STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285054	A. Building B. Wing	04/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Banyan at Montclair	2525 South 135th Avenue Omaha, NE 68144

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17285 Licensure Reference Number 175 NAC 12-006.18 Based on observation and interview, the facility failed to maintain the cleanliness and condition of ventilation systems, fixtures, baseboards and walls in 12 (resident rooms 106, 110, 111, 112, 204, 307, 309, 315, 317, 402, 404 and 409) of 73 occupied resident rooms. The facility census was 107. Findings are: Observation on 03/29/23 between 8:35 AM and 9:15 AM with the facility Director of Maintenance [DM], the Regional Director of Maintenance, the Business office Manager acting on behalf of the Administrator and the Director of Housekeeping revealed the following issues with the facility environment: - Ventilation covers dust covered in resident bathrooms: 106, 110, 111, 112, 307, 309, 315, 317, 402, 404, 409 - Missing toilet paper holder in resident bathroom: 204 - Stained toilet base and cracked or missing caulking in resident bathrooms: 112, 204, 317 - Baseboard pulled away from the hall in resident bathrooms: 204 - Holes / scratches in the walls in resident bathrooms: 112, 204 Interview on 03/29/23 at 9:20 with the DM confirmed the observations and issues identified: - Ventilation covers dust covered in resident bathrooms: 106, 110, 111, 112, 307, 309, 315, 317, 402, 404, 409 - Missing toilet paper holder in resident bathroom: 204 - Stained toilet base and cracked or missing caulking in resident bathrooms: 112, 204, 317 - Baseboard pulled away from the hall in resident bathrooms: 204 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285054	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2023
NAME OF PROVIDER OR SUPPLIER The Banyan at Montclair		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 South 135th Avenue Omaha, NE 68144	

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Holes / scratches in the walls in resident bathrooms: 112, 204 Interview on 03/29/23 at 10:00 AM with the Maintenance Director revealed a work order for issues in room [ROOM NUMBER] dated 2/23/23 but confirmed the issues in room [ROOM NUMBER] had not been addressed as of 3/29/23. The MD confirmed that no work orders had been made for the other resident rooms identified with environmental issues.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 45614 Based on record review and interview the facility failed to ensure 1(Resident 43) of 1 resident was given a letter explaining the reason for transfer to the hospital. The facility staff identified a census of 107. Findings are: A record review of Resident 43s' electronic health record revealed Resident 43 was discharge to the hospital on 3/20/23. Further record review failed to reveal a letter of transfer being issued to Resident 43 prior to Resident 43's departure to the hospital. An interview on 03/29/2023 at 3:25PM with Clinical Consultant (CC) Z confirmed that a letter of transfer was not given to Resident 43 explaining the reason for transfer to the hospital.

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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. 47733 LICENSURE REFERENCE 175 NAC 12-006.09c3 Based on record review and interview, the facility failed to complete discharge summaries/ recapitulation for 1(Resident 110) of 3 sampled residents. The facility identified a census of 107. Findings are: Record review for 2/8/23 documentation in the progress note reveals that the Resident (110) left against medical advice (AMA). Record review of the Electronic Medical Record (EMR) further revealed no discharge summary or recapitulation (Reason for the Resident's stay, What the facility did as well as the Resident's condition upon discharge) of stay was completed. Interview with Corporate Nurse Consultant Z on 03/28/23 at 3:23 PM confirmed there was not a discharge summary/ recapitulation of stay on Resident's 110.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 17285 Licensure Reference Number 175 NAC 12-006.09D2 Based on observation, record review and interview, the facility failed to identify, obtain treatment orders and monitor a skin abrasion for 1 (Resident 60) of 1 sampled resident. The facility census was 107. Findings are: Record review of a Policy entitled Skin Tears - Abrasions and Minor Breaks, Care of dated September 2013 revealed the following: - General Guidelines: 1. An abrasion is an area on the skin that has been damaged by friction, scraping, rubbing or trauma. A skin tear is the disruption of epidermis resulting in a lifting or friction of the skin. - Preparation: 1. Obtain a Physicians order as needed. Document physician notification in medical record. 2. Review the residents care plan, current orders, and diagnoses to determine resident needs. 3. Check the treatment. 4. Generate an alteration in skin form and complete. - Documentation: Record the following information in the resident's medial record: 1. Complete risk management / investigation of causation when abrasion / skin tear is discovered. 2. Generate / update alteration 3. Document physician and family notification in the medical record. 6. Any complications related to the abrasion (e.g., pain, redness, drainage, swelling, bleeding). 8. Interventions implemented or modified to prevent additional abrasions may be placed on the care plan. -Reporting: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Notify the responsible family member. Physician notification may be routine (that is, non immediate) if the abrasion is uncomplicated or not associated with significant trauma. 2. Notify the physician of any abnormalities (i,e., excessive bleeding, localized swelling, redness, drainage, tenderness, pain etc.) 3. Report other information in accordance with facility policy/guideline and professional standards of practice. Record review of Resident 60's most recent Minimum Data Set [a comprehensive assessment used to develop a care plan for the resident] dated 3/7/23 identified a Brief Interview for Mental Status [BIMS] score of 3 which indicated severe cognitive impairment. The MDS identified that resident 60 had a diagnosis of Dementia and did not identify any skin impairments present. Observation on 03/27/23 at 08:35 AM and 2:29 PM revealed Resident 60 seated in lobby area by nurse's station in a wheelchair eating breakfast. There was a small, round wound present on the right cheek of the resident with a spot of blood present. Observation on 03/28/23 at 02:54 PM revealed Resident 60 seated in a wheelchair at table near the nurses station. There was a small, round wound present on the right cheek of the resident with a spot of blood present. Record review of Resident 60's Electronic Medical Record [EMR] revealed evidence that the facial wound had been identified, evaluated or monitored and no treatment orders had been obtained. Interview on 03/28/23 at 08:13 AM with the Director of Nursing [DON] confirmed that there was an area on Resident 60's right cheek that appeared to be a lesion or abrasion that the resident had picked. The DON confirmed that the nurse on duty on 3/27/23 had not identified or evaluated the area, had not obtained treatment orders, and had not started monitoring of the wound. The DON stated that the nurse should have evaluated it, obtained treatment orders, and started monitoring of the wound to Resident 60's right cheek. The DON stated they would evaluate the wound, obtain treatment orders and start monitoring of the wound for Resident 60. Record review of a Physician order dated 3/28/23 revealed the following orders: - Right cheek abrasion skin care- cleanse area with normal saline, pat dry, apply thin layer of A&D[a specific brand of ointment] ointment to abrasion. 2 times a day for 14 days, encourage resident to not scratch the area. every shift for abrasion treatment. Record review of a Skin alteration Evaluation dated 3/28/23 revealed the following assessment: - Resident has a small dime size area to rt [right] cheek appears to have 2 small dry areas together and some slight bruising. CNA [certified nursing assistant] states resident has been scratching area and noted to have small amount of dried blood noted. Small amt of dried blood noted to index finger on rt [right] hand. Resident redirected to not scratch area.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40338 LICENSURE REFERENCE NUMBER 175 NAC 12-006.18E3, 175 NAC 12-006.09D7 Based on observation, record review and interview; the facility failed to ensure water temperatures in resident rooms and a bathing area were maintained at a temperature to prevent the potential for scald burns for rooms 111, 112, 202, 203, 204, 205, 208, 209, 300, 307, 309, 317, 409, 406, 401, and the North spa room. The facility census was 107. Findings are: A. On 03/27/23 at 09:00 AM an observation of the water temperatures in room [ROOM NUMBER] was 129 degrees. room [ROOM NUMBER] had a water temperature of 126 degrees, room [ROOM NUMBER] had a water temperature of 127.1 degrees and room [ROOM NUMBER] had a water temperature of 123.9. Resident 1 resides in room [ROOM NUMBER] and has a BIMS (Brief Interview for Mental Status) of 5. According to the MDS [NAME] a score of 5 indicates a resident is cognitively impaired. Resident 1 is mobile per wheelchair. Resident 54 resides in room [ROOM NUMBER] has a BIMS of 2 which indicates the resident is cognitively impaired. Resident 54 is ambulatory. Resident 67 and Resident 3 reside in room [ROOM NUMBER]. Resident 67 has a BIMS of 5 indicating cognitive impairment and Resident 3 has a BIMS of 3 indicating cognitive impairment. Resident 67 and Resident 3 are both mobile per wheelchair. 17285 B. Record review of Federal Tag F 689's Time and Temperature Relationship to Serious Burns identified that water may reach hazardous temperatures in hand sinks, showers, tubs, and any other source or location where hot water is accessible to a resident and may put residents at increased risk for burns caused by scalding. Decreased cognition may put residents at risk for burns caused by scalding. The degree of injury depends on factors including the water temperature, the amount of skin exposed, and the duration of exposure. The following information illustrates damage to skin in relation to the temperature of the water and the length of time of exposure: - Water at 140 degrees F could cause 3rd degree scald burns after 5 seconds of exposure. - Water at 133 degrees F could cause 3rd degree scald burns after 15 seconds of exposure. - Water at 127 degrees F could cause 3rd degree scald burns after 1 minute of exposure. - Water at 124 degrees F could cause 3rd degree scald burns after 3 seconds of exposure. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation on 3/27/23 between 9:00 AM and 10:00 AM revealed that the following hot water temperatures in resident bathroom sinks on the 100 and 200 halls of the facility: - room [ROOM NUMBER]: 127.4 Degrees Fahrenheit [F] - room [ROOM NUMBER]: 127.5 F - room [ROOM NUMBER]: 126 F - room [ROOM NUMBER]: 126 F - room [ROOM NUMBER]: 126.8 F - room [ROOM NUMBER]: 127.1 F - room [ROOM NUMBER]: 128.8 - room [ROOM NUMBER]: 126.8 F Observation on 3/27/23 at 10:00 AM revealed that there was a total of 14 residents that resided in the rooms with hot water accessible. Interview on 03/27/23 at 10:10 AM with Nursing Assistant [NA] G confirmed the water was hot and stated, If the water is too hot, I turn on some cold to even it out and then report it immediately to maintenance. Interview on 03/27/23 at 10:15 AM with NA H confirmed the water was hot and stated, I turn on the cold water and then report it to maintenance right away. Interview on 3/27/23 at 3:00 PM with Director of Maintenance [DM] C revealed that the hot water is checked in one room on each hall weekly. DM C confirmed that they were not aware the water was too hot. DM C stated that the water temperatures were increased in January to keep the pipes from freezing. Interview on 04/03/23 at 09:50 AM with Licensed Practical Nurse [LPN] J revealed that, of the 14 residents that resided in the rooms with hot water accessible, Resident 5 and Resident 34 were self-mobile once in their wheelchairs and were severely cognitively impaired. LPN J confirmed that Resident 5 and 34 would be able to wheel themselves into the bathroom and up to the hot water faucet to access the hot water. LPN J confirmed that Resident 5 and 34 had very poor safety awareness. LPN J confirmed that Residents 5 and 34 were most at risk for scald burns due to being self-mobile, severely cognitively impaired and had poor safety awareness. Record review of Resident 5's most recent Minimum Data Set [MDS] [a mandatory clinical comprehensive assessment used for care planning] dated 3/16/23 revealed a Diagnoses of Non - Alzheimer's Dementia and a Brief Inventory of Mental Status [BIMS] [a brief screening tool that aids in detecting cognitive impairment] score of 5 [severe cognitive impairment]. The MDS identified that Resident 5 required supervision with locomotion in the room and on the unit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident 34's most recent MDS 2/8/23 revealed a Diagnoses of Non - Alzheimer's Dementia and a [BIMS] score of 4 [severe cognitive impairment]. The MDS identified that Resident 5 required limited assistance with locomotion in the room and on the unit. 45614 C. The following water temperatures were observed on 03/27/23 at 1:18 PM revealed the following information: -The water temperature in the bathroom of room [ROOM NUMBER] was 127.7 degrees Fahrenheit. - The water temperature in the bathroom of room [ROOM NUMBER] was 125.7 degrees Fahrenheit. - The water temperature in the bathroom of room [ROOM NUMBER] was 125.3 degrees Fahrenheit. - The water temperature in the North spa (bathhouse) was 129.9 degrees Fahrenheit. An observation on 03/28/2023 at 10:16 AM revealed the resident in room [ROOM NUMBER] attempting to get to walk to the bathroom on their own. RN- T (Registered Nurse) intervened and assisted the resident to the bathroom. On 3-28-2023 at 10:16 AM a interview was conducted with Registered nurse (RN)-T During the interview RN T reported the resident had the physical ability to get to the bathroom and had a dementia diagnosis. This diagnosis also places the resident at risk for burns from excessively hot water. On 03/27/23 at 12:22 PM an interview with BA (Bath Aide) S. During the interview BA S reported maintenance staff check the temperature of the water everyday before showers are given. 28155 D. Review of a Daily Round sheet of water temperature for February 2023 revealed the following information: -2-10-2023: -100 hall, 135.4 degrees. -200 hall, 137.6 degrees. -300 hall, 138.2 degrees. -400 hall, 140.1 degrees. -500 hall, 124.7 degrees. -South Spa 121.8 degrees. -North Spa 136.4 degrees. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-2-13-2023: -200 hall, 128.6 degrees. -300 hall, 133.3 degrees. -500 hall 126.1 degrees. -600 hall 123.6 degrees. -2-16-2023: -100 hall 123.3 degrees. -300 hall 134.2 degrees. -South spa 125.7 degrees. Record review of A daily Rounds sheet of water temperature for March 2023 revealed the following information: -3-2-2023: -100 hall was 126.8 degrees. -400 hall was 127.5 degrees. -500 hall was 127.5 degrees. -600 hall was 125.6 degrees. -South Spa was 122.9 degrees. -North Spa was 122.1 degrees. -3-8-2023: -South Spa 124.5 degrees. -North Spa 141.0 degrees. -3-10-2023: -200 hall was 126.6 degrees. -300 hall was 138.5 degrees. -400 hall was 135.0 degrees. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-South Spa was 125.0 degrees. -North Spa was 135.0 degrees. -3-17-2023: -100 hall was 135.5 degrees. -300 hall was 132.0 degrees. -South Spa was 125.6 degrees. -North Spa was 133.5 degrees. Review of the policy revealed: -Test temperature in shower areas. Shower should be between 100 and 110. -Test temperature at the mixing valve. -Check resident rooms at the end of each wing on a rotating basis or by facility policy. Resident rooms in Nebraska should be between 110 and 120. -Record results in the water temperature log. -Note any discrepancies. -Adjust water heater settings as required. -Retest as necessary. Interview on 3/27/2023 at 10:00 AM with the Maintenance Director revealed information had been provided for maintenance to leave the water temperatures high so the pipes would not freeze during the winter. The TELS (a system for documenting and tracking maintenance activities) instructions are the policy for checking water temps. Interview on 3/27/2023 at 11:45 AM with Consultant Z revealed the mixing valve have been adjusted and they will be checking all sinks at 15 min intervals and readjusting as needed. Interview on 03/29/23 at 1:35 PM with Consultant Z revealed the water had been adjusted down and now is too cold and the facility has had to suspend bathing and has called in a plumber. As outlined by Consultant Z of the facility on 3/27/2023 at 12:30 PM the facility initiated the following plan to address the immediacy of the situation and abate the immediate jeopardy situation: 1. The facility immediately verified the main hot water heater/mixing valve is set at 100 degrees and began adjusting it according to room temperature readings. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. The facility immediately initiated and are continuing to check water temps in resident rooms and shower areas. 3. Facility educated residents and staff to increase use of hand sanitizer while temps are being monitored. Additional staff sent to memory unit. 4. Facility immediately educated maintenance personnel to regulations and policies associated with Water temps, 110-120 degrees at sinks, and 100-110 in shower areas. and the practice of placing the results in TELS system going forward. 5. The facility immediately initiated facility wide education on Azria Water Temps, and regulations associated with water temps, 110-120 degrees at sink and 100 to 110 degrees in shower areas. Azria Water Temps states that if at any time the water feels excessive to touch they will report to the immediate supervisor. The education will take place before staff work their next shift. 6. The DON educated and competencies bath aides on ensuring water temps are between 100-110 degrees on daily basis before first shower/ bath of the day/ shift. The facility maintenance staff and /designees will continue to audit water temps facility wide and adjust the main water heater mixing valves as needed until temps reach regulatory requirement, 110-120 degrees at sinks, and 100-110 in shower areas. Those staff will alert administrator / designee of any temps outside of the regulatory requirements and further action / adjustments to the water heater/mixing valve will be completed. Facility maintenance staff/ designee will audit random water temps on each station and each bath house daily x 2 weeks, then 3x's a week x 6 weeks, and then return to periodically per policy. Staff will alert administrator / designee of any temps outside of the regulatory requirements and further action/ adjustments to the water heater/mixing valve will be taken. Results of all audits will be taken to QAPI for further review and analysis. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	With the above interventions initiated, the immediate jeopardy was abated and the scope and severity of the deficiency was lowered to an E

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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. 40338 LICENSURE REFERENCE NUMBER 175 NAC 12-006.09D6 Based on observation, record review and interview; the facility failed to ensure nebulizer (a small machine that turns liquid medicine into a mist that can be easily inhaled) equipment was stored in a manner to prevent the potential for cross contamination and changed weekly for 2 (Resident 1 and 49) of 2 sampled residents. The facility staff identified a census of 107. The findings are: An observation on 03/27/23 at 11:56 AM revealed a Nebulizer mask laying on the floor under the chair in Resident 1's rooms. The date on the nebulizer tubing was 02/19/23. An observation on 03/27/23 at 2:12 PM revealed the nebulizer mask continued to be on the floor under the chair in Resident 1's room. An observation on 03/28/23 at 7:37 AM revealed the nebulizer mask remained on the floor under the chair in Resident 1's room. An observation on 03/28/23 at 2:30 PM revealed the nebulizer mask remained on the floor under the chair in Resident 1's room. Record review of Resident 1's orders for February 2023 revealed a nebulizer treatment three times a day for 5 days was ordered 2/27/23 and ended 3/3/23. Further review of Resident 1's orders in February 2023 revealed a nebulizer treatment three times a day for 7 days dated 2/3/23 and ended 2/10/23. An observation and interview on 03/29/23 at 2:41 PM with The Assistant Director of Nursing (ADON)F confirmed the nebulizer tubing for Resident 1 was dated 2/19/23 and the nebulizer mask was laying on the floor under the chair in Resident 1's room. During the interview ADON-F was unable to explain the 2/19/23 date on the tubing. ADON-F revealed that the policy is to change the nebulizer equipment weekly and the staff document on the MAR (Medication Administration Record)/TAR (Treatment Administration Record). Review of the MAR/TAR with ADON-F confirmed there was no documentation of the nebulizer equipment for Resident 1 being changed weekly. Review of the Policy for Administering Medications through a Small Volume (Handheld) Nebulizer revised October 2010 revealed the following: -When treatment is complete, turn off nebulizer and disconnect T-piece, mouthpiece and medication cup. Wash pieces with warm soapy water, rinse with ht water, and allow to air dry on paper towel. -When equipment is completely dry, store in a plastic bag. -Change out equipment and tubing every 7 days, or according to facility protocol. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	45614 B. An observation on 03/29/23 at 1:06 PM revealed Resident 49's nebulizer mask was lying on the residents' side table with a plastic bag attached to the side of the tray table. A record review of the facility policy Administering Medication through a Small Volume (Handheld) nebulizer dated 2001 and revised October 2010 revealed the following Steps in the Procedure. When treatment is complete, turn off nebulizer and disconnect T-piece, mouthpiece and medication cup. Rinse and disinfect the nebulizer equipment according to facility protocol or; a. wash pieces with warm soapy water b. rinse with hot water c. allow to air dry on a paper towel. When equipment is completely dry, store in a plastic bag with the resident's name and the date on it. An interview with RN-T (Registered Nurse) on 03/29/23 at 1:45 PM confirmed the facility policy is to wash, rinse and air dry the nebulizer mask and then store it in a plastic bag until it is to be used next. RN-T confirmed that the procedure was not followed with Resident 49's nebulizer equipment on 03/29/2023.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 28155 Based on Observation, record review and interviews the facility failed to ensure a dialysis access site was checked daily and failed to maintain a fluid restriction order for 1 (Resident 2) of 1 sampled resident. The facility census was 107. Findings are: A. Review of Resident 2's Medical Diagnosis in the Electronic Medical Record (EMR) revealed the following: -Dependence on Renal Dialysis -End state renal disease Review of Resident 2's Nursing Note dated 3/15/2023 revealed Resident 2 returned from the hospital after having a procedure to place an arteriovenous (AV) fistula (a type of dialysis access site). Review of the After Procedure Summary dated 3/17/2023 for care of the new fistula instructs to check for thrill each day. Review of Resident 2's Treatment Administration Record (TAR) revealed no documentation of assessment of bruit and thrill (sound and feel of blood running in the site) for the new dialysis access site. Review of Resident 2's care plan revealed an intervention initiated on 2/14/2023 to Monitor AV fistula for thrill or bruit daily Review of the policy dated September 2010 titled Hemodialysis Access Care revealed to prevent infection and/or clotting the following should be done: -Check for signs of Infection at the access site when performing routine care and at regular intervals -Check the color and temperature of the fingers and the radial pulse of the access arm when performing routine care and at regular intervals. -Check patency of the site at regular intervals. Palpate the site to feel the thrill, or use a stethoscope to hear the whoosh or bruit of blood flow through the access. Interview on 03/29/23 11:27 AM with Consultant Z revealed the Bruit and Thrill should be checked daily. Interview on 03/29/23 at 3:00 PM with Consultant Z revealed the Thrill was not being checked daily after the AV fistula was placed. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Review of Resident 2's physician orders dated 1/19/2023 revealed an order for a fluid restriction every shift and not exceed 1500 milliliters (ml's) in 24 hours related to End Stage Renal Disease. Document total ml at the end of every shift. Review of Resident 2's Treatment Administration Record (TAR) for March 2023 revealed the facility staff documentation the amount of fluids Resident 2 had in a 24 time frame: -5th 1910 ml -6th 2180 ml -7th 1760ml -9th 1800ml -12th 2150ml -14th 2100ml -15th 1880 ml -20th 1950 ml -22nd 1780 ml -23rd 1820 ml -24th 1800 ml Review of Resident 2's progress note revealed no Dietary note to specify how Resident 2's fluids were to be distributed through out the day. Review of Resident 2's care plan revealed no care plan for fluid restriction. Interview on 3/29/2023 at 2:30 PM with Consultant Z revealed a prescribed fluid restriction was not initiated for Resident 2 to limit his fluid intake.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17285 Licensure Reference Number 175 NAC 12.006.11E Nebraska Food Code 4-601.11(C) Based on observation and interview; the facility dietary staff failed to maintain the cleanliness and condition of ceiling tiles, stove back splash, shelf above the stove, floors in the [NAME] cooler, plate warmer, light fixtures and ventilation covers in the facility kitchen to avoid the potential for food borne illness. This had the potential to affect 107 residents that ate food prepared in the facility kitchen. The facility census was 107. Findings are: Observation on 03/29/23 between 10:30 AM and 10:55 AM with the District Manager Dietary [DMD] identified the following issues in the kitchen: - Water damaged ceiling tiles with a black appearing substance present above the dish machine in the dirty dish area. - Stove back splash has black burned on areas and grease present and food spatters present. - Shelf above stove grease present and food spatters present. - Transition strip pulled away from the floor in the [NAME] cooler - Food spatters present inside the plate warmer - Cracked light fixture cover over the food prep area - Dust covered ventilation cover directly over the steam table in the kitchen Interview 03/29/23 11:00 AM with the DMD confirmed the identified areas of concern and confirmed that the issues needed to be addressed and corrected: - Water damaged ceiling tiles with a black appearing substance present above the dish machine in the dirty dish area. - Stove back splash has black burned on areas and grease present and food spatters present. - Shelf above stove grease present and food spatters present. - Transition strip pulled away from the floor in the [NAME] cooler - Food spatters present inside the plate warmer (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Cracked light fixture cover over the food prep area - Dust covered ventilation cover directly over the steam table in the kitchen Interview on 03/30/23 at 6:41 AM with the DMD confirmed that all residents in the facility ate foods prepared in the facility kitchen.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 28155 Licensure Reference Number 175 NAC 12-006.02 Based on observation, record review and interviews, the facility failed to ensure the facility and corporate administration utilize resources in a manner to ensure resident safety and quality of care. The facility census was 107. Findings are: The facility was found to be out of regulatory compliance in multiple areas resulting in an extended survey related to substandard quality of care for accidents. Please refer to the Tag citations for specific detailed findings. -F584-Based on observation and interview, the facility failed to maintain the cleanliness and condition of ventilation systems, fixtures, base boards and walls in 12 (resident rooms 106, 110, 111, 112, 204, 307, 309, 315, 317, 402, 404 and 409) of 73 occupied resident rooms. -F623-Based on record review and interview the facility failed to ensure Resident 43 was given a letter explaining the reason for transfer to the hospital. -F661-Based on record review and interview, the facility failed to complete discharge summaries/ recapitulation for Resident 110. -F684- Based on observation, record review and interview, the facility failed to identify, obtain treatment orders and monitor a skin abrasion for 1 (Resident 60) of 1 sampled resident. -F689-Based on observation, record review and interview; the facility failed to ensure water temperatures in resident rooms and a bathing area were maintained at a safe temperature to prevent the potential for scald burns for rooms 111, 112, 202, 203, 204, 205, 208, 209, 300, 307, 309, 317, 409, 406, 401, and the North spa room. -F695-Based on observation, record review and interview; the facility failed to ensure nebulizer (a small machine that turns liquid medicine into a mist that can be easily inhaled) equipment was stored in a manner to prevent the potential for cross contamination and changed weekly for 2 (Resident 1 and 49) of 2 sampled residents. -F698-Based on Observation, record review and interviews the facility failed to ensure a dialysis access site was checked daily and failed to maintain a fluid restriction order for Resident 2. -F812-Based on observation and interview; the facility dietary staff failed to maintain the cleanliness and condition of ceiling tiles, stove back splash, shelf above the stove, floors in the walk-in cooler, plate warmer, light fixtures and ventilation covers in the facility kitchen to avoid the potential for food borne illness. This had the potential to affect 107 residents that ate food prepared in the facility kitchen. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-F867- Based on observations, record reviews and interviews, the facility Quality Assurance Performance Improvement (QAPI) team failed to identify high water temperatures to avoid the potential for burns and failed to maintain compliance as evidenced by repeat deficient practice. -F880-Based on observation, interview and record review the facility, failed to ensure staff wore the designated PPE in rooms in precautions, failed to ensure staff followed the masking requirements, failed to ensure infection control procedures were followed during catheter care for 1 resident (Resident 15) and failed to disinfect blood glucose machines between 2 residents (Residents 71 and 74). -F923-Based on observation, record review and interview; the facility failed to ensure a working ventilation system in 17 resident bathrooms (rooms 106, 110, 111, 112, 202, 203, 204, 205, 208 209, 307, 309, 315, 317, 402, 404, 409) of 73 occupied resident rooms. -F940-Based on observation, record review and interview; the facility failed to provide education/orientation specific to maintenance job duties to the maintenance employees. Interview on 03/30/23 at 10:39 AM with Consultant Z revealed the Quality Assurance Performance Improvement (QAPI) committee has been primarily focusing on the plan of correction from the previous complaint survey deficient practice.

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 28155 Licensure Reference Number 175 NAC 12-006.07 Based on observations, record reviews and interviews, the facility Quality Assurance Performance Improvement (QAPI) team failed to identify high water temperatures to avoid the potential for burns and failed to maintain compliance as evidenced by repeat deficient practice. The facility census was 107. Findings are: Review of the facility Quality Assessment and Assurance (QA&A) policy dated March 2023 revealed the following members: Administrator, Director of Nursing, Assistant Director of Nursing, Business office manager (BOM) and Assistant BOM, housekeeping supervisor, Social services director, Maintenance Director, Dietary manager, Activities director, Medical records, Staffing, Concierge. Review of the facility policy dated February 2022 titled Quality Assurance and Performance improvement (QAPI) Program revealed: -The facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents. -The objective of the QAPI program is to provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators. -The owner and/or governing board of our facility is ultimately responsible for the QAPI program. -The committee meets monthly to review reports, evaluate data, and monitor QAPI-related activities and makes adjustments to the plan. Review of the facility [NAME] report revealed repeat tags during the past 3 annual surveys: -F584 Safe/clean/comfortable/homelike environment. -F623 Notice requirements before transfer/discharge. -F689 Free of Accident Hazards. -F695 Respiratory care. -F812 Kitchen cleanliness. -F867 Quality Assurance performance Improvement. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-F880 Infection Control. Additional repeat tags from complaint surveys since last annual survey on 10/14/2021 include: -F880 Infection Control -F689 Free of Accident Hazards -F695 Respiratory care -F812 Kitchen cleanliness Interview on 03/30/23 at 10:39 AM with Consultant Z revealed the Quality Assurance Performance Improvement (QAPI) committee has been primarily focusing on the plan of correction from the previous complaint survey deficient practice.

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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** 45614 Licensure Reference Number 175 NAC 12-006.17B Based on observation, interview and record review the facility failed to ensure staff wore the designated PPE in rooms in precautions, failed to ensure staff followed the masking requirements, and failed to disinfect blood glucose machines between use for 2 (Residents 71 and 74) of 2 residents. The facility census was 107. Findings are: A. An observation on 03/28/2023 at 08:45AM revealed NA-L, (Nurse Assistant) entered room [ROOM NUMBER] to deliver a breakfast tray. NA-L did not don a face shield or use hand sanitizer prior to entering room [ROOM NUMBER] or after exiting room [ROOM NUMBER]. A sign on the door of room [ROOM NUMBER] identified the room was a [NAME] zone. The sign indicated a face mask and face shield were required on entering the room. An interview on 03/28/2023 at 9:00AM with NA-L confirmed the NA-L did not don a face shield on entering the room and did not use hand sanitizer before entering or after exiting room [ROOM NUMBER]. An interview on 03/30/2023 at 10:33AM with the Infection Preventionist confirmed that the facility is doing contact tracing because of a known infection source in the most recent outbreak. The residents confirmed to be within 6 feet of the infected residents are placed in a TAN zone which requires all staff entering the room to wear a face shield and a mask. B. An observation on 03/29/2023 at 1:30PM revealed NA-R feeding lunch to Resident 15. NA-R was seated beside the bed facing the resident. NA-R had their face mask pulled down on their face to beneath their chin while feeding the resident. An interview on 03/30/23 at 11:21AM was completed with the Director of Nursing (DON). During the interview the DON confirmed that NA-R should have kept their mask on their face and not under their chin while feeding the resident. C. An observation on 03/29/2023 at 1:40 PM revealed Residents 43's nebulizer mask, tubing and nebulizer machine lying on the residents' bed. An interview on 03/29/2023 at 1:45 PM with RN- K(Registered Nurse) confirmed that the nebulizer mask should be rinsed, allowed to air dry and then be stored in a plastic bag until it is next used on the Resident. A record review of the facility policy Administering Medications through a small volume (Handheld) nebulizer, dated 2001 and revised October 2010 confirmed the following: Rinse and disinfect the nebulizer equipment according to facility protocol, or; A. Wash pieces with warm soapy water; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	B. Rinse with hot water; C. Allow to air dry on a paper towel. When equipment is completely dry, store in a plastic bag with the residents' name and the date on it. 47733 D. Observation on 3-29-2023 at 6:45 AM revealed Certified Medication Assistant (CMA) A obtained a Glucometer(machine used to test blood sugar levels). CMA A did not ensure the glucometer had been disinfected prior to use with Resident 71. Further observation on 3-29-2023 starting at 6:45 AM revealed CMA A did not disinfect the glucometer after using it with Resident 71. CMA A using the same glucometer tested Resident 74's sugar levels. An interview on 3/29/23 at 7:00 AM was conducted with the Corporate Nurse Consultant (CNC) Z. During the interview CNC Z confirmed the MA did not disinfect the glucometer inbetwwen use.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. 17285 Licensure Reference Number 175 NAC 12-007.04D Based on observation, record review and interview; the facility failed to ensure a working ventilation system in 17 resident bathrooms (rooms 106, 110, 111, 112, 202, 203, 204, 205, 208 209, 307, 309, 315, 317, 402, 404, 409) of 73 occupied resident rooms. The facility census was 107. Findings are: Observations of the facility environment on 3/27/23 between 9:00 AM and 10:00 AM revealed that the ventilation system in resident bathrooms in rooms 111, 112, 202, 203, 204, 205, 208 and 209 did not draw a 1 ply square of tissue to the surface of the ventilation covers in resident bathrooms. The fact that the tissue square was not drawn to the cover indicated that the system was non-operational at the time of the observation. Observation on 03/29/23 Between 8:35 AM and 9:15 AM the Director of Maintenance [DM] C, the Regional Director of Maintenance, the Business Office Manager acting on behalf of the Administrator and the Director of Housekeeping revealed that the ventilation system in resident bathrooms in rooms 106, 110, 111, 112, 202, 203, 204, 205, 208 209, 307, 309, 315, 317, 402, 404, 409 did not draw a 1 ply square of tissue to the surface of the ventilation covers in resident bathrooms. The fact that the tissue square was not drawn to the cover indicated that the system was non-operational at the time of the observation. Interview on 03/29/23 at 10:00 AM with DM C confirmed that the ventilation system had last been checked on 3/2/23 and was operational at that time. The DM C confirmed that the ventilation system was checked monthly but was not sure when it became inoperable after 3/2/23.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 40338 LICENSURE REFERENCE NUMBER 175 NAC 12-006.04B Based on observation, record review and interview; the facility failed to provide education/orientation specific to maintenance job duties to 3 of 3 maintenance employees. The facility identified a census of 107. The findings are: On 03/27/23 at 09:00 AM observations were conducted of water temperatures in resident rooms and a bathing area that were not maintained at a safe temperature to prevent the potential for scald burns for rooms 111, 112, 202, 203, 204, 205, 208, 209, 300, 307, 309, 317, 409, 406, 401, and the North spa room. According to the facility guidelines the water temperatures in resident rooms in Nebraska should be between 110 and 120. On 04/03/23 at 7:11 AM an interview conducted with the MD (Maintenance Director) C revealed MD-C has been employed a little over a year and was not aware of what the water temperatures should be. Review of MD-C employee file revealed no documentation of education/orientation to maintenance duties. On 04/03/23 at 7:15 AM an interview with MA (Maintenance Assistant) D revealed MA-D has been employed since June 2022 and was not aware of what the water temperatures in resident rooms should be. Review of MA-D employee file revealed no documentation of education/orientation to maintenance duties. On 04/03/23 at 7:18 AM an interview with MA-E revealed MA-E has been employed for 2 1/2 months and was unaware that water temperatures were suppose to be taken and what the water temperature should be. Review of MA-E employee file revealed no documentation of education/orientation to maintenance duties. All three of the maintenance employees stated that their orientation to their position was a tour of the facility, being handed keys, codes to the facility doors, and general facility orientation. There was no director of maintenance doing orientation. Upon hire all three of the maintenance employees were not aware of what the water temperatures should be or that they were suppose to be doing water temps. Interview on 04/03/23 at 7:45 AM with RN-Z revealed the orientation to the maintenance position is an informal process on the job training with going through all the books and the Technology Enhanced Life Safety (TELS: software designed to help maintenance teams drive efficiency and cost savings. Improve Compliance. Increase Visibility. Boost Operational Efficiency. RN-Z confirmed there was no written documentation of orientation to the maintenance position. (continued on next page)

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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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Assistant Regional Maintenance on 04/03/23 at 10:38 AM revealed orientation for maintenance personnel is an informal process of going through the books and TELS. The Assistant Regional Maintenance confirmed there is no written documentation of orientation for maintenance personnel. Review of the Maintenance Director Job Description last updated 2/21/21 revealed essential functions of Operates the maintenance department in a safe manner by ensuring compliance with Federal, State, and local regulations and following established policies and procedures.