden Scale for Predicting Pressure Sore Risk-V2 Effective date of 01/05/2025 revealed a score of 16 Category of At Risk. Record review of Resident 20's Braden Scale for Predicting Pressure Sore Risk-V2 effective date of 02/10/2025 revealed score of 17 Category of At Risk. Record review of Resident 20's Pressure Ulcer Record dated 02/03/2025 revealed a deep tissue injury measuring 2.1 cm x 3.1 cm area to left lateral heel and is oval and dark pink to light purple in color. No open area noted. Initiated betadine twice daily and heel boots. Record review of Resident 20's Pressure Ulcer Record dated 02/13/2025 revealed a deep tissue injury measuring 2.1 cm x 3.1 cm area pink. Prevlon boots and betadine continued. Record review of Resident 20's Pressure Ulcer Record dated 02/20/2025 revealed a deep tissue injury measuring 2.1 cm x 3.1 cm area pink. Blue boots in bed and betadine continued-improving. Record review of Resident 20's weights revealed: 12/27/2024 179.6 pounds 02/27/2025 191.5 pounds Record review of Resident 20's Physician Visit Communication Form dated 02/04/2025 revealed reason for visit/fax for weights stating there was a 14.5-pound weight increase since admission on 12/27/2024. Had 2+ pitting edema. Record review of Resident 20's Physician Visit Communication Form dated 02/04/2025 revealed reason for visit/fax due to continues to have deep tissue pressure injury to heel. Wound status is still approximated (close fit of wound edges), and discoloration has improved the last few weeks. Current treatment is to paint with betadine two times daily (BID). Has blue boots which is mostly compliant with. Also is not on any nutritional supplement at this time with physician response to continue with current orders and reviewed and agree with the plan of care. Record review on 02/27/2025 at 0820 AM of the Facility's Policy on Skin and Wound Management Standard Revised on 04/2019 revealed: Key Elements: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Edema wear/TED hose can cause injuries! Must be removed and skin assessed every shift. Check top of foot and around Achillies (back of lower leg above ankle) and knees. - Deep Tissue Pressure Injury (DTPI) can develop 48-72 hours after pressure is relieved. Assess new admissions every day at least for the first 72 hours. - Braden Scale for Predicting Pressure Ulcer Risk will be completed at bedside upon admission/readmission, daily times three then every week times three more weeks then quarterly, annually and PRN. - Repositioning. Heels should be floated (not touching any surface) using pillows or off-loading boot. - Routine Skin check. Weekly basis done by RN/LPN. - Monitoring. Team members will perform routine skin inspections with bathing and cares. Identified concerns will be documented on the Skin Care Alert Tool. Any findings should be documented on pressure or non-pressure forms -It is the expectation that all charge nurses will be knowledgeable and involved in preventing, identifying, assessing, treating, and documenting all skin and wound conditions. Observation on 02/25/2025 at 10:20 AM revealed Resident 20 sitting in recliner chair with feet on floor and edema wear on lower legs, diabetic shoes on feet. Stated, I have pain in my legs and back which is at a 5 and is tolerable. Complained of having a sore on her foot that doesn't hurt. Could not recall which foot it was. Interview with Licensed Practical Nurse (LPN)-F on 02/25/2025 at 10:35 AM confirmed that Resident 20 did have a deep tissue injury on left lateral heel and treatment was to put betadine on area two times daily. Observation of LPN-F on 02/25/2025 at 4:00 PM revealed with treatment to left lateral heel and wound that skin is intact and dark purple in color. No odor. LPN-F pressed on the wound and Resident 20 stated, It doesn't hurt. Had diabetic shoes on prior to treatment. Sitting in recliner with feet down following treatment. Observation on 02/26/25 at 8:40 AM revealed Resident 20 laying in bed with eyes closed. Does not have Prevlon boots on feet or heels floated with pillow. Observation on 02/26/2025 at 12:35 PM revealed Resident 20 sitting up in wheelchair without feet elevated. Edema wear on lower extremities with no shoes or Prevlon boots on feet. Interview with Nurse Aide (NA)-A on 02/26/2025 at 11:50 AM revealed that Resident 20 did not have blue off-loading boots on feet. Stated, If Resident 20 is up in the chair or wheelchair there should have been a pillow under lower legs to float heels and/or wear the off-loading boots and have feet up. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Registered Nurse (RN)-G on 02/26/2025 at 12:00 Noon revealed that if the resident is found to have a pressure sore the nurse is to go assess it and measure the area. Get the Wound Nurse (WN) or other nursing staff from leadership to come look at it. The nurse would then contact the doctor and call the family. Interview with Dietary Manager (DM) on 02/26/2025 at 1:10 PM revealed DM is notified of wounds in the Risk Management Meeting held weekly and nursing. Stated, I would then do a dietary assessment on the resident and notify the Dietician. DM stated, I didn't notify the Dietician about Resident 20's wound yet because I didn't know if nursing management wanted Resident 20 to have any supplements. DM stated, I must have missed that Risk Meeting because I'm not sure what went on. Interview with Wound Nurse (WN) on 02/26/2025 at 12:40 PM confirmed that Resident 20 had a deep tissue injury to left heel and was not admitted with a pressure sore. WN confirmed Resident 20 had an increased weight gain in the month of 01/2025. WN is to discuss any issues of skin or wound issues in the Risk Management meeting held weekly. WN stated The nurse or me are to assess the wound weekly on the Pressure Ulcer Record. WN was given the copy of the Pressure Ulcer Record and asked if it was done weekly and dates on the record were as follows: 02/03/2025, 02/13/2025, and 02/20/2025. WN confirmed to not having the Pressure Ulcer Record done weekly following the initial evaluation. Interview with Therapy Manager (TM) on 02/26/2025 at 1:32 PM revealed that Resident 20 came off skilled services due to a decline. Stated, I did not know or get contacted from Nursing Management that Resident 20 had a deep pressure injury on left heel and would of assessed what pressure relieving devices would prevent further decline of heel wound. Interview with Occupational Therapist (OT) on 02/26/2025 at 2:00 PM revealed that on admission started working with Resident 20 and was unaware of the pressure wound on the left heel. Stated nursing management is supposed to contact us and then we assess for positioning and off-loading the pressure area. OT confirmed Resident 20 has Diabetic Shoes on when up in recliner or wheelchair and they do help relieve pressure but to be total pressure free would have to be specific off-loading devices for that area. Stated I just took Resident 20 off skilled services this past week. Interview with Corporate Nurse (Corp. Nurse) on 02/26/2025 at 4:20 PM revealed the staff are to follow the Skin and Wound management policy. If the resident is at risk for wounds, nursing staff are to put the resident on a pressure relieving mattress and cushion for the chair or wheelchair. The management staff have a weekly Risk Management Meeting where all the information on Residents conditions is discussed. We record it in the Shared Drive for other management to read. Training is done for skin and wound management on hire and annually for nursing staff members.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52169 LICENSURE REFERENCE NUMBER 175-12-.006.09(H)(v) Based on observations, interviews and record reviews the facility failed to provide therapy or restorative services for one (Resident 38) of one sampled resident to prevent decline of resident condition. The facility identified a census of 56. Findings are: Record review of Resident 38's Census Data revealed the resident was admitted [DATE]. Record review of Resident 38's Face sheet revealed the resident was admitted with the following diagnosis: Weakness, Parkinsonism, Pain in left hip, Age related Osteoporosis without current pathological fracture, other Chronic pain. admitted to hospice 4/30/2024, removed from hospice 12/13/2024 due to slowed progression of disease and overall improvement. Record review of Resident 38's Significant change Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a residents functional capabilities and helps nursing home staff identify health problems) dated 12/20/2024 significant change: Section C, Brief Interview for Mental Status (BIMS), a brief screener that aids in detecting cognitive impairment score:13-15: cognitively intact, 8-12: moderately impaired,0-7: severe impairment) Resident had a score of 7 indicating severe impairment. Section GG showed Eating-Maximum assist, toileting Dependent, Bed mobility Dependent, transfers Dependent. Section O no special treatments including hospice, Section J question 14000 indicated the resident does not have a life expectancy of under 6 months. Record Review of Resident 38's Care Plan: ADLS revealed Dependent for all cares 2 assist (A) except eating is 1A. No Care Plan for therapy or restorative. Care Plan revised on 5/02/24 showed terminal prognosis related to terminal diagnosis Atherosclerotic Heart Disease of Native Coronary with unspecified angina pectoris. Terminal prognosis and hospice remain on care plan even though patient removed from hospice 12/20/2024. Record review of Resident 38 progress note date 12/14/2024 indicated resident came off hospice no documentation found that resident went on comfort care. An interview on 2/24/2025 with Resident 38's Resident Representative (RR) at 12:50 PM revealed the resident came off hospice over a month ago and restorative was requested and the facility told them they did not have restorative available right now. A few weeks later they were told someone was hired but still no restorative was offered or therapy screen completed. An interview with Licensed Practical Nurse (LPN)-E on 2/26/2025 at 9:05 AM revealed that Resident 38 would cooperate and benefit from restorative. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Therapy Director (TD), on 2/26/2025 at 9:25 AM revealed that Resident 38 is on hospice. Further discussion revealed the TD was told by nursing the resident remained on comfort care. When TD was asked what the process would be if a resident gets removed off hospice, the TD replied, they would typically screen and get an order to evaluate and treat and then determine a restorative program if therapy was not appropriate. An observation on 2/26/2025 at 3:09 PM revealed Resident 38 sitting in wheelchair, when cued to raise arms and open hands, resident complied and participated and stated that feels good. An interview with RR on 2/26/2025 at 3:50 PM confirmed family would like therapy to screen Resident 38 and that a different sibling had relayed that information several times to the facility. The RR went on to say that with Resident 38 having Parkinsons, Residents 38's legs get stiff but when you move them around the resident can stand better and tells family that it feels good to move them. An interview with Social Service Director (SSD) on 2/26/2025 at 3:45 PM confirmed Resident 38's RR wanted restorative or physical therapy for Resident 38. SSD also confirmed that 11/13/2025 was the last care plan completed, and 12/20/2024 the resident had a significant change and was taken off hospice. SSD stated, we should have had a care plan meeting then, it was a lack of communication and that is what I told the RR. SSD also verbalized there really is no process if someone comes off hospice that this is something they will have to investigate and fix the process.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47406 Licensure Reference Number 175 NAC ,d+[DATE].09(H)(vi)(3) Based on interview, observations and record reviews, the facility failed to obtain a physician's order for the settings of CPAP (Continuous Positive Airway Pressure -a treatment that uses mild air pressure to keep your breathing airways open), and ensure the machine has a filter for one (Resident 109) of one sampled residents. The facility had a census of 56. Record review of Resident 109's admission record dated [DATE] revealed Resident 109 admitted to the facility on [DATE]. Observation on [DATE] at 1:35 PM revealed Resident 109's CPAP machine has no filter in the machine. Record review of Resident 109's Physician orders dated [DATE] revealed: -CPAP per home settings, on at HS (hour of sleep) off in AM every day and night shift -start date [DATE]. Record review of Resident 109's assessment dated [DATE] revealed Resident's BIMS (Brief Interview for Mental Status, a test used to get a quick snapshot of a resident's cognitive function, scored from ,d+[DATE], the higher the score, the higher the cognitive function) was 14, indicating that Resident 109 in cognitively intact. Observation on [DATE] at 9:30 AM of Resident 109's CPAP machine did not have a filter. Record review of Resident 109's Diagnosis dated [DATE] revealed: Chronic Obstructive Pulmonary Disease, and Obstructive Sleep Apnea. Observation on [DATE] at 2:00 PM of Resident 109's CPAP machine did not have a filter. Interview on [DATE] at 2:04 PM with DON confirmed that Resident 109's CPAP machine did not have a filter and that the facility needed to obtain the specific CPAP home settings according to the physician orders for the CPAP settings. Record review of Continuous positive airway pressure (CPAP) use dated [DATE] revealed: Continuous positive airway pressure (CPAP) provides constant positive pressure into the patient's airway to help hold the airway open, mobilize secretions, treat atelectasis, and generally ease the work of breathing period. CPAP helps treat moderate to severe obstructive sleep apnea. CPAP keeps the patients airway open, from the nares to the alveoli, thereby increasing functional residual capacity and improving gas exchange. Inspect all equipment and supplies if a product is expired, is defective, or has compromised integrity, remove it from the patient, use, label it as expired or defective, and report the expiration or defect as directed by your facility. (continued on next page)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Verify the practitioner's order. -Documentation associated with continuous positive airway pressure (CPAP) use includes CPAP settings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285297	A. Building B. Wing	02/27/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47406 Licensure Reference Number 175 NAC 12-006.18, 1-005.06 (D)(E)(F) The facility failed to ensure staff wore masks above the nose and below the chin, the laundry staff performed hand hygiene for at least 20 seconds, the CPAP (Continuous Positive Airway Pressure -a treatment that uses mild air pressure to keep your breathing airways open), mask was cleaned every day for Resident 109, failed to have a barrier on the counter outside of a Covid positive resident's room where laundry items were placed, provide peri care after incontinence for Resident 11, and staff failed to remove PPE (Personal Protective Equipment used to protect healthcare workers, patients, and others from potentially contacting and/or spreading potential infections) correctly when exiting a positive Covid 19 residents room to prevent the potential spread of Covid 19. This had the potential to affect all residents in the facility. The facility had a census of 56. Findings are: A) Observation on 2/24/25 at 11:00 AM the entry desk of the facility has a tan-colored zone signage saying that masks are required. Record review of Transmission Based Precaution list with residents with Covid positive in rooms 307, 401, 403, 408, and 412. Observation on 2/24/25 at 11:04 AM of Guest Relations Staff Member (GR-C) had mask on below the nose. Observation on 2/24/25 at 4:14 PM of Guest Relations Staff Member (GR-D) had mask on below the nose. Observation on 2/25/25 at 9:12 AM of GR-D had mask on below the nose. Interview with Director of Nursing (DON) on 2/26/25 at 1:52 PM revealed that masks should be wore above the nose and below the chin. Record review of Covid 19 Education dated January 2021 revealed: Follow facility PPE instructions: -Wear a mask over your nose and mouth. B) Observation on 2/26/25 at 7:35 AM of hand washing by laundry staff member (LS-B). LS-B had placed linens in the wash machine, then removed their gown, goggles and gloves. LS-B performed hand hygiene with soap and water for 12 seconds. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 2/26/25 at 7:40 AM with LS-B confirmed [gender] should have washed hands for 20 seconds. Interview on 2/26/25 at 9:30 AM with Houseker/Laundry Supervisor (HLS) confirmed that hand washing should be for 20 seconds. Record review of Covid-19 Guidelines Policy dated 10/20 revealed: purpose of this guideline is to provide clarification to policies and procedures the facility will take regarding COVID-19, to minimize exposure and properly identify residents, team members and visitors. With clinical features and risk for COVID-19. Prevention measures: -Wash your hands for at least 20 seconds. -When to perform hand hygiene. -After touching a resident or handling their belongings. -After any contact with body fluids. -After handling contaminated items (linens, garbage, briefs, etcetera. -Before and after gloving. C) Observation on 2/24/25 at 1:35 PM of Resident 109's CPAP (Continuous Positive Airway Pressure - a treatment that uses mild air pressure to keep your breathing airways open) revealed mask seal has facial oils on it. Interview on 2/24/25 at 1:37 PM with Resident 109 revealed the facility doesn't clean the mask. Record review of Resident 109's assessment dated [DATE] revealed Resident's BIMS (Brief Interview for Mental Status, a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function) was 14, which indicated that Resident 109 is cognitively intact. Record review of Resident 109's Diagnosis dated 2/25/25 revealed: Chronic Obstructive Pulmonary Disease, and Obstructive Sleep Apnea. Record review of Resident 109's admission record dated 2/25/25 revealed admission to facility was 2/21/25. Observation on 2/25/25 at 9:30 AM revealed Resident 109's CPAP mask with white specks of debris on inside of mask and facial oils on the seal of the mask. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 2/25/25 at 2:00 PM revealed Resident 109's CPAP mask had white specks of debris on inside of mask and facial oils on seal of the mask. Interview on 2/25/25 at 2:04 PM with DON confirmed the CPAP masks should be cleaned every day. Observation on 2/27/25 at 2:07 PM revealed Resident 109's CPAP has white specks of debris on the inside the CPAP mask. Record review of Resident 109's Physician Orders dated 2/25/25 revealed: -Daily CPAP cleaning: Wipe the portion of the mask that comes in contact with the resident's skin with damp cloth. Empty remaining water from the humidifier chamber, fill the chamber with soapy warm water and shake vigorously. Rinse the chamber with clean water and air-dry every day shift. Record review of Using Oxygen with Your CPAP/Bi-Level Unit policy undated revealed: Cleaning your CPAP/Bi-Level Equipment- Daily cleaning: -Wipe the portion of the mask that comes in contact with your skin with a damp cloth. This removes most skin oil from the mask. Record review of Continuous positive airway pressure (CPAP) use dated 11/18/24 revealed: Continuous positive airway pressure (CPAP) provides constant positive pressure into the patient's airway to help hold the airway open, mobilize secretions, treat atelectasis, and generally ease the work of breathing period. CPAP helps treat moderate to severe obstructive sleep apnea. CPAP keeps the patients open air and tire airway open, from the nares to the alveoli, therefore increasing functional residual capacity and improving gas exchange. -When the CPAP therapy is complete, follow these steps. Clean and disinfect the usable equipment according to the manufacturer's instructions and store it properly. D) Observation on 2/26/25 at 1:10 PM of LS-B delivering resident's laundry on hallway 300. LS-B placed a Covid positive resident's laundry on the nurse-server counter outside their room without sanitizing the counter or placing the laundry in a bag. Interview with LS-B on 2/26/25 at 1:18 PM revealed [gender] was not sure how to place the laundry of Covid positive residents on the nurse server counter without contaminating the clothes. Interview with the DON on 2/26/25 at 1:52 PM confirmed the laundry of Covid positive residents should be placed on a barrier on the nurse server counter outside of the resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	52169 E) Record review of Resident 11's Census Data revealed the resident was readmitted to the facility on [DATE]. Record review of Resident 11's Face Sheet revealed the resident admitted with the following diagnosis: Unspecified dementia, unspecified severity, with behavioral disturbance, polyosteoarthritis, Parkinson's Disease and muscle weakness. Record review of Resident 11's annual Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 12/05/2024 revealed under Section C the Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score: 13-15: cognitively intact, 8-12: moderately impaired, 0-7: severe impairment, the resident had a score of 5, indicating severe cognitive impairment. Section H0200 shows a zero for toileting plan. Section GG indicated the resident was dependent for toileting and maximum assistance for transfers and bed mobility. An observation on 2/25/2025 from 11:25 AM to 11:40 AM revealed Nurse Aide (NA)-A was in Resident 11's room wearing a face shield, N-95 mask, isolation gown and gloves as resident was in isolation due to having Covid-19 infection. NA-A was transferring Resident 11 with gait belt from wheelchair to toilet. Resident 11's sweatpants were visibly soaked with urine to below the knees and the wheelchair cushion was also noted to be wet with urine, and the incontinent pull up was saturated with tan colored urine. Resident verbalized that pants and wheelchair were wet. NA-A removed the soiled sweatpants and pull up while resident was sitting on the toilet. NA-A assisted the resident to stand and obtained 4 peri wipes and placed them together. NA-A then cleansed the resident by doing 4 swipes from the lower center of the buttocks crease to top of the buttocks crease using the same wipes folding once, and the wipes had visible feces on them. No incontinent cares provided to peri area, hips, thighs, or outer buttocks. NA-A removed soiled gloves, and without the benefit of hand hygiene or new gloves, NA-A put a clean pull up and pants on the resident. NA-A then assisted the resident to sit down in the wheelchair on the wet cushion without cleaning the cushion. NA-A continued to complete cares, without gloves on in an isolation room. NA-A completed cares, then when getting ready to exit room, NA-A used soiled hands and grabbed the inside of the isolation gown at the neck to remove the gown, touching the NA's clothing and skin below. NA-A used hand sanitizer, exited the room with face shield and mask on, took the face shield off and placed it on the counter outside the room, instead of a trash container. No further hand hygiene observed. An interview with NA-A on 2/25/2025 at 11:30 AM confirmed that Resident 11 is not on a toileting plan and that the resident was saturated with urine and the NA did not think about cleansing the buttocks, hips and back of legs. NA-A also confirmed that no hand hygiene had been completed at any time during the cares, nor new gloves applied. An interview with the Director of Nursing (DON) on 2/26/2025 at 10:27 AM confirmed that NA-A did not follow expectations for incontinence cares for Resident 11 due to not cleansing areas exposed to urine and not using separate wipes during cares. DON also confirmed NA-A should have cleansed the wheelchair cushion after incontinence, and did not remove the isolation gown or dispose of face shield correctly. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of Donning and Doffing Competency last revised 3/2021 with Sequence for safe removal of personal protective equipment (PPE) under number 2: place face shield in designated receptacle for reprocessing, otherwise, discard in waste container. Number 2 of the Competency revealed removal of gown to reach up to the shoulders and carefully pull gown down and away from the body, rolling the gown and placing in receptacle. Review of Mosby's textbook for Nursing Assistants, 6th edition, page 382: Incontinence can put a resident at risk for skin irritation, infection, and pressure ulcers if good skin care not performed with incontinence.