STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285259	A. BUILDING _____ B. WING _____	07/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BLUE VALLEY LUTHERAN NURSING HOME	P O BOX 166, 220 PARK AVENUE HEBRON, NE 68370

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 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** State Licensure Reference 12-006.090B Based on interviews and record review, the facility failed to code the MDS (Minimum Data Set, a comprehensive assessment used to develop a resident's care plan) to reflect the PASARR (Preadmission Screening and Resident Review) Level II for one of one resident (Resident 15) reviewed for PASARR. The census was 54. Findings are: Review of Resident's 15 PASARR identification screen, dated 06/05/96, revealed Level II results. Review of Resident's 15 Annual MDS (Minimum Data Set, a federally mandated comprehensive assessment used to develop a resident's care plan), dated on 05/14/20, revealed the resident had the active [DIAGNOSES REDACTED]. Under Section A1500: Is the resident currently considered by the state Level II PASARR process to have serious mental illness and/or intellectual disability (mild intellectual disabilities) or a related condition? The facility had documented no. Review of Resident 15's Face Sheet revealed an admission date of [DATE]. The July 2020 Medication Administration Review included [DIAGNOSES REDACTED]. Interview on 07/23/20 at 10:25 AM with Social Worker-A indicated that Resident 15 was a PASARR Level II. Interview on 07/21/20 at 1:05 PM with the Minimum Data Set Coordinator indicated Resident 15 was a PASARR Level II, and it was an oversight in coding. Interview on 07/21/20 at 1:10 PM with the Director of Nursing indicated that going forward the resident's PASARR level would be verified before coding section A1500 of the full Minimum Data Set (MDS).
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** State Licensure Reference 12-006.09C1c Based on observations, interviews and record review, the facility failed to develop and implement a resident centered care plan to address behavior monitoring and interventions for one (Resident 26) of 16 residents reviewed for care plans. Finding are: Review of the clinical record for Resident 26 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) (a comprehensive resident assessment tool) with an assessment reference date of 05/28/20, revealed the resident scored 6 of 15 points on the Brief Interview of Mental Status, indicating the resident had significant cognitive impairment. Resident 26 experienced hallucinations and delusions daily. The MDS indicated the resident had physical and verbal behavioral symptoms and rejection of care. It further indicated the behaviors were worse compared to the prior MDS assessment. Review of Resident 26's plan of care revealed the resident had a history of [REDACTED]. Observation of Resident 26 on 07/20/20 at 9:30 AM revealed Resident 26 was coloring while seated next to a nurse in the unit's nursing office. Observation of Resident 26 on 07/20/20 at 11:30 AM revealed the resident was wandering in the hallway. The resident spoke to another resident, demanding they move from the couch in the common area while watching TV. Interview with the Director of Nursing, the Assistant Director of Nursing and the Infection Preventionist on 07/21/20 at 3:30 PM confirmed Resident 26's mood and behaviors as labile, and to some extent, predictable with changes in Resident 26's tone and speech patterns. They confirmed the care plan lacked behaviors to be addressed and specific interventions to be used when the resident displayed behaviors. This placed Resident 26 at risk of experiencing changes in behaviors and ineffective or inconsistent interventions.
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** State Licensure Reference 12-006.07. 12-006.07C Based on staff interview, record review and review of the facility policy and procedures, the facility's Quality Assessment and Performance Improvement (QAPI) Committee failed to maintain implemented procedures and monitor the interventions that were put in place following the annual recertification survey conducted 02/07/19. This was for recited deficiencies in the areas of accuracy of assessments (F641) and infection prevention and control (F880). These deficiencies were recited during the annual recertification and complaint survey conducted on 07/23/20. The continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QAPI program. The facility census was 54. Findings are: 1. Cross Refer F641 - The facility failed to code the MDS (Minimum Data Set, a comprehensive assessment used to develop a resident's care plan) to reflect the PASARR (Preadmission Screening and Resident Review) Level II for one of one sampled resident (Resident 15) review for PASARR. During the facility's annual recertification and complaint investigation on 02/07/19 the facility was cited for F641 for failing to accurately code the MDS to reflect the PASRR Level II. The facility's Administrator and Social Worker (SW) were interviewed on 07/23/20 at 1:20 PM. During the interview, the Administrator stated (gender) had started working at the facility in 09/19. The Administrator stated (gender) expected the current areas of concern were in the QA based on the previous survey. The Administrator stated the facility looked at infection control and accidents daily in the morning meetings, weekly in the Interdisciplinary Team (IDT) meetings, and monthly in the QA meetings. 2. Cross Refer F880. The facility failed to assist residents with hand hygiene prior to meal service for residents residing on the East Wing, failed to prevent contamination of a resident's bed linens for 1 of 3 residents (Resident 39) observed and failed to discard open medications that came in contact with the top of the medication cart for 1 of 3 medication passes observed. During the facility's annual recertification and complaint investigation on 02/07/19 the facility was cited for F880 for failing to complete a dressing change in a manner to prevent potential cross contamination. The facility's Administrator and Social Worker (SW) were interviewed on 07/23/20 at 1:20 PM. During the interview, the Administrator stated (gender) had started working at the facility in 09/19. The Administrator stated (gender) expected the current areas of concern were in the QA based on the previous survey. The Administrator stated the facility looked at infection control and accidents daily in the morning meetings, weekly in the Interdisciplinary Team (IDT) meetings, and monthly in the QA meetings.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** State Licensure Reference 12-006.17D, 12-006.18C1 Based on observations and staff interviews, the facility failed to assist residents with hand hygiene prior to meal service for residents residing on the East Wing, failed to prevent contamination of a resident's bed linens for 1 of 3 residents (Resident 39) observed and failed to discard open medications that came in contact with the top of the medication cart for 1 of 3 medication passes observed. The facility census was 54. Findings are: 1. Observation in the East Wing dining area on 07/21/20 at 12:00 PM revealed residents being served lunch. Residents requiring assistance were seated at their assigned seat and the meal was placed in front of them. Interview with CNA-B (Certified Nursing Assistant) on 07/21/20 at 12:30 PM confirmed she was assisting residents to the dining room and serving

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) the food. CNA-B stated (gender) did not assist residents with hand hygiene prior to meal service. Interview with the Assistant Director of Nursing (ADON) on 07/21/20 at 12:30 PM indicated the usual routine was to assist residents to toilet as needed and assist the residents with hand hygiene, but confirmed this did not occur prior to meal service. The ADON indicated resident were not assisted as needed to perform hand hygiene prior to meals. 2. Observation on 07/22/20 at 9:15 AM revealed CNA-A (Certified Nursing Assistant) and CNA-C providing personal care to Resident 39. A clean plastic bag was placed on the foot of the occupied bed for the soiled linens to be placed inside. After performing personal care, the bagged linens were placed on the floor while the resident was being repositioned. CNA-C then picked up the bag of soiled linens and placed the contaminated bag on the foot of the resident's bed, contaminating the resident's bedding. Interview with CNA-C on 07/22/20 at 9:30 AM confirmed that items that are on the floor are considered dirty and should not be placed on a clean surface, including the resident's bed. CNA-A and CNA-B stated they did not recall being instructed to not place dirty items on a resident's bed. 3. During an observation of a medication administration pass on 07/21/20 at 9:28 AM, Nurse-A was observed to use hand sanitizer and then open cartridges containing tablets and dispense into a medication cup. 11 pills were dispensed into the cup, when Nurse-A opened the next cartridge with two Potassium Chloride (KCL) capsules that hit the edge of the medication cup and tipped it over. The KCL capsules spilled onto the top of the medication cart. The other pills stayed within the confines of the medication cup. The nurse scooped the KCL capsules with her fingers into the cup and proceeded with the medication pass. On 07/21/20 at 9:47 AM, immediately following the medication administration, an interview was conducted with Nurse-A. The nurse stated (gender) had not cleaned off the top of the medication cart because (gender) had not spilled anything on it. The nurse stated (gender) cleaned the cart at the end of the shift and restocked the cart for the next shift. The nurse indicated this was the procedure the staff followed and thought the previous shift had probably cleaned off the cart and restocked it for the current shift. The nurse was not sure if medications could be administered to a resident if they had spilled and had been picked back up with (gender) hands. On 07/21/20 at 1:19 PM, an interview was conducted with the Infection Control Nurse who stated medications were expected to be discarded if they fell out of the cup. On 07/22/20 at 12:41 PM, an interview was conducted with the Director of Nursing (DON). The DON stated it was the expectation that medications be discarded if they spilled out of the cup and new medications should be dispensed. The DON stated the expectation was staff would not touch medications with their hands before dispensing.