STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	07/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER: 175 NAC 12-006.09D2 Based on record review and interview, the facility failed to provide monitoring to ensure wound healing for Resident 6. The sample size was 3 and the facility census was 36. Findings are: Review of Resident 6's Minimum Date Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 4/28/20 revealed the resident had [DIAGNOSES REDACTED]. The resident required extensive staff assistance with transfers, bed mobility, toilet use and personal hygiene. Review of the resident's undated Care Plan identified the resident had a venous ulcer (wound usually on the leg which is very slow to heal, usually because of weak blood circulation to the area) to the left leg and to the right ankle. Nursing interventions included documentation of assessment and monitoring of wounds on a weekly basis and to measure the length, width and depth where possible. In addition, staff were to document status of the wound perimeter, the wound bed and the healing progress. Review of a Weekly Observation Tool dated 3/31/20 at 5:40 PM revealed the ulcer to the resident's left lower leg measured 13 millimeters (mm) by 19 mm with a depth of 1 mm. 25 percent of the wound bed was identified as having necrosis and/or slough (dead tissue). There was no evidence to indicate the wound was measured and/or assessed between 3/31/20 and 6/23/20 (3 months). Review of a Weekly Observation Tool dated 3/31/20 at 5:45 PM revealed the wound to the resident's right ankle measured 16 mm by 15 mm with a depth of 2 mm. There was no evidence to indicate the wound was measured and/or assessed between 3/31/20 and 6/23/20 (3 months). Review of a Skin Observation Tool dated 5/20/20 at 10:23 PM revealed the resident had a 1 centimeter (cm) by 1 cm open area to the inner aspect of the right foot, last digit. There was no evidence to indicate the area was measured and/or assessed between 5/20/20 and 6/23/20 (1 month). Interview with Registered Nurse (RN)-F revealed staff were to measure all wounds and complete an assessment of wounds on a weekly basis. Staff were to document assessments in the resident's medical record. RN-F further indicated the resident did refuse treatment at times and was not always compliant with treatment. In addition, the resident had been seen weekly by the wound clinic but the resident was placed on isolation and remained in isolation due to positive COVID-19 diagnosis.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09D7 Based on record review and interview; the facility failed to accurately assess/reassess the safety needs of 2 (Resident 4 and 16) of 3 sampled residents and to implement interventions for the prevention of elopement (leaving the facility unattended and without staff knowledge) for Resident 16. The facility census was 36. Findings are: A. Review of the facility policy Missing Residents and Elopement (undated) revealed all residents were to be assessed for behaviors or conditions that put them at risk for elopement. An elopement risk assessment was to be completed upon admission, quarterly and with any significant change of condition. B. Review of Resident 16's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 4/21/20 included the following: -admitted [DATE]; -diagnoses of [MEDICAL CONDITION] [MEDICAL CONDITION] and autistic disorder; and -cognitively intact. Review of a Wandering Risk Scale dated 3/18/20 at 3:04 PM revealed the following related to Resident 16: -admission assessment; -resident was ambulatory with no [DIAGNOSES REDACTED]. Review of Nursing Progress Notes dated 4/1/20 revealed the following: -9:30 AM staff were unable to find the resident. All rooms, closets and the premises were searched. Staff attempted to call the resident's cell phone but when the staff tried to speak to the resident, the resident hung up; -4:40 PM a call was received from the Sheriff's office and the resident was found at a siblings house in another town. Family refused to let the resident into their home; -5:36 PM the resident was brought back to the facility by a cab driver and the sheriff; -7:33 PM the resident refused to come into the building initially. The resident was agitated and angry. The resident was finally persuaded to come inside and a wander guard bracelet (a device attached to the resident that sets off an alarm when the resident passes by facility exits that are equipped with sensor devices activated by the bracelet) was placed on the resident; and -7:54 PM an elopement risk assessment was completed and an elopement log initiated. Review of a Nursing Progress Note dated 5/3/20 at 5:25 AM revealed the resident had removed the wander guard bracelet and was threatening to leave the facility. The resident was able to vocalize the door code and indicated the resident could leave at any time. 15 minute checks were initiated at 5:00 AM due to inability to put the wander guard bracelet back on the resident. Review of the resident's Medication Administration Record [REDACTED]. Further review revealed staff were initialing each shift but failed to document the resident's location. Review of a Treatment Administration Record (TAR) dated 6/2020 revealed an order dated 4/2/20 for the resident to wear a wander guard bracelet at all times. Further review revealed the following: -6:01 AM to 2:00 PM staff documented the resident was wearing the wander guard bracelet on 6/1-6/5 and on 6/7-6/30 (a total of 29 days). Staff documented resident refusal on 6/6/20; -2:01 PM to 10:00 PM staff documented the resident was wearing the wander guard bracelet on 6/1, 6/4-6/7, 6/9-6/23 and 6/25-6/30 (a total of 26 days). Refusal was documented on 6/2, 6/3 and 6/8 and no documentation on 6/24/20; and -12:00 AM to 10:00 PM staff documented the resident was wearing the wander guard on 6/1, 6/2, 6/7, 6/8, 6/15, 6/16, 6/20, 6/22 and 6/26 (a total of 9 days), documented refusal on 6/3, 6/4, 6/6, 6/9-6/14, 6/17, 6/18, 6/19, 6/23, 6/24, 6/25, 6/27-6/30 and no documentation on 6/5 and on 6/21/20. Review of a Nursing Progress Notes dated 7/2/20 revealed the following: -12:08 PM resident frequently not compliant with facility wide restriction for residents to stay in their rooms due to COVID-19. Staff provide with frequent reminders but continues ambulating in the hallways; and -8:22 PM has exited room multiple times and walking throughout the hallways. Review of Progress Notes dated 7/3/20 revealed the following: -9:00 AM the facility received a phone call from a caller who resided in the community and whose home was a few blocks away. The caller reported a Nursing Home resident was at the caller's home and was requesting a ride to a department store; -9:05 AM the staff determined Resident 16 was not in the facility; -9:25 AM resident was located at the caller's home and staff attempted to bring the resident back to the facility; -9:52 AM the resident refused and local law enforcement was called for assistance; and -10:15 AM the resident continued to refuse transport back to the facility but agreed to a transfer to the hospital. The resident was taken to the hospital for a psychiatric evaluation per the ambulance. Review of Resident 16's TAR from 7/1/20 to 7/3/20 revealed from 6:01 AM to 2:00 PM and from 2:01 PM to 10:00 PM, the staff documented the resident's wander guard bracelet was in place all at all times. Review of the residents MAR from 7/1/20 to 7/3/20 regarding the resident's every 15 minute checks revealed staff were initialing each shift but failed to document the resident's location. During an interview on 7/8/20 at 11:00 AM the Administrator confirmed the following: -Resident 16 left the faciity on [DATE] without the staff's knowledge; -staff

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 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) were to have reassessed the resident's risk for wandering after this event but there is no documentation to indicate the assessment was completed; -a wander guard had been placed on the resident but the resident had removed and so was uncertain if the resident was still wearing the wander guard bracelet; and -staff were to document the resident's location every 15 minutes. During an interview on 7/8/20 at 11:45 AM, Registered Nurse (RN)-G confirmed the following regarding Resident 16: -worked as the Charge Nurse 7/3/20 when the resident eloped; -was not aware the resident was to have 15 minute safety checks and thought checks were to be completed every hour; -was not aware who was responsible for completing the safety checks for the resident; and -had not seen the resident on 7/3/20 from 6:00 AM until 9:00 AM when the facility received a phone call regarding the resident's elopement. C. Review of Resident 4's Progress Notes revealed: - On 7/1/20 at 2:42 PM, the resident attempted to leave the facility through the front door while a care giver was bringing in a trash can. The resident began to curse and swing arms. The resident stated I'm getting out of here I don't care if I die, leave me alone. The resident was brought back inside. - On 7/1/20 at 5:08 PM, Licensed Practical Nurse (LPN)-K let the resident out the backdoor near the resident's room for some air, LPN-J then voiced concerns that the resident might run away. Review of Resident 4's Wandering Risk Scale dated 7/6/20 identified the resident at Low Risk for elopement. The risk assessment failed to identify if the resident had episodes of wandering.
F 0727 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.** Licensure Reference Number 175 NAC 12-006.04C2 Based on interview and record review; the facility failed to ensure 8 hours of consecutive Registered Nurse (RN) coverage every 24 hours was provided. This had the potential to affect all residents. The sample size was 13 and the facility census was 36. Findings are: Review of the facility Daily Assignment Sheets from 6/10/20 through 7/8/20 revealed: - On 6/13/20 the facility had 6 hours of RN coverage, - On 6/14/20 the facility had no RN coverage, - On 6/18/20 the facility had 2 hours of RN coverage, - On 6/23/20 the facility had 2 hours of RN coverage, - On 7/4/20 the facility had no RN coverage, and - On 7/5/20 the facility had no RN coverage. Interview with the Temporary Manager (via email) on 7/10/20 at 12:31 PM confirmed the facility did not have 8 hours of RN coverage daily.
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** LICENSURE REFERENCE NUMBER 175 NAC 12-006.11D Based on observation and interview, the facility failed to ensure room trays were palatable and served at the proper temperature. This had the potential to affect all residents that resided in the facility. The facility staff identified a census of 36. Findings are: A. Review of the facility policy titled Food Temperatures (undated) revealed all hot foods were to be cooked to appropriate internal temperatures and reheated to at least 165 degrees Fahrenheit (F) prior to serving. This referred to the temperature of food when it reached the resident. If the food transportation time was extensive, food was to be transported using a method to maintain temperatures. The policy further identified food temperatures were to be taken and recorded before each meal service. In addition, food temperatures were to be taken at other times, during or at the end of the meal service to ensure temperatures were held within acceptable ranges. B. The following was observed during the noon meal service on 7/8/20 from 11:23 AM to 12:20 PM: -Dietary Cook (DC)-I removed food items from the oven (ham slices, baked potatoes and a green bean casserole) and placed items on the top of the stove. Food was stored in separate containers and had been covered with a sheet of tin foil; -DC-I removed the tin foil and proceeded to check temperatures. A temperature of 180 degrees F was obtained for the ham slices, 150 degrees F for the baked potatoes and 160 degrees F for the green bean casserole; -DC-I proceeded to place food items into individual Styrofoam containers. Room trays were prepared according to hallways with the North hall completed first, the South hall completed second and the Center hall completed last; and -with completion of the final room tray. DC-I filled an additional Styrofoam container with the remaining food items. Food temperatures were obtained with ham slices at 120 degrees F, the baked potatoes at 135 degrees F and the green bean casserole at 130 degrees F. Interview with DC-I revealed the food should be at least 165 degrees F for service to assure the food is palatable.