STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285239	A. Building B. Wing	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Nursing & Rehab Legacy Pointe LLC	3110 Scott Circle Omaha, NE 68112

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. 19186 Based on record review, interviews, and review of policy and procedures, the facility failed to ensure to contact the resident and/or Responsible Party to notify that the resident's trust account balance exceeded $2,000.00 for nine (Residents 3, 6, 14, 20, 26, 32, 48, 55, and 60) of 42 residents with resident account balances over $2,000.00. The facility failed to ensure residents' funds were conveyed within 30 days of discharge for five (Residents 169, 170, 171, 172, and 173) of five residents reviewed for conveyance of funds. The facility census was 67. Findings are: A. A review of Resident 3's Face Sheet revealed the facility admitted Resident 3 on 09/06/2016. A review of Resident 3's Resident Trust Account statements revealed that Resident 3 had a balance over $2,000.00 for the months of 08/2020 through 11/2021. B. A review of Resident 6's Face Sheet revealed the facility admitted Resident 6 on 07/25/2016. A review of Resident 6's Resident Trust Account statements revealed that Resident 6 had a balance over $2,000.00 for the months of 08/2020 through 11/2021. C. A review of Resident 14's Face Sheet revealed the facility admitted Resident 14 on 08/14/2014. A review of Resident 14's Resident Trust Account statements revealed that Resident 14 had a balance over $2,000.00 for the months of 04/2021 through 11/2021. D. A review of Resident 20's Face Sheet revealed the facility admitted Resident 20 on 04/26/2017. A review of Resident 20's Resident Trust Account statements revealed that Resident 20 had a balance over $2,000.00 for the months of 11/2020 through 11/2021. E. A review of Resident 26's Face Sheet revealed the facility admitted Resident 26 on 10/21/2015. A review of Resident 26's Resident Trust Account statements revealed that Resident 26 had a balance over $2,000.00 for the months of 06/2021 through 11/2021. (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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. A review of Resident 32's Face Sheet revealed the facility admitted Resident 32 on 10/30/2018. A review of Resident 32's Resident Trust Account statements revealed that Resident 32 had a balance over $2,000.00 for the months of 08/2020 through 11/2021. G. A review of Resident 48's Face Sheet revealed the facility admitted Resident 48 on 09/19/2008. A review of Resident 48's resident trust account statements revealed that Resident 48 had a balance over $2, 000.00 for the months of 08/2020 through 04/2021 and 07/2021 through 11/2021. H. A review of Resident 55's Face Sheet revealed the facility admitted Resident 55 on 03/17/2020. A review of Resident 55's Resident Trust Account statements revealed that Resident 55 had a balance over $2,000.00 for the months of 04/2021 through 11/2021. I. A review of Resident 60's Face Sheet revealed the facility admitted Resident 60 on 07/15/2020. A review of Resident 60's Resident Trust Account statements revealed that Resident 60 had a balance over $2,000.00 for the months of 08/2021 through 11/2021. During an interview on 11/03/2021 at 9:19 AM, the Human Resources & Business Office Director indicated they were not aware that the balances of residents with Medicaid benefits could not be over $2,000.00 in their resident trust accounts. During an interview on 11/03/2021 at 4:23 PM, the Director of Nursing (DON) indicated that they were unaware that there were residents with balances over $2,000.00 in their resident trust accounts. During an interview on 11/03/2021 at 4:48 PM, the Administrator confirmed they were aware that Resident Trust Account balances of residents receiving Medicaid benefits could not exceed $2,000.00. The Administrator indicated that this was one of the reasons the facility employed a new Business Office Director. A review of the facility's undated policy titled, Accounting and Records of Resident Funds, revealed, 6.a. If the balance in his/her personal funds account reaches $200.00 less than the resident's SSI (Supplemental Security Income) resource limit; and b. That if the amount in the account (plus the value of the resident's other non-exempt resources) reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. J. A review of Resident 169's Face Sheet revealed the facility discharged the resident on 09/16/2021. A review of Resident 169's Resident Trust Account statement dated 11/02/2021 revealed that Resident 169 had a balance of $3,459.59, indicating the resident's funds were not conveyed within 30 days of discharge. K. A review of Resident 170's Face Sheet revealed the facility discharged the resident on 12/03/2020. (continued on next page)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 170's Resident Trust Account statement dated 11/02/2021 revealed that Resident 170 had a balance of $0.50, indicating the resident's funds were not conveyed within 30 days of discharge. L. A review of Resident 171's Face Sheet revealed the facility discharged the resident on 12/10/2020. A review of Resident 171's Resident Trust Account statement dated 11/02/2021 revealed that Resident 171 had a balance of $60.00, indicating the resident's funds were not conveyed within 30 days of discharge. M. A review of Resident 172's Face Sheet revealed the facility discharged the resident on 02/09/2021. A review of Resident 172's Resident Trust Account statement dated 11/02/2021 revealed that Resident 172 had a balance of $924.30, indicating the resident's funds were not conveyed within 30 days of discharge. N. A review of Resident 173's Face Sheet revealed the facility discharged the resident on 12/30/2020. A review of Resident 173's Resident Trust Account statement dated 11/02/2021 revealed that Resident 173 had a balance of $496.58, indicating the resident's funds were not conveyed within 30 days of discharge. During an interview on 11/03/2021 at 9:19 AM, the Human Resources & Business Office Director indicated that they were not aware that the residents' funds had to be conveyed within 30 days of the discharge date . As of 11/03/2021 the five residents' funds were not conveyed. The Human Resources & Business Office Director indicated that all identified residents' responsible parties were contacted on 11/02/2021. During an interview on 11/03/2021 at 4:21 PM, the Director of Nursing (DON) indicated that from that point on, discharged residents would be discussed in the daily stand-up meetings and the residents' funds would be expected to be conveyed within 30 days of the discharge date . During an interview on 11/03/2021 at 4:50 PM, the Administrator indicated that conveyance of funds would be included in the discharge planning process and the residents' funds were expected to be conveyed within 30 days of the discharge date . A review of the facility's undated policy titled, Accounting and Records of Resident Funds, revealed, 8. Upon the discharge, eviction, or death of resident with personal fund deposited with the facility, the facility must convey within 30 days. The resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law.

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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure the security of all personal funds of residents deposited with the facility. 19186 Based on record review, interviews, and review of policy and procedures, the facility failed to ensure the surety bond covered or exceeded the residents' trust account. This deficient practice affected 42 of 67 residents in the facility with a resident trust account, and 5 of 5 discharged residents with funds that had not been conveyed. The facility census was 67. Findings are: A review of the facility's Resident Fund Trust Account bank statement for 09/01/2021 through 09/30/2021 revealed that the ending balance in the account was $57,618.08. The October 2021 Resident Fund Trust Account bank statement was not available. A review of the facility's surety bond revealed a bond in the amount of $40,000, with an effective date of 08/01/2021, which would terminate on 08/01/2022. During an interview on 11/03/2021 at 9:19 AM, the Human Resources & Business Office Director indicated that they were not aware that the surety bond had to equal or exceed the total of the residents' trust accounts. During an interview on 11/03/2021 at 4:21 PM, the Director of Nursing (DON) confirmed that the surety bond should be equal to or exceed the total amount of the residents' trust accounts. During an interview on 11/03/2021 at 4:48 PM, the Administrator confirmed that the surety bond should be equal to or exceed the total amount of the residents' trust accounts. The Administrator further indicated that the Administrator was unaware the residents' trust account was greater than the surety bond. A review of the facility's amended surety bond in the amount of $60,000.00 had an effective date of 11/01/2021. The surety bond was amended after bringing it to the attention of the facility's Administrator. A review of the facility's undated policy titled, Surety Bond, revealed the following, Policy statement: Our facility has a current surety bond or provides self-insurance to assure the security of all residents' personal funds deposited with the facility. Policy interpretations and implementation: 1. This facility holds a surety bond to guarantee the protection of residents' funds managed by the facility on behalf of its residents. 2. A surety bond is an agreement between the facility, the insurance company, and the resident or the State acting on behalf of the resident, wherein the facility and the insurance company agree to compensate the resident for any loss of residents' funds that the facility holds, safeguards, manages, and accounts for. 3. The purpose of the surety bond is to guarantee that the facility will pay the resident for losses occurring from any failure by the facility to hold, safeguard, manage and account for the residents' funds (i.e., losses occurring as a result of acts or errors of negligence, incompetence, or dishonesty). 4. Inquiries concerning the financial security of personal funds managed by the facility should be referred to the Administrator.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44524 Based on record review, interviews, and review of policy and procedures, the facility failed to report the results of an alleged abuse investigation to the State Survey Agency within five working days of the incident for two (Resident 2 and Resident 4) of five residents reviewed for abuse. The facility census was 67. Findings are: The facility admitted Resident 2 with diagnoses that included Alzheimer's disease, vascular dementia with behavioral disturbances, unspecified psychosis, and cognitive communication deficit. The quarterly Minimum Data Set (MDS), dated [DATE], revealed the Staff Assessment for Mental Status (SAMS) indicated the resident was moderately cognitively impaired. The facility admitted Resident 4 with diagnoses that included Alzheimer's disease and cognitive communication deficit. The quarterly Minimum Data Set (MDS), dated [DATE], revealed the Staff Assessment for Mental Status (SAMS) indicated the resident was moderately cognitively impaired. A facility-reported incident was received by the Nebraska Department of Health on 01/26/2021 that indicated Resident 2 and Resident 4 were roommates, and Resident 4 had an altercation with Resident 2, which resulted in Resident 2 being pushed to the ground. Resident 2 complained of pain, and an x-ray was completed, but there were no results at the time of the submission of the report. Resident 2 was placed in a private room for the evening. The report indicated there was no five-day facility report as of 02/02/2021 at 2:00 PM. In a progress note on 01/23/2021 at 8:04 PM, Registered Nurse (RN) A indicated that around 7:00 PM that evening, RN A was called to the resident's room and upon entry, RN A found Resident 2 lying on the floor, holding their left upper extremity, and complaining of pain. The note indicated an unnamed certified nursing assistant (CNA) was in the bathroom assisting Resident 2, and Resident 4 opened the bathroom door, yelled at Resident 2, and shoved Resident 2. Resident 2 stumbled back and fell on their left side. RN A assessed the resident, who complained of pain in their left shoulder and had limited range of motion in that arm. Resident 2 was transferred to their bed per their request. There was bruising noted to the resident's left hand. The physician was called, and an order was placed for an x-ray of the left shoulder. Additional progress notes written by RN A on 01/23/2021 indicated that at 9:30 PM, the x-ray company arrived and by 10:24 PM, the facility received the results of the x-rays, which were negative. In an interview on 11/01/2021 at 9:00 AM, the Administrator was asked to provide a list of facility-reported incidents (FRI) from April 2020 until October 2021. In an interview on 11/02/2021 at 12:09 PM, the Administrator was asked for any reports related to resident-to-resident altercations between Resident 2 and Resident 4, due to not receiving a FRI on the list that was requested on 11/01/2021. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/03/2021 at 5:45 PM, the Administrator stated they were unable to locate any information regarding the incident between Resident 2 and Resident 4. In an interview on 11/04/2021 at 2:00 PM, the Director of Nursing (DON) stated that allegations of abuse should be reported within two hours if there were any injuries and twenty-four hours if there were no injuries. The DON stated that allegations of abuse should be reported to the DON, the Administrator, Adult Protective Services (APS), and the Department of Health and Human Services (DHHS). The DON stated they were not aware of the incident, since they had only been employed for approximately four weeks. The DON stated that the final report should be sent into the state within five days. In an interview on 11/04/2021 at 2:35 PM, the Administrator stated that resident-to-resident altercations should be investigated and should be reported to APS and DHHS, and the facility should report an outcome within five days. The Administrator stated they did not have any information regarding the incident between Resident 2 and Resident 4, except a nursing progress note. The [NAME] President (VP) of Operations was present during the interview and stated they were unable to locate any information regarding reporting the allegation to APS. During the interview, the VP made a telephone call to a person unknown to the surveyor, and after the call, the VP stated that the facility did send in a facility-reported incident to APS regarding the allegation, but there was no other documentation located regarding the incident. A review of the facility policy titled, Preventing, Reporting and Investigating Abuse, revised 11/2017, revealed for allegations of abuse, 26. The Administrator or designee will provide a written report of the results of all abuse investigations and appropriate action if required to the state survey and certification agency, the local police department, the ombudsman, and others as may be required by state or local laws, within five (5) working days of the reported incident.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44524 Based on record review, interviews, and review of policy and procedures, the facility failed to investigate an alleged abuse violation for two (Resident 2 and Resident 4) of five residents reviewed for abuse. The facility census was 67. Findings are: The facility admitted Resident 2 with diagnoses that included Alzheimer's disease, vascular dementia with behavioral disturbances, unspecified psychosis, and cognitive communication deficit. The quarterly Minimum Data Set (MDS), dated [DATE], revealed the Staff Assessment for Mental Status (SAMS) indicated the resident was moderately cognitively impaired. The facility admitted Resident 4 with diagnoses that included Alzheimer's disease and cognitive communication deficit. The quarterly Minimum Data Set (MDS), dated [DATE], revealed the Staff Assessment for Mental Status (SAMS) indicated the resident was moderately cognitively impaired. A facility-reported incident was received by the Nebraska Department of Health on 01/26/2021 that indicated Residents 2 and Resident 4 were roommates, and Resident 4 had an altercation with Resident 2, which resulted in Resident 2 being pushed to the ground. Resident 2 complained of pain, and an x-ray was completed, but there were no results at the time of the submission of the report. Resident 2 was placed in a private room for the evening. The report indicated there was no five-day facility report as of 02/02/2021 at 2:00 PM. In a progress note on 01/23/2021 at 8:04 PM, Registered Nurse (RN) A indicated that around 7:00 PM that evening, RN A was called to the resident's room and upon entry, RN A found Resident 2 lying on the floor, holding their left upper extremity, and complaining of pain. The note indicated an unnamed certified nursing assistant (CNA) was in the bathroom assisting Resident 2, and Resident 4 opened the bathroom door, yelled at Resident 2, and shoved Resident 2. Resident 2 stumbled back and fell on their left side. RN A assessed the resident, who complained of pain in their left shoulder and had limited range of motion in that arm. Resident 2 was transferred to their bed per their request. There was bruising noted to the resident's left hand. The physician was called, and an order was placed for an x-ray of the left shoulder. Additional progress notes written by RN A on 01/23/2021 indicated that at 9:30 PM, the x-ray company arrived and by 10:24 PM, the facility received the results of the x-rays, which were negative. In an interview on 11/01/2021 at 9:00 AM, the Administrator was asked to provide a list of facility-reported incidents (FRI) from April 2020 until October 2021. In an interview on 11/02/2021 at 12:09 PM, the Administrator was asked for any reports related to resident-to-resident altercations between Resident 2 and Resident 4, due to not receiving a FRI on the list that was requested on 11/01/2021. In an interview on 11/03/2021 at 5:45 PM, the Administrator stated they were unable to locate any information regarding the incident between Resident 2 and Resident 4. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/04/2021 at 2:00 PM, the Director of Nursing (DON) stated that allegations of abuse should be reported within two hours if there were any injuries and twenty-four hours if there were no injuries. The residents should have been separated and assessed and an intervention put into place based on the resident's cognition. The facility should have figured out what caused the incident and moved forward to prevent it from happening again. They should have interviewed staff, had written statements, and followed up with those statements. The DON stated they were not aware of the incident since they had only been employed for approximately four weeks. In an interview on 11/04/2021 at 2:35 PM, the Administrator (ADM) stated that resident-to-resident altercations should be investigated and should be reported to Adult Protective Services (APS) and the Department of Health and Human Services (DHHS) and the facility should report an outcome within five days. The ADM stated they did not have any information regarding the incident between Resident 2 and Resident 4, except a nursing progress note. The ADM stated they should have completed an investigation and put interventions in place to keep the incident from happening again. The [NAME] President (VP) of Operations was present during the interview and stated they were unable to locate any information regarding reporting the allegation to APS. During the interview, the VP made a telephone call to a person unknown to the surveyor, and the after the call, the VP stated that the facility did send in a facility-reported incident to APS regarding the allegation, but there was no other documentation located regarding the incident. A review of the facility policy titled, Preventing, Reporting and Investigating Abuse, revised 11/2017, revealed for allegations of abuse, an investigation should be completed and should include, e. Review of completed documentation forms; f. Review the resident's medical record to determine events leading up to the incident; g. Interview the person(s) reporting the incident; h. Interview any witnesses to the incident; i. Interview the resident (as medically appropriate)' j. Interview the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition; k. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; l. Interview the resident's roommate, family members, and visitors; m. Interview other residents to whom the accused employee provides care or services; and n. Review all events leading up to the alleged incident.

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** 45555 Title 175 NAC 12-006.09D7 Based on observations, record review, interviews, and review of policy and procedures, the facility failed to provide a safe environment and supervision to prevent falls for two (Resident 44 and Resident 26) out of eight residents reviewed for accidents and failed to keep medications stored securely for two (Resident 55 and Resident 44) of two residents reviewed for self-administering medications. Specifically, the facility failed to implement and care plan interventions and complete neurological assessments after each fall for Resident 44 and follow care planned interventions to prevent Resident 26 from falling out of bed. The facility also failed to ensure prescription medications for Resident 55 and Resident 44 were not left out in resident rooms. The facility census was 67. Findings are: A. A review of the Face Sheet revealed the facility admitted Resident 44 with diagnoses which included end stage renal disease (ESRD) with dependence on dialysis, left below the knee amputation (LBKA), absence of right toes, and age-related osteoporosis. A review of the quarterly Minimum Data Set (MDS) assessment, dated 09/15/2021, indicated the resident was cognitively intact, with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. A further review of the MDS indicated the resident required supervision of one person for bed mobility, locomotion on and off the unit, dressing, and eating. The resident required limited assistance of one person for transfers, toilet use, and personal hygiene, and extensive assistance of one person for bathing. The resident used a wheelchair for mobility and had a limb prosthesis. The resident was occasionally incontinent of bowel and bladder. The resident had two falls with no injury since the prior assessment. A review of the comprehensive care plan, dated 03/10/2021, revealed the resident was at risk for falls related to having a LBKA with limitations in balance and required assistance with transfers. The goal was for the resident to not have any falls resulting in injury. Interventions included the following: - Fall assessment quarterly and as needed (PRN). - Keep bed locked and in lowest position. - Keep call light within reach at all times when in room. - Keep all frequently-used items in reach. - Provide adequate lighting. - Encourage the resident to call staff when needing assistance or when transferring. - Keep hallways and room clean and clutter free. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Ensure the resident has proper footwear. - One assist for transfers. - Has prosthetic for lower extremity and uses wheelchair. - Staff to ensure foot pedals are used when propelling resident in wheelchair. - Remove foot pedals and lock wheelchair before transfers. A review of a nurse's note, dated 06/23/2021, revealed the resident was found on the floor in front of their wheelchair by the bedside. A review of an unwitnessed fall investigation, dated 06/23/2021, indicated that at 1:28 PM, the resident was found on the floor in front of their wheelchair by the bedside after attempting to transfer themselves. There were no injuries. The investigation indicated the resident was educated on the use of the call light, the staff was reminded to offer to assist the resident, and the resident was to be checked on frequently. The facility was unable to provide a neurological assessment flow sheet for the fall on 06/23/2021, indicating the assessment was not completed. A review of the Post Fall Assessment, dated 06/23/2021, revealed it was not signed until 06/30/2021, with vital signs used that were obtained on 06/28/2021. The assessment indicated the resident had no pain and no change in their range of motion (ROM). The Post Fall Assessment form indicated the assessment was to be done every shift for 72 hours. A review of Resident 44's record revealed the Post-Fall Assessment was completed once for the fall on 06/23/2021. A review of the comprehensive care plan indicated it was updated on 06/25/2021 with the 06/23/2021 fall, indicating the resident fell after transferring on their own, and initiated interventions to include educating the resident to call for assistance with transfers and place the wheelchair close to transfer surface. A review of nurse's notes, dated 06/26/2021, indicated the resident fell in the bathroom and stated they were scooting and fell . A review of an unwitnessed fall investigation, dated 06/26/2021, indicated that at 1:23 AM, the resident was found lying on the floor in the bathroom and stated they tried to scoot back on the toilet and slid off. There were no injuries. A review of the neurological assessment flow sheet for the fall on 06/26/2021 revealed it was blank, indicating the assessment was not completed. A review of the care plan indicated it was updated on 06/28/2021 to include the resident had a fall in the bathroom on 06/26/2021 while scooting, and the intervention to add traction strips in the bathroom was initiated. (continued on next page)

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	285239	A. Building B. Wing	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Nursing & Rehab Legacy Pointe LLC	3110 Scott Circle Omaha, NE 68112

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the record revealed no Post-Fall Assessments were completed for the fall on 06/26/2021. A review of an incident note, dated 07/16/2021, indicated a certified nursing assistant (CNA) witnessed the resident fall on the floor after going into the room to assist the resident get ready for a shower. A review of a witnessed fall investigation, dated 07/16/2021, indicated that at 4:13 AM, the resident was observed self-transferring in the bathroom. However, the investigation did not identify the witness, and no statement was obtained from the resident. The investigation indicated no injuries were observed at the time of the incident. No interventions were initiated after this fall to keep the resident safe from falling. A review of a nurse's note, dated 07/17/2021, indicated the resident was sitting on the floor on their bottom, and the resident stated they were trying to get in their wheelchair, lost their balance, and slid down the side of the bed to the floor. The note indicated the resident was reminded to use their call light and wait for assistance when transferring. The note indicated the resident's prosthetic leg was loose and ill-fitting and recommended therapy to eval and treat. A review of a 07/17/2021 unwitnessed fall investigation indicated that at 10:02 PM, the resident was found sitting on the floor in their room, and the resident stated they were trying to get in their wheelchair and lost their balance and slid down the side of the bed to the floor. There were no injuries. The investigation indicated the resident's prosthetic leg was loose fitting, and they would have therapy evaluate and treat the resident. The facility was not able to provide a neurological assessment flow sheet for the fall on 07/17/2021, indicating the assessment was not completed. A review of an interdisciplinary team (IDT) note, dated 07/19/2021, indicated the resident had another fall over the weekend, and orders were obtained for physical therapy (PT) to evaluate and treat. A review of the care plan revealed it was updated on 07/19/2021 to include therapy to evaluate and treat. A review of an IDT note, dated 07/20/2021, indicated the resident's falls, not using the call light, and self-transferring were discussed with the resident. The note indicated the resident agreed to start using their call light and working with occupational therapy with a goal of gaining strength to possible self-transfer. A review of a PT evaluation and plan of treatment, dated 07/20/2021, indicated the resident exhibited a significant decline in functional mobility with the recent fall and required increased assistance to complete transfers, gait and standing performance during activities of daily living (ADL), limiting independence, and requiring staff assistance. The resident required skilled therapy to restore safe mobility in gait, transfers, and standing performance through training in lower extremity and trunk strength, gait mechanics and stability, balance training, and fall recovery. Without therapy, the resident was at risk for falls and increased care. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of an 08/18/2021 unwitnessed fall investigation indicated that at 12:44 AM, the resident was found lying under their wheelchair, and the resident stated they were trying to get into their wheelchair to go to the bathroom. The investigation indicated the resident was weaker and needed more assistance with transfers because the resident had no sense of balance and was not strong enough to maintain an upright position. The investigation indicated the resident was encouraged to ask for assistance, with signs being put up in the resident's room to remind them to call for assistance. The report indicated the resident needed to be re-evaluated for transfers due to being extremely unsteady and shaky, even with the use of their prosthetic leg, and it was difficult for the resident to get up and in their wheelchair because the resident had no balance and was very weak. A review of the resident's progress notes revealed no documentation of a fall on 08/18/2021. A review of the comprehensive care plan indicated it was updated with the fall on 08/18/2021 when self-transferring, with an intervention to put signs up in the room as a reminder to call staff to help with transfers. A review of the Neurological Assessment Flow Sheet revealed no assessments were completed on 08/18/2021 after 4:00 AM due to the resident being at dialysis. No further assessments were documented as being completed when the resident returned from their dialysis treatment. A review of a Post-Fall Assessment, dated 08/18/2021 at 9:44 AM, revealed it was not signed until 08/19/2021 at 6:28 AM, and the vital signs documented were not obtained at the time of the assessment but later in the day. The blood pressure and pulse were obtained on 08/18/2021 at 6:12 PM, and the temperature, respirations, and oxygen saturation were obtained on 08/18/2021 at 10:12 PM. The assessment indicated the resident's level of consciousness (LOC) was unchanged, and their range of motion (ROM) was within normal limits. The staff encouraged the resident to use the call light and wait for assistance. A review of a Post-Fall assessment dated [DATE] at 5:44 PM, revealed it was not signed until 08/19/2021 at 8:25 PM, and the vital signs documented were not obtained at the time of the assessment. The blood pressure and pulse were the same as what was documented on the assessment earlier in the day at 9:44 AM, and the temperature, respirations, and oxygen saturation were obtained the next day on 08/19/2021 at 9:33 AM. A review of the resident's record revealed three Post-Fall Assessments were dated as being completed on 08/19/2021 but signed on 08/20/2021, and the vital signs documented were not obtained at the time of the assessment. A review of the resident's record revealed only one Post-Fall Assessment was dated for 08/20/2021 but was signed as being completed on 08/22/2021, with all the vital signs being documented as being completed at the time the assessment was signed. A review of the resident's record revealed one Post-Fall Assessment was dated for 08/21/2021 but was signed as being completed on 09/21/2021, with vital signs being documented as being completed at the time the assessment was signed. A review of a nurse's note, dated 08/23/2021, indicated the physical therapy evaluation was completed on 07/20/2021, and the facility was waiting for insurance approval. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of an 08/24/2021 IDT note indicated the team discussed the prosthetic fitting with PT/OT (occupational therapy) and fall interventions for recent falls. The note indicated the facility was waiting on payor source approval for therapy to see the resident. A review of a Fall Risk Evaluation, dated 08/24/2021, revealed it was signed on 09/30/2021 and indicated the resident had a score of five. The evaluation indicated if the score was 10 or greater, the resident should be considered high risk for potential falls. A further review of the evaluation revealed it was incorrect. It indicated the resident had no falls in the past three months (the resident had three or more), only took 1-2 of the medications listed (the resident took 3-4 of the listed medications) and had none of the predisposing diseases (the resident had 3 or more present). If done correctly, the score should have been 16. A review of an IDT note, dated 08/25/2021, indicated the resident was discussed for refusing dialysis, falls, inappropriate fitting of prosthesis, and weight. The note indicated a referral would be made for a mental health therapist, and therapy was to discuss payment with the administrator so therapy could proceed. A review of a nurse's note, dated 08/25/2021, indicated the resident was found on the floor at 10:45 AM with their prosthetic leg tangled in the footrest, leaning on their knees with their bottom in the air and their head in a trash can under the bed. The note indicated the resident had a change in level of consciousness (LOC) and was sent to the emergency room for further evaluation. The facility was unable to provide an investigation for the fall on 08/25/2021, indicating an investigation was not completed. A review of a Resident Transfer Form, dated 08/25/2021, indicated the resident was being transferred to the hospital following a fall with altered mental status. A review of incident notes, dated 08/25/2021, revealed the resident fell and struck their head and was sent to the emergency room , where a CT scan of the head was done and showed no acute findings. A review of an 08/26/2021 nurse's note revealed therapy was notified of the fall on 08/25/2021, and the therapist stated interventions and treatment would begin once funding was approved. A review of an occupational therapy evaluation and plan of treatment, dated 08/27/2021, indicated the evaluation was completed and recommended the resident be seen three times a week for four weeks, from 08/27/2021 through 09/24/2021. A review of a speech therapy evaluation and plan of treatment, dated 08/27/2021, indicated the resident was referred due to a decline in safety awareness and recent fall, where the resident reportedly hit their head on the trash can and now complained of foggy cognition. The evaluation indicated the resident was to be seen 10 times in five weeks from 08/27/2021 until 10/01/2021. A review of a speech therapy discharge summary, dated 09/03/2021, indicated the resident reached maximum potential with skilled services and recommended appropriated redirection with the resident and eliminate background noise. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a nurse's note, dated 10/04/2021, indicated the resident was observed lying on the floor next to the bed, and the resident stated they were trying to transfer themself from the wheelchair into the bed and lost their balance. The note indicated the floor was noticeably sticky from a drink the resident spilled earlier that did not get mopped up. A review of an unwitnessed fall investigation, dated 10/04/2021, indicated that at 9:49 PM, the resident was found lying on the floor next to their bed with no injuries, and the resident stated they were trying to transfer themself from the wheelchair to the bed and lost their balance. The investigation indicated the floor was noticeably sticky from a drink that was spilled earlier, and the floor needed to be stripped. It indicated the resident had poor safety awareness. A review of the care plan revealed the care plan was updated with the fall on 10/04/2021, with the intervention to have housekeeping address the sticky floors and possibly strip the floor. A review of the record revealed only one Post-Fall Assessment was completed for the fall on 10/04/2021. The assessment was dated 10/05/2021 but was not signed until 10/17/2021, and the vital signs were not obtained at the time of the assessment. A review of a nurse's note, dated 10/09/2021, indicated the resident was observed lying on their right side next to the bed, and the resident stated they lost their balance trying to transfer themself from the bed to the wheelchair. A review of an unwitnessed fall investigation, dated 10/09/2021, indicated that at 11:30 PM, the resident was lying on their right side on the floor next to the bed without injury, and the resident stated they lost their balance trying to transfer themself from the bed to the wheelchair. A review of the record revealed only one Post-Fall Assessment was completed for the fall on 10/09/2021. The assessment was dated 10/10/2021 but was not signed until 10/17/2021, and vital signs documented were not obtained at the time of the assessment. A review of a nurse's note, dated 10/11/2021, indicated that at 11:30 PM on 10/10/2021, Resident 44's roommate reported the resident was on the floor. The resident was sitting on the floor next to the bed, with their back up against the wall, and Resident 44 stated they were trying to transfer from the bed to the wheelchair and lost their balance. A review of an unwitnessed fall investigation, dated 10/11/2021, indicated that at 11:30 PM on 10/10/2021, the resident was found on the floor next to the bed, and the resident stated they were trying to transfer from the bed to the wheelchair, lost their balance, and fell . The investigation indicated the resident complained of increased pain and bruising to their right shoulder and upper back but refused to be evaluated at the emergency room . It indicated the resident was non-compliant with waiting for assistance to transfer. A review of the Neurological Assessment Flow Sheet for the fall on 10/10/2021 revealed no assessment was completed on 10/11/2021 at 8:30 AM, 12:30 PM, or 4:30 PM. A review of the comprehensive care plan revealed it was updated on 10/11/2021 for the falls on 10/09/2021 and 10/10/2021 and included the resident refused to wait for assistance and then refused staff assistance. No new interventions were initiated to prevent the resident from falling again. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the record revealed one Post-Fall Assessment was completed for the fall on 10/10/2021. The assessment was dated 10/11/2021 but was signed on 10/17/2021, and the vital signs documented were not obtained at the time of the assessment. (The vital signs were the same vital signs used on the 10/04/2021 and 10/09/2021 Post-Fall Assessments). A review of a physical therapy transitional evaluation and plan of treatment, dated 10/14/2021, revealed the resident was to be seen three times a week for four weeks. A review of a nurse's note, dated 10/16/2021, indicated that at approximately 1:30 PM, the resident was lying on the floor and stated they were transferring to their wheelchair, and the brake did not lock so they slid down onto their left side. The note indicated the incident was witnessed by the resident's roommate. A review of a witnessed fall investigation, dated 10/16/2021, indicated that at 1:49 PM the resident was found lying on the floor, and the resident stated they were transferring, and the wheelchair brake did not lock, and they slid down on their side. There was no injury. The investigation indicated the fall was witnessed by the resident's roommate. A review of the record revealed no new interventions were initiated after the fall. A review of the care plan revealed it was not updated with the fall on 10/16/2021. A review of an unwitnessed fall investigation, dated 10/21/2021 at 3:00 AM, indicated that at 3:00 AM, the resident had a fall in the bathroom and was found facing the stool with their back against the wall. The investigation indicated the resident was drowsy and was unable to give a description of what happened and stated they were very tired from dialysis. A review of the resident's progress notes revealed no documentation of the fall on 10/21/2021. A review of the Neurological Assessment Flow Sheet provided by the facility for this fall revealed it was not dated. The first time on the sheet did coincide with the time of the fall. A review of the record revealed no new interventions were initiated after the fall. A review of the care plan revealed it was not updated with the fall on 10/21/2021. A review of the physical therapy discharge summary, dated 11/03/2021, revealed the resident was being discharged because the highest practical level was achieved. During an interview with Registered Nurse (RN) B on 11/04/2021 at 9:42 AM, the RN stated that whenever a resident had a fall where they hit their head or if the fall was unwitnessed, then neurological checks needed to be done. The RN said they always tried to initiate new interventions after a resident fell , but sometimes it was difficult to think of something that would work, especially for Resident 44. RN B stated Resident 44 could not accept that they were no longer able to do things for themself and would not ask for help to transfer and would frequently fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 11/04/2021 at 10:15 AM, the DON stated that if a resident had an unwitnessed fall or if they hit their head during a fall, neurological checks should always be done, and all parts of the assessment were important to complete, including the vital signs, to determine if the resident was having a change in the level of consciousness. The DON said Resident 44 was very difficult to keep from falling and the DON felt like they had done everything they could to keep the resident from falling. The DON stated they did not know why an investigation for the fall Resident 44 had on 08/25/2021 was not done but stated it should have been completed. During an interview with the Rehabilitation Director (RD) on 11/04/2021 at 2:45 PM, the RD stated they were part of the fall committee that met weekly to review falls to do a root cause analysis and determine if there were any trends. The RD stated Resident 44 was very challenging to keep from falling because the resident was very independent and felt like they did not need assistance. The RD stated knowing the resident was going to transfer unassisted, the staff needed to anticipate this and plan by placing the wheelchair accessible and ensuring the resident's personal items were within reach. The RD stated the facility also reviewed falls every weekday morning to ensure effective interventions were in place and the interventions were care planned. During an interview with the Administrator (ADM) on 11/04/2021 at 3:38 PM, the ADM stated Resident 44 was non-compliant with allowing staff to assist them with transferring, and it resulted in several falls, but the facility needed to come up with ways to keep the resident safe. A review of the facility's policy titled, Falls - Clinical Protocol, last revised 03/2018, indicated, The staff and practitioner will begin to try to identify possible causes within 24 hours of the fall. If the cause of a fall is unclear or if the individual continues to fall despite attempted interventions, a physician will review the situation and help further identify causes and contributing factors. The staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. If the individual continues to fall, the staff and physician will re-evaluate the situation and reconsider possible reasons for the resident's falling and also reconsider the current interventions. A review of the facility's policy titled, Neurological Assessment, 10/2010, indicated, Neurological assessments are indicated upon physician order, following an unwitnessed fall, following a fall or other accident/injury involving head trauma or when indicated by resident's condition. When assessing neurological status, always include frequent vital signs. Particular attention should be paid to widening pulse pressure (difference between systolic and diastolic pressures). This may be indicative of intercranial pressure (ICP). Any change in vital signs or neurological status in a previously stable resident should be reported to the physician immediately. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. A review of the Face Sheet revealed the facility admitted Resident 26 with diagnoses which included cerebral infarction (stroke) and quadriplegia. A review of the quarterly Minimum Data Set (MDS) assessment, dated 08/31/2021, indicated Resident 26 had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of six out of 15, and behaviors included inattention and disorganized thinking that fluctuated, verbal behavioral symptoms directed toward others, and other behavioral symptoms not directed toward others that occurred one to three days during the assessment period. The resident was dependent on one to two staff for all activities of daily living (ADL). The resident was always incontinent of bowel and bladder. The resident had no falls since the prior MDS assessment. A review of the comprehensive care plan, dated 01/08/2021, indicated Resident 26 had a potential for falls and injuries, with a goal that the resident would not sustain any major fall-related injuries. Interventions included for staff to ensure foot pedals were used when propelling the resident in the wheelchair and three-persons assistance for transfers using the Hoyer (total weight bearing) lift. A review of a nurse's note, dated 05/19/2021, indicated that at 4:30 PM, two aides were changing the resident's brief, and the resident slid out of the bed and hit their head. The note indicated a bariatric bed and air mattress would be ordered in the morning, and the resident would have three-persons assistance with all cares and transfers. A review of an incident report, dated 05/19/2021 at 6:30 PM, revealed Resident 26 slid out of bed while two aides, one on each side of the bed, were changing the resident's brief. The report indicated the resident was lying on their right side, and when the aide reached for the brief at the bottom of the bed, the resident rolled onto their stomach and off the bed. The report indicated a bariatric bed and air mattress were to be implemented, and there were to be three staff members during all cares and transfers. A review of the comprehensive care plan revealed it was updated on 05/29/2021 to include three-persons assistance for care while in bed and bed mobility and a bariatric bed with perimeter defining air mattress. A further review of the comprehensive care plan indicated Resident 26 had a fall out of bed during repositioning on 06/21/2021. No new interventions were added after the fall. A review of Resident 26's progress notes revealed no fall was documented on 06/21/2021, and the facility was unable to provide an investigation for a fall occurring on 06/21/2021. During an interview with the Nurse Consultant (NC) on 11/02/2021 at 11:39 AM, the NC stated they could not find any evidence of a fall occurring on 06/21/2021 other than it being noted on the resident's care plan. A review of the 06/15/2021 fall risk evaluation indicated the resident was at risk for falls with a score of 13. The evaluation indicated if a total score was 10 or greater, the resident should be considered high risk for potential falls and prevention protocol should be initiated immediately and documented on the care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a 09/07/2021 nurse's note indicated the resident was observed lying on the floor at 9:45 AM. The note indicated the resident had no bruising or lacerations but complained of pain to their whole body. The note indicated pain medication was administered. The note did not indicate if any interventions were initiated to prevent the resident from having another fall. A review of an incident report, dated 09/07/2021, indicated Resident 26 was receiving a bed bath by one staff member (instead of the care planned intervention of three staff for all care while in bed) and when the resident was turned on their side to wash their back, they rolled to the other side and fell out of the bed. The report indicated there was no injury, but the resident complained of their whole body hurting and was administered pain medication for a headache. The report indicated the resident would have two bath aides to give the resident bed baths and would obtain a large reclining shower chair for the resident to use. A review of the neurological assessment for the 09/07/2021 fall revealed no blood pressure was documented for the resident on 09/08/2021 at 10:45 AM or at 2:45 PM. A review of the comprehensive care plan indicated it was updated on 09/07/2021 to include having two bath aides give a bath, and the facility would source a large reclining shower chair. During an interview with Certified Nursing Assistant (CNA) I on 11/04/2021 at 9:32 AM, the CNA stated Resident 26 required total assistance with all cares, and they were to always use three staff members. CNA I stated they had a bath aide and did not assist with bathing Resident 26. During an interview with Bath Aide (BA) A on 11/04/2021 at 9:35 AM, the BA stated they did not know they were supposed to have anyone help with Resident 26 with bathing. BA A stated they felt bad when the resident rolled off the bed. They said therapy was assisting them to bathe the resident now since the facility had gotten a new shower chair, but Resident 26 was scared of it so they were trying to get the resident used to the new chair. During an interview with Registered Nurse (RN) B on 11/04/2021 at 9:42 AM, the RN stated that whenever a resident had a fall where they hit their head or if the fall was unwitnessed, then neurological checks needed to be done. The RN said they always tried to initiate new interventions after a resident fell , but sometimes it was difficult to think of something that would work. Resident 26 was totally dependent on staff for all activities of daily living (ADL) and required three staff members for safety whenever providing care because the resident was a large person and had already had a couple of falls out of the bed. During an interview with the Director of Nursing (DON) on 11/04/2021 at 10:15 AM, the DON stated that if a resident had an unwitnessed fall or if they hit their head during a fall, neurological checks should always be done, and all parts of the assessment were important to complete, including the vital signs, to determine if the resident was having a change in the level of consciousness. The DON said Resident 26 was to have two people always assist with the resident's care. The DON said they were not aware the care plan indicated three-persons assistance and did not think it was necessary or practical. She stated the resident's plan of care would need to be re-evaluated. She said Resident 26 was currently being seen by therapy for positioning and assistance with bathing. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Rehabilitation Director (RD) on 11/04/2021 at 2:45 PM, the RD stated they were part of the fall committee that met weekly to review falls to do a root cause analysis and determine if there were any trends. The RD stated the facility also reviewed falls every weekday morning to ensure effective interventions were in place and the interventions were care planned. The RD stated Resident 26 was currently on caseload for positioning and assisting the bath aide with bathing the resident and getting them used to the new shower chair the facility had obtained for the resident. The RD stated the resident feared the new chair, and they were having to take it slowly to get the resident and the bath aide used to the new chair and how to safely use it. The RD stated that, because the resident was a large person, it was safer to have a minimum of two staff members present during care to prevent any accidents. They stated they were not aware the resident was care planned for three staff members. During an interview with the Administrator (ADM) on 11/04/2021 at 3:38 PM, the ADM stated the bath aide was at fault with

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	285239	A. Building B. Wing	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Nursing & Rehab Legacy Pointe LLC	3110 Scott Circle Omaha, NE 68112

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 45555 Title 175 NAC 12-006.09D Based on observations, interviews, record review, and review of policy and procedures, the facility failed to have an effective pain management program for two (Resident 55 and Resident 26) of six residents reviewed for pain. Specifically, the facility failed to evaluate Resident 55's and Resident 26's complaints of increased pain, provide non-pharmacological and pharmacological interventions to relieve Resident 55's and Resident 26's pain, and administer pain medications as ordered and in a timely manner for Resident 55 and Resident 26. This failure resulted in Resident 55 having unnecessary, unrelieved pain on a daily basis. The facility census was 67. Findings are: A. A review of the Face Sheet indicated the facility admitted Resident 55 with diagnoses which included chronic obstructive pulmonary disease (COPD), osteoarthritis, peripheral vascular disease (PVD), and chronic pain syndrome. A review of the quarterly Minimum Data Set (MDS) assessment, dated 09/25/2021, indicated the resident had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 12 out of 15. The MDS indicated the resident required supervision to limited assistance of one person for their activities of daily living (ADL). The resident had pain almost constantly that made it hard to sleep at night and limited day-to-day activities. The resident received scheduled and as-needed pain medication but no non-medication interventions for pain. The resident rated their worst pain over the last five days of the assessment period at a 9 on a scale of 1-10. The resident received an opioid seven out of seven days during the assessment period. A review of the comprehensive care plan, dated 01/08/2021, revealed Resident 55 was at risk for pain due to arthritis and PVD. The goal was for the resident to verbalize their pain was controlled. Interventions included to keep the physician and family aware of pain management, conduct a pain assessment as needed, verbally ask the residents pain level at least two times a day, administer pain medication as ordered, apply topical patch for pain as needed (PRN), and report objective signs or voiced complaints of pain to charge nurse for further evaluation. During an interview with Resident 55 on 11/01/2021 at 10:40 AM, the resident stated they were having severe back pain and had been waiting all morning for their routine pain medications. The resident was sitting on the edge of the bed and was observed to be uncomfortable by rocking back and forth on the bed and attempting to adjust their position. The medication aide (MA)-B was notified at 10:45 AM and stated they were going to give Resident 55's medication next. At 11:15 AM, the MA-B had not yet entered Resident 55's room with the resident's medications. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview with Resident 55 on 11/02/2021 at 10:20 AM, the resident stated they were waiting to get their morning medications, which included their pain medications. Resident 55 stated their pain was not managed on the medications the staff were giving. The resident stated they had chronic low back pain but approximately three months ago their shoulders started hurting, the right more than the left. The resident stated they had not had any falls or any other trauma. The resident stated they got morphine every 12 hours, but it wore off before the next dose was due and that was why the resident requested the PRN oxycodone every evening. Resident 55 stated the diclofenac seemed to help better than anything, so the staff left it in the room for the resident to be able to apply it themself. The resident stated they did not know they had an order for muscle rub and had never used it. Resident 55 stated they were not happy with the physician at the facility and wanted to see the physician at the Veteran Affairs (VA). A review of the November 2021 computerized physician orders (CPO) revealed the resident had the following orders for pain management: - Lidocaine 4% patch. Apply one patch to the skin once daily to painful area, for back pain, and remove after 12 hours. This was ordered 07/07/2021. - Meloxicam 15 milligrams (mg). Take one tablet by mouth once daily for inflammation. This was ordered 07/06/2021. - Morphine sulfate extended release (ER) 15 mg. Take one tablet by mouth twice daily for pain. This was ordered 08/13/2021. - Acetaminophen 500 mg. Take two tablets by mouth three times daily for pain. This was ordered 03/29/2021 - Acetaminophen 325 mg. Take two tablets by mouth every four hours as needed for pain.This was ordered 09/17/2021. - Acetaminophen suppository 650 mg. Insert one suppository rectally every four hours PRN for pain. This was ordered 02/17/2021. - Muscle rub cream 10-15%. Apply to back and shoulders twice daily PRN. May keep at bedside and self-apply for pain. This was ordered 08/26/2021. - Oxycodone immediate release (IR) 5 mg. Take one tablet by mouth once daily as needed for pain. This was ordered 07/06/2021. - Diclofenac 1 % gel. Apply two grams to bilateral shoulders twice daily and apply four grams to lower back twice daily. This was ordered 08/02/2021. - Pain rating twice daily: ask resident if having pain, if pain present have resident rate or use PAINAD (pain assessment in advanced dementia) scale and follow up accordingly every, This was ordered 05/26/2021. A review of the October 2021 medication administration record (MAR) revealed the following: (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	- One tablet of morphine sulfate 15 mg was scheduled to be administered at 8:00 AM and 8:00 PM. - Two tablets of acetaminophen 500 mg were scheduled to be administered at 8:00 AM, 12:00 PM and 5:00 PM. - No PRN acetaminophen was documented as being administered for the month of October 2021. - The muscle rub cream was not administered in the month of October 2021. - The PRN oxycodone was administered every evening for pain rated between 7 and 10, and the effectiveness was documented as being ineffective 26 out of 31 times it was administered. A review of the record revealed no documentation of non-pharmacological interventions being attempted prior to the PRN pain medication being administered and no documentation of any follow up being done to address the resident's continued complaint of unrelieved pain. A review of the controlled drug administration record for Resident 55's morphine sulfate 15 mg from 10/17/2021 through 11/03/2021 revealed the following: - On 10/23/2021, one tablet was signed out at 10:00 AM (two hours after it was scheduled to be administered). - On 10/25/2021, one tablet was signed out at 9:03 PM (over an hour after it was scheduled to be administered.) - On 10/26/2021, one tablet was signed out at 10:00 PM (two hours after it was scheduled to be administered). - On 10/27/2021, one tablet was signed out at 9:19 PM (over an hour after it was scheduled to be administered). - On 10/30/2021, no time was documented when one tablet was signed out. - On 10/31/2021, one tablet was signed out at 10:53 AM (almost three hours after it was scheduled to be administered). - On 11/01/2021, no time was documented when one tablet was signed out. - On 11/02/2021, one tablet was signed out at 10:39 AM (over two and a half hours after it was scheduled to be administered). During an interview with Registered Nurse (RN) B on 11/04/2021 at 9:42 AM, the RN stated if a resident's pain medication was not relieving their pain, other medications the resident had ordered should be tried. If they still were not effective, then the physician should be contacted. She stated they did use non-pharmacological interventions also such as repositioning, but they did not document it anywhere. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview with MA-B on 11/04/2021 at 2:04 PM, the QMA stated that if a resident was not obtaining pain relief with the routine medications they were receiving, then as-needed (PRN) medications should be used along with non-pharmacological interventions such as heat and ice or repositioning. MA-B stated if the resident was still having pain, the physician should be notified. MA-B stated routine medication could be given from an hour before to an hour after it was due. Otherwise, it was considered a medication error. During an interview with Licensed Practical Nurse (LPN) B on 11/04/2021 at 2:10 PM, the LPN stated a resident's pain level should be evaluated every shift, with every medication pass, and as needed (PRN). They said the resident should be able to tell them what the resident's acceptable pain level was, and if they were not able to then the LPN assumed it was a 0. LPN B stated the resident's pain level should be reevaluated approximately an hour after medication was administered to determine the effectiveness. If the resident was still having pain, then non-pharmacological interventions should be attempted such as repositioning, adding pillows, ice, and heat. If that was not effective, then other medications should be tried if the resident had an order. If not, the physician should be contacted. LPN B stated every resident's pain level was different, and they had to go by what the resident was telling them. During an interview with MA-A on 11/04/2021 at 2:20 PM, the MA stated if a resident was still having pain after receiving medication, then they would give the resident something else if the resident had orders, or if the resident had a routine pain medication that was due soon, they would just wait to administer the routine dose. If the resident did not have any other medications to administer, the MA would notify the charge nurse. MA-A stated medication could be given from an hour before to an hour after it was scheduled. If it was given outside of that time frame, the physician should be notified. During an interview with the Director of Nursing (DON) on 11/04/2021 at 2:59 PM, the DON stated scheduled medications could be given from an hour before to an hour after they were scheduled. If they were given outside of this time frame, depending on the medication and how often it was ordered, the physician should be notified for further instructions. The DON stated any time a resident continued to complain of pain after receiving pain medication, the resident should be reassessed, provided non-pharmacological interventions, and offered other medications if they had orders for them. If the resident continued to have pain, the physician should be contacted for further instructions. The DON stated Resident 55 always rated their pain a 10 out of 10, even after receiving pain medication, and the DON felt it was more behavioral attention seeking than actual pain. The DON stated the staff should be documenting non-pharmacological interventions that they try with the resident. During an interview with the Administrator (ADM) on 11/04/2021 at 3:38 PM, they stated staff should be trying non-pharmacological interventions along with medications to relieve a resident's complaints of pain, and if they were not able to relieve the resident's pain, the physician should be notified for further recommendations. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	A review of the facility's policy titled, Pain-Clinical Protocol, last revised 03/2018, indicated, The physician will order appropriate non-pharmacological and medication interventions to address the individual's pain. Generally, and to the extent possible, an analgesic regimen should utilize the simplest regimen and lowest risk medications before using more problematic or higher risk approaches. Staff will provide the elements of a comforting environment and appropriate physical and complementary interventions, for example, local heat or ice, repositioning, massage, and the opportunity to talk about chronic pain .The staff will reassess the individual's pain and related consequences at regular intervals, at least each shift for acute pain or significant changes in levels of chronic pain and at least weekly in stable chronic pain. Periodically the physician will evaluate and summarize the status of an individual with chronic or fluctuating pain including the status of any active conditions that exacerbate pain, consequences or complications of pain and effectiveness of current interventions for pain. If the resident's pain is complex or not responding to standard interventions, the attending physician may consider additional consultative support. B. A review of the Face Sheet revealed the facility admitted Resident 26 with diagnoses which included cerebral infarction (stroke), quadriplegia, aphasia, vascular dementia with behavioral disturbances, major depressive disorder, anxiety, restlessness and agitation, schizophrenia, convulsions, and pain disorder with related psychological factors. A review of the Minimum Data Set (MDS) assessment, dated 08/31/2021, indicated Resident 26 had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 6 out of 15, and behaviors included inattention and disorganized thinking that fluctuated, verbal behavioral symptoms directed toward others, and other behavioral symptoms not directed toward others that occurred one to three days during the assessment period. The resident was dependent on one to two staff for all activities of daily living (ADL). The resident was always incontinent of bowel and bladder. The resident received scheduled pain medication but not as-needed (PRN) pain medication or non-pharmacological interventions for pain. The resident complained of pain occasionally, rated 2 on a scale of 0-10. The resident received an opioid seven days during the assessment period. A review of Resident 26's comprehensive care plan, dated 01/08/2021, indicated the resident had chronic pain and took scheduled opioid pain medication. The goal was for the resident to verbalize relief of pain. Interventions included to do a pain assessment daily and as needed (PRN), consider physical therapy (PT) and occupational therapy (OT) to treat pain modalities, administer medications and treatments per the medication administration record (MAR) and treatment administration record (TAR), and offer non-pharmacological interventions for pain such as repositioning. A review of a pain tool, dated 08/30/2021 but not signed as being completed until 10/03/2021, did not indicate the resident's acceptable level of pain or location of pain. The face pain scale was used, and it indicated the resident currently had no pain but was rated Hurts Even More when pain was at its least and affected the resident's sleep and rest, social activities, appetite, physical activity and mobility, emotions, and intimacy. The tool indicated medication made it feel better and was the only intervention listed. A review of a Pain in Advanced Dementia (PAINAD), dated 10/03/2021, indicated a score of four. It indicated total scores ranged from 0 to 10, with a higher score indicating more severe pain. According to the November 2021 computerized physician orders (CPO), the resident had the following orders for pain management: (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	- Acetaminophen 500 milligrams (mg). Take two tablets (1,000 mg) by mouth twice daily for pain. This was ordered 09/13/2020. - Baclofen 10 mg. Take half of a tablet (5 mg) by mouth three times daily for muscle spasms. This was ordered 09/13/2020. - Gabapentin 100 mg. Take one capsule by mouth three times daily for pain. This was ordered 09/13/2020. - Oxycodone immediate release (IR) 5 mg. Take two tablets (10 mg) by mouth every six hours scheduled for pain. This was ordered 09/13/2021. - Fentanyl patch 100 micrograms (mcg) per hour. Apply one patch every 72 hours for pain. This was ordered 08/16/2021. - Bio-freeze 4% gel. Apply topically to upper back three times daily as needed for pain. This was ordered 10/08/2021. - Acetaminophen 325 mg. Take two tablets by mouth every six hours as needed (PRN) for pain. This was ordered 09/13/2020. A review of the October 2021 MAR revealed the following: - The resident received PRN acetaminophen on 10/22/2021 at 12:45 PM after receiving their scheduled oxycodone IR 10 mg at 12:00 PM for pain rated 10 and was documented as being ineffective at 1:31 PM. The resident continued to rate their pain at an eight. A review of the record revealed no further interventions, non-pharmacological or pharmacological, were offered to the resident to relieve their pain. - The resident received PRN acetaminophen on 10/27/2021 at 9:57 AM for pain rated at an eight and their routine oxycodone IR 10 mg at 11:00 AM. The resident's pain was documented as being ineffective at 11:23 PM, and the resident continued to rate their pain at a five. A review of the record revealed no further interventions, non-pharmacological or pharmacological, were offered to the resident to relieve their pain. - The Bio-freeze was never documented as being utilized during the month of October 2021. A review of the controlled drug administration record for Resident 26's oxycodone IR 5 mg from 09/28/2021 through 11/03/2021 revealed the following: - On 09/29/2021 no tablets were signed out for the 12:00 AM scheduled dose. - On 09/30/2021 the 6:00 PM dose was signed out at 7:26 PM. - On 10/01/2021 no tablets were signed out for the 12:00 AM scheduled dose. - On 10/02/2021 the 6:00 PM dose was signed out at 4:00 PM. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	- On 10/09/2021 the 6:00 PM dose was signed out at 4:51 PM. - On 10/10/2021 only one tablet was signed out for the 6:00 PM dose instead of the ordered two tablets. (A medication error report was completed). - On 10/14/2021 only one tablet was signed out for the 6:00 AM dose instead of the ordered two tablets. (No medication error report was completed.) No tablets were signed out as being administered for the 12:00 PM dose. - On 10/20/2021 the 6:00 PM dose was signed out at 4:42 PM. - On 10/30/2021 the 12:00 PM dose was signed out at 1:43 PM, and then the 6:00 PM dose was signed out at 5:05 PM (less than three and a half hours after the last dose was given). During an interview with Resident 24, who was Resident 26's roommate, on 11/01/2021 at 1:35 PM, the resident stated they had put on the call light for Resident 26 when they were in pain and had to wait over 40-45 minutes for the staff to bring their roommate pain medication. An observation of Resident 26 on 11/04/2021 at 9:28 AM revealed the resident was lying in bed with the head of the bed up 90 degrees. The resident had a pained expression on their face and verbalized pain, rated 10 out of 10. MA-A was notified. A review of the November 2021 MAR revealed the MA administered acetaminophen 1,000 mg to Resident 26 on 11/04/2021 at 9:35 AM for pain rated 10 out of 10. The MA documented the medication as being ineffective at 10:32 AM and the resident rated their pain eight out of 10. An administration progress note indicated the resident would be given their routine pain medication at 11:00 AM. No other interventions, non-pharmacological or the bio-freeze, was offered. During an interview with Certified Nurse Aide (CNA) I on 11/04/2021 at 9:32 AM, the CNA stated Resident 26 frequently said they were in pain and would yell out. CNA I stated they would notify the MA so the MA could give the resident some medication. CNA I stated they would also go in and reposition the resident to try and make them more comfortable. During an interview with Registered Nurse (RN) B on 11/04/2021 at 9:42 AM, the RN stated if a resident's pain medication was not relieving their pain, other medications the resident had ordered should be tried. If they still were not effective, then the physician should be contacted. She stated they did use non-pharmacological interventions also such as repositioning, but they did not document it anywhere. During an interview with MA-B on 11/04/2021 at 2:04 PM, the MA stated that if a resident was not obtaining pain relief with the routine medications they were receiving, then as-needed (PRN) medications should be used along with non-pharmacological interventions such as heat and ice or repositioning. M- B stated if the resident was still having pain, the physician should be notified. MA-B stated routine medication could be given from an hour before to an hour after it was due. Otherwise, it was considered a medication error. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview with Licensed Practical Nurse (LPN) B on 11/04/2021 at 2:10 PM, the LPN stated a resident's pain level should be evaluated every shift, with every medication pass, and as needed (PRN). They said the resident should be able to tell them what the resident's acceptable pain level was, and if they were not able to then the LPN assumed it was a 0. LPN B stated the resident's pain level should be reevaluated approximately an hour after medication was administered to determine the effectiveness. If the resident was still having pain, then non-pharmacological interventions should be attempted such as repositioning, adding pillows, ice, and heat. If that was not effective, then other medications should be tried if the resident had an order. If not, the physician should be contacted. LPN B stated every resident's pain level was different, and they had to go by what the resident was telling them. During an interview with MA-A on 11/04/2021 at 2:20 PM, the MA stated if a resident was still having pain after receiving medication, then they would give the resident something else if the resident had orders, or if the resident had a routine pain medication that was due soon, they would just wait to administer the routine dose. If the resident did not have any other medications to administer, the MA would notify the charge nurse. MA-A stated medication could be given from an hour before to an hour after it was scheduled. If it was given outside of that time frame, the physician should be notified. During an interview with the Director of Nursing (DON) on 11/04/2021 at 2:59 PM, the DON stated scheduled medications could be given from an hour before to an hour after they were scheduled. If they were given outside of this time frame, depending on the medication and how often it was ordered, the physician should be notified for further instructions. The DON stated any time a resident continued to complain of pain after receiving pain medication, the resident should be reassessed, provided non-pharmacological interventions, and offered other medications if they had orders for them. If the resident continued to have pain, the physician should be contacted for further instructions. The DON stated Resident 26 always rated their pain a 10 out of 10, even after receiving pain medication, and the DON felt it was more behavioral attention seeking than actual pain. The DON stated the staff should be documenting non-pharmacological interventions that they try with the resident. During an interview with the Administrator (ADM) on 11/04/2021 at 3:38 PM, they stated staff should be trying non-pharmacological interventions along with medications to relieve a resident's complaints of pain, and if they were not able to relieve the resident's pain, the physician should be notified for further recommendations. A review of the facility's policy titled, Pain-Clinical Protocol, last revised 03/2018, indicated, The physician will order appropriate non-pharmacological and medication interventions to address the individual's pain. Generally, and to the extent possible, an analgesic regimen should utilize the simplest regimen and lowest risk medications before using more problematic or higher risk approaches. Staff will provide the elements of a comforting environment and appropriate physical and complementary interventions, for example, local heat or ice, repositioning, massage, and the opportunity to talk about chronic pain .The staff will reassess the individual's pain and related consequences at regular intervals, at least each shift for acute pain or significant changes in levels of chronic pain and at least weekly in stable chronic pain. Periodically the physician will evaluate and summarize the status of an individual with chronic or fluctuating pain including the status of any active conditions that exacerbate pain, consequences or complications of pain and effectiveness of current interventions for pain. If the resident's pain is complex or not responding to standard interventions, the attending physician may consider additional consultative support.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 43017 Based on observations, document review, interviews, and review of policy and procedures, it was determined the facility failed to post a daily staffing schedule. This had the potential to affect all residents. The census was 67. Findings are: On 11/01/2021 at 9:00 AM, an unannounced Recertification Survey was conducted. Upon entry, the surveyor observed a daily staffing schedule dated 10/26/2021 posted in the entry of the facility. The posted daily staffing schedule was not updated during the dates of the survey, 11/01/2021 through 11/04/2021. The posting was still dated 10/26/2021 when observed on 11/04/2021. During an interview on 11/04/2021 at 11:03 AM, the Administrator was asked who was responsible for the posting of the daily staffing schedule. The Administrator stated the Director of Nurses (DON) would give the daily schedule to the secretary to post. The Administrator reviewed the current daily staffing schedule which was dated 10/26/2021 and agreed the daily schedule was not current. During an interview on 11/04/2021 at 11:09 AM, the secretary stated the DON would bring the schedule to be posted. The secretary stated 10/26/2021 was the last time the daily schedule had been posted. During an interview on 11/04/2021 at 11:56 AM, the DON stated it was the DON's responsibility to provide a daily staffing schedule to the secretary, who in turn would post the daily schedule. The DON stated 10/26/2021 was the last time the daily staffing schedule had been posted. The facility policy titled, Posting Direct Care Daily Staffing Numbers, dated 07/2016, revealed, Our facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents .Within (2) hours of the beginning of each shift .nursing personnel directly responsible for resident care will be posted in a prominent location

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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 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. 06124 Title 175 NAC 12-006.11E Based on observations, staff interviews, and facility policy and procedures review, the facility failed to prepare, distribute, and serve food under sanitary conditions. Specifically, the facility failed to ensure staff handled dishes from the dish machine area in a sanitary manner, removed dirt and grime from the kitchen stove, and air-dried dishes that were washed. This had the potential to affect all residents that ate from the kitchen. The census was 67. Findings are: A. During an observation in the kitchen on 11/02/2021 at 9:36 AM, Dietary Aide (DA) A wore plastic gloves while loading two racks of dirty dishes into the dish machine. The DA was then observed taking clean dishes out of the dish machine. The DA failed to wash their hands and change gloves between loading the dirty dishes into the dish machine and taking the clean dishes out. The clean dishes were contaminated by the dirty gloves. When DA A was interviewed during the observation, the aide was unaware of the need to wash hands and change into clean gloves before clean dishes were handled. During a follow-up observation on 11/02/2021 at 9:52 AM with the Administrator (ADM) at the dish machine area, DA A continued to load the dish machine with dirty meal trays. The DA removed the clean dish trays from the machine without washing hands and changing into clean gloves. The clean dishes were contaminated and stored for use during the next meal service. During the observation on 11/02/2021 at 9:52 AM, serving trays that were washed were not allowed to air dry before they were placed on a cart for later use during meal service. There were 17 meal trays stacked wet. The ADM said an in-service was planned for kitchen staff for 11/03/2021, which had to be rescheduled because the Food Services Director (FSD) was out of the facility for an emergency. Further observations were made on 11/02/2021 at 3:40 PM of the serving trays and domes that were used to cover plates containing residents' food. There were 11 dome lids and 34 serving trays stored wet. The ADM was present for the observation, and DA A was directed to rewash the items and allow the items to air dry. During an observation and interview on 11/03/2021 at 10:52 AM with the evening dietary cook/supervisor (DC), 10 resident plates were stored wet. The DC directed DA A to rewash the plates. The DC indicated that the resident plates should be allowed to air dry. An interview was conducted with the ADM and Director of Nursing (DON) on 11/04/2021 at 9:24 AM regarding the policy for handling dishes from the dish machine and proper storage of the dishes and trays used for the residents' meal service and it was indicated that a staff in-service would be scheduled, and the identified issues would be addressed immediately with staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285239	A. Building B. Wing	11/04/2021

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An undated facility policy titled, Kitchen Operations - Sanitation, revealed, Food preparation equipment and utensils that are manually washed will be allowed to air dry whenever practical. Air-dry dishes in a clean and sanitized dish rack. B. During an observation in the kitchen on 11/02/2021 at 9:36 AM, the top of the dish machine was observed to be dirty with a light brown substance. DA A indicated that it was unclear who was responsible for cleaning the top of the dish machine. During an observation conducted in the kitchen area on 11/03/2021 at 10:52 AM, three service men from an outside company worked on the stove and flat top grill. The area was dirty with dark brown build-up around the hole and around the edges of the hole at the front of the grill top. Also, the four gas burners on the stove top had dark brown and black build-up on the burners. The Food Service Supervisor (FSS) said there was a fire in the kitchen the evening prior around 5:00 PM on 11/02/2021. The fire was extinguished with the extinguisher in the kitchen very quickly and the stove was not to be used again until the service men finished the repair and cleared it for safe use. The Administrator (ADM) was interviewed on 11/03/2021 at 11:47 AM regarding the fire that took place on 11/02/2021 in the kitchen. It was confirmed that there was a fire that was quickly extinguished with the kitchen fire extinguisher. The stove was taken out of service, and the service men were called to service the stove. An interview was conducted on 11/03/2021 at 2:40 PM with the FSS about the cleaning schedule for the stove and oven, as a weekly cleaning schedule was not posted in the kitchen. The FSS indicated there was no cleaning schedule, but each cook should clean the stove weekly. An observation was conducted of the stove which revealed a buildup of black/brown matter under each burner. The oven was opened and contained black/brown build-up along with white powder from the extinguisher. The side of the stove had brown and black spilled matter on the side. An interview was conducted with the ADM and Director of Nursing (DON) on 11/04/2021 at 9:24 AM regarding the policy for proper stove and oven cleaning. The ADM and DON indicated a staff in-service would be scheduled and the issue would be addressed immediately with staff. An undated facility policy titled, Kitchen Operations - Sanitation, indicated, 17. The Food Services Manager will be responsible for regular cleaning of the kitchen and dining areas. Food service staff will be trained to maintain cleanliness through their work areas during all tasks, and to clean after each task before proceeding to the next assignment. The policy indicated that the Food Services Manager was responsible for scheduling staff for regular cleaning of the kitchen.

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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** 43016 Title 175 NAC 12-006.17 Based on observations, interviews, and review of policy and procedures, it was determined the facility failed to practice hand hygiene during the delivery of lunch meal trays to the memory care unit. This had the potential to affect 19 residents who received meal trays in the facility. The census was 67. Findings are: On 11/01/2021 from 12:47 PM to 1:02 PM, Certified Nursing Assistant (CNA) K was observed delivering lunch meal trays to the memory care unit. CNA K was observed wearing gloves while delivering the lunch tray to the resident in room [ROOM NUMBER]. At 12:49 PM, after delivering this tray, CNA K was observed retrieving the next tray from the meal cart and delivering it to room [ROOM NUMBER] without changing their gloves or sanitizing their hands. In room [ROOM NUMBER], CNA K was observed adjusting the foot of the recliner, removing food items from the tray, leaving the room, and returning the empty tray to the cart. CNA K was observed continuing to wear the same gloves and did not sanitize their hands after touching the items in room [ROOM NUMBER]. CNA K was observed touching the curtains on the food cart, removing the next tray, knocking on the door of room [ROOM NUMBER], and placing the tray on the bedside table. After delivering the tray to room [ROOM NUMBER], CNA K was observed to remove and dispose of the gloves. CNA K was observed to then roll the meal cart to the other end of the unit. CNA K was observed to don a new pair of gloves, without washing or sanitizing their hands. CNA K was observed to deliver a tray to room [ROOM NUMBER]B and move items on the bedside table to make room for the meal. CNA K was then observed delivering a meal tray to room [ROOM NUMBER]A and taking a plastic cup from the resident who wanted to discard it. CNA K was observed delivering the last meal tray to room [ROOM NUMBER] without changing gloves or washing or sanitizing their hands. After completing the meal tray delivery, CNA K was observed removing the gloves. Immediately after observing the meal tray deliveries, on 11/01/2021 at 1:02 PM, CNA K was asked about the plastic cup the resident had given to them. CNA K stated the resident had given it to them to throw away and stated it was dirty. CNA K was asked if their hands should have been washed or sanitized between delivering trays to different residents and rooms while touching various items and surfaces, and CNA K said, Yes, they really should. During an interview on 11/04/2021 at 10:45 AM, the Administrator (ADM) stated that when delivering meal trays, staff should have hands sanitized after touching the recliner and before delivering the next tray. The ADM stated staff should have hands sanitized after picking up resident trash and before delivering the next tray. During an interview on 11/04/2021 at 8:20 AM, the Director of Nursing (DON) and the Clinical Consultant (CC) were informed of the meal tray pass and concerns with hand hygiene. The CC stated hand hygiene should be practiced between the delivery of trays, and gloves should not be worn for the entire meal pass. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility policy titled, Handwashing/Hand Hygiene, dated 08/2019, indicated an alcohol-based hand rub, containing at least 62% alcohol, or soap and water should be used after contact with objects in the immediate vicinity of the resident and after removing gloves.