STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285210	A. BUILDING _____ B. WING _____	**08/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CROWELL MEMORIAL HOME	**245 SOUTH 22ND STREET BLAIR, NE 68008**

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 0565 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to organize and participate in resident/family groups in the facility.** Licensure Reference Number 175 NAC 12-006.06B Based on resident and staff interviews and record reviews, the facility failed to resolve grievances as indicated in the monthly Resident Council minutes for four of six months reviewed (October 2019, November 2019, December 2019, February 2020). Findings are: During resident interviews on 08/05/20 at 11:00 AM, Residents 19 and 23 reported the grievances were not acted on promptly by the facility and there were no explanations given as to the reason the grievances were not resolved. Review of the monthly Resident Council meeting minutes from October 2019 until March 2020 were reviewed. The minutes revealed no response for the following grievances: Review of the Resident Council minutes, dated 10/11/19, indicated the residents reported staff were being seen on their phones, mostly the agency aides. One resident had a blanket she would like placed on the bed as it is warmer and longer. Further review of the council minutes revealed no response for the residents' concerns. Review of the Resident Council minutes, dated 11/08/19, revealed the residents expressed dissatisfaction at having the same menu items multiple times a week such as fish, meatloaf, and chicken. It was also stated some dietary staff had not been wearing hairnets and nursing staff being on their phones instead of answering lights was brought up again the council meeting. Further review of the council minutes revealed no response for the residents' concerns. Review of the Resident Council minutes, dated 12/13/19, indicated a resident voiced concern about a missing fleece blanket. Further review of the council minutes revealed no response for the resident's concerns. Review of the Resident Council minutes, dated 02/20, indicated baths were being done weekly for one resident. The resident stated they have to fight to receive the 2nd bath for the week. Further review of the council minutes revealed no response for the residents' concerns An interview was conducted with the Activity Director (AD) on 08/06/20 at 1:44 PM. The AD indicated the grievances from the Resident Council meetings for the last year were forwarded to the specific departments for resolution. The AD was not aware before March 2020 that AD was to follow up and document the resolutions from the department heads. An interview was conducted with the Administrator on 08/06/20 at 3:00 PM. The Administrator stated the facility grievance resolution system was under review. The Administrator stated the expectation was all grievances would be investigated when reported. The results of the investigations should be documented and reported to ensure resolution.
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the facility failed to ensure advanced directives were reviewed to ensure they reflected the current wishes of two (Residents 5 and 44) of 24 residents. Findings are: 1. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's annual Minimum Data Set (MDS) assessment, dated 07/15/20, revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating severe impairment. A document titled, Advance Directives Acknowledgment, was signed by Resident 5's responsible party and dated 11/14/14. No more recent advance directive documents were found. A review of care conference notes from July 2019 to July 2020 revealed no documentation advance directives were discussed. On 08/06/20 at 10:30 AM, an interview was completed with Social Services (SS) Manager-A. SS-A said during care plan conferences, a resident's code status (choice to have cardiopulmonary resuscitation efforts or not) is discussed. Advance directives are not discussed, but families or the resident could request changes if they wished to change anything. An interview was completed with Director of Nurses (DON)-C on 08/06/20 at 12:59 PM. DON-C reported code status would be discussed during care plan meeting, but advance directives would not routinely be talked about. 2. Resident 44 was admitted on [DATE]. Review of Resident 44-s quarterly Minimum Data Set (MDS) assessment, dated 07/01/20, noted a Brief Interview for Mental Status (BIMS) score of 00, indicating severe impairment. Review of the document titled, Advance Directives Acknowledment (sic), was dated 11/17/15 and signed by Resident 44's responsible party. On 08/06/20 at 10:30 AM, an interview was completed with Social Services (SS) Manager-A. SS-A said during care plan conferences, a resident's code status (choice to have cardiopulmonary resuscitation efforts or not) is discussed. Advance directives are not discussed, but families or the resident could request changes if they wished to change anything. An interview was completed with Director of Nurses (DON)-C on 08/06/20 at 12:59 PM. The DON reported code status would be discussed during care plan meeting, but advance directives would not routinely be talked about.
F 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05 (20) Based on observations and staff interviews, the facility failed to protect the dignity of two (Residents 5 and 36) of 24 residents by posting personal information where it could be seen by others. Findings are: 1. Resident 5's annual Minimum Data Set (MDS) assessment, dated 07/15/20, noted a Brief Interview for Mental Status (BIMS) score of 3, indicating severe impairment. On 08/05/20 at 8:59 AM, Resident 5's room was observed. From the hallway, a sign was observed on the wall that instructed not to put a prosthetic undergarment in the laundry. On 08/10/20 at 5:46 PM, the sign regarding undergarments was still visible from the doorway. An interview was completed with Nurse-E on 08/11/20 at 9:40 AM. Nurse-E said, If we hang up any signs that have personal information on them, we have to cover them or turn them over so they can't be read. On 08/11/20 at 9:51 AM, an interview was completed with Nurse-D. Nurse-D said if signs in resident rooms contained any personal care information, it would be covered. On 08/11/20 at 10:18 AM, an interview was completed with the Director of Nurses (DON). The DON said if any personal information was on visible signs, it should be covered for privacy. 2. Resident 36's significant change Minimum Data Set (MDS) assessment, dated 06/23/20, revealed Resident 36 had both long and short-term memory problems. On 08/05/20 at 11:56 AM, an observation was completed of Resident 36's room. On the bathroom door was a sign that noted toileting precautions to be taken for 48 hours after [MEDICAL CONDITION] treatments were completed. The sign also noted the day of the week that Resident 36 was scheduled to have [MEDICAL CONDITION]. During a second observation on 08/10/20 at 5:47 PM, the sign remained visible on the bathroom door. An interview was completed with Nurse-E on 08/11/20 at 9:40 AM. Nurse-E said, If we hang up any signs that have personal information on them, we have to cover them or turn them over so they can't be read. On 08/11/20 at 9:51 AM, an interview was completed with Nurse-D. Nurse-D said if signs in resident rooms contained any personal care information, it would be covered. On 08/11/20 at 10:18 AM, an interview was completed with the Director of Nurses (DON). The DON said if

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 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) any personal information was on visible signs, it should be covered for privacy. The DON reported Resident 36's treatment had changed, and that sign would no longer reflect Resident 36's care. On 08/12/20 at 11:40 AM, the signage was still posted and visible in Resident 36's room.
F 0606 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Not hire anyone with a finding of abuse, neglect, exploitation, or theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.04A3a, 175 NAC 12-006.04A3c Based on personnel file review, interviews and facility policy review, the facility failed to screen employees by employing an individual who had been found guilty of theft/misappropriation of property by a court of law. This affected one of 15 (Dietary Aid-KK) personnel files reviewed. Findings are: On 08/05/20 at 1:10 PM, the personnel file of Dietary Aid-KK was reviewed. Dietary Aid-KK was hired 08/2018. The personnel file revealed a criminal background record dated 08/06/18. The record included the following: Disposition date: 03/08/18 Charge level: Class 2 Misdemeanor, amended to Class 1 Misdemeanor Charge: Theft - unlawful taking $0.00 - $500.00 to Theft - unlawful taking $500 - $1500 Disposition: 196 days jail On 08/06/20 at 12:37 PM, Personnel-LL was interviewed. Personnel-LL stated Dietary Aid KK was very disrespectful to the staff. Personnel-LL recalled an incident when Dietary Aid-KK was thought to be hallucinating in the dining room in front of all the residents. When it was reported, it was swept under the carpet . On 08/06/20 at 1:25 PM, the Assistant Administrator-K was interviewed. The Assistant Administrator-K met with Dietary Aid-KK after the criminal background check came back. The Assistant Administrator-K stated the Dietary Aid-KK did not deny the conviction but wanted a fresh start. Assistant Administrator-K stated Dietary Aid-KK was terminated in July 2019 based on a recommendation from the Board of Directors after they received complaints about Dietary Aid-KK. The background investigation policy, revised June 2015, documented in Section #9, Applicants found guilty of abuse, neglect, exploitation or mistreatment of [REDACTED].
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** Licensure Reference Number 175 NAC 12-006.02(7). 175 NAC 12-006.02(8) Based on interviews and review of policies and procedures, it was determined the facility failed to develop and implement policies which provided staff with procedures to properly identify suspicious injuries, and the facility failed to include instructions on how to investigate all types of abuse including injuries of unknown origin, failed to include interviewing all persons involved in or who had knowledge of an incident to determine a root cause, and failed to identify where documentation of incidents could be found, and failed to direct. timely reporting congruent with current regulations. Findings are: During a review of the facility's abuse policy, dated 10/2017, and titled, (Facility name) Abuse Policy, the following was noted: -While the facility policy indicated how to conduct investigations for Staff to Resident Abuse/Neglect/Exploitation and Resident Abuse by Other than Staff, the policy did not include instructions on how to investigate for Injuries of Unknown Origin. The policy only included a definition of Injuries of Unknown Source. - The facility ' s abuse policy indicated timeframes of reporting not consistent with current regulatory requirements. The policy documented, Time Frames: Immediately (within 2 hours if injury, within 24 hours if no injury.) . - The facility ' s abuse policy indicated allegations of Resident to Resident Abuse were isolated and not preventable or foreseeable by facility staff did not need to be reported unless there was physical injury. - While the facility ' s policy provided instructions to interview witnesses, the resident involved, and the perpetrator during an investigation, the policy did not indicate interviewing all persons involved who had knowledge of the incident. The policy did not include investigating to find a root cause. - The policy did not include information regarding where documentation of an incident could be found or would be accessible. - The facility policy was vague regarding who should begin an internal investigation. The policy documented, any alleged abuse should be reported to .your supervisor . and on the same page, under the title Time Frames, the policy indicated .Begin your internal investigation . It was unclear if these instructions were addressed to the same person or different people, so it was unclear as to who was to begin the internal investigation. On 08/13/20 at 10:00 AM, the Administrator (ADM) stated their abuse policy had been taken directly off the CMS (Centers for Medicare Medicaid Services) website. The ADM was informed regulations had been updated just after the date of the policy. A facility policy, dated June 2008, titled, Procedure For Identifying Injuries of Unknown Origin or Possible Signs of Abuse, documented: (Named facility) will investigate and report large bruises over 10 cm (centimeters) in diameter, bruises on suspicious body part, skin tears over 5 cm, lacerations and/or any other injury for which there is no known cause and which abuse is suspected . On 08/13/20 at 10:00 AM, the DON (Director of Nurses) confirmed this was the policy used when deciding to report.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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** Licensure Reference Number 175 NAC ,[DATE].02(8) Based on observations, interviews, record reviews and review of policy and procedures, it was determined the facility failed to report an injury of unknown source for two residents (Residents 16 and 46) of two sampled residents reviewed for injuries of unknown origin. Findings are: 1. Resident 16 had [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS), dated [DATE], indicated the resident was severely impaired in cognitive skills for daily decision making. The resident required extensive assistance from one staff member with bed mobility, transfers, and personal hygiene. The resident was not steady and only able to stabilize with staff assistance when moving from a seated to a standing position, moving on and off the toilet, and transferring between surfaces. The resident used a wheelchair for mobility. A care plan, dated [DATE], indicated Resident 16 had a memory deficit related to the [DIAGNOSES REDACTED]. A late-entry Nurses' Progress Note, dated [DATE] at 10:21 PM, by Registered Nurse RN)-V indicated at 7:50 PM they were summoned to the tub room where the resident was receiving a bath. The resident was observed to have a baseball size purple bruise to the left inner thigh. The Progress Note documented, Resident does not remember how (gender) obtained the bruise. A late-entry Nurses' Progress Note, dated [DATE] at 10:23 PM, by Licensed Practical Nurse (LPN)-W indicated, on [DATE] at 8:00 PM, they were summoned to the resident's room while the resident was being readied for bed. The note indicated the nurse observed a bruise measuring 5 cm (centimeters) by 6.5 cm on the resident's left inner thigh. It was documented the bruise was purple with a raised area in the center and yellowing edges. The note documented the resident didn't know how it happened. On [DATE] at 4:02 PM, Assistant Administrator (AA)-K, was asked for some examples of injuries of unknown origin, and they replied, Bruising. AA-K was asked what actions were expected from staff if an injury of unknown origin had been identified, and AA-K stated staff were expected to report the injury of unknown origin to the Director of Nurses (DON), to call and report the injury immediately or within two hours to the State, and to start an investigation to determine the cause of the injury. AA-K stated staff was expected to fill out a 24-hour Incident Report. On [DATE] at 5:29 PM, the Administrator (ADM) was asked if any investigative reports had been completed for Resident 16, during the month of [DATE], and they stated there were none. On [DATE] at 2:47 PM, the DON was asked what actions were expected from staff when they discovered an injury of unknown origin. The DON stated staff were expected to report injuries of unknown origin to the DON and the Administrator (ADM). The DON stated injuries of unknown origin should be brought to the attention of the Charge Nurse and APS (Adult Protective Services) should be called about it. The DON was asked who was responsible for completing the Investigative Report, and the DON stated the nurse who first discovered the injury of unknown origin was responsible for reporting it and starting an investigation. The DON stated if the injury of unknown origin was determined to be abuse, APS would be called about it and a 5-Day Report would be written. The DON stated, otherwise, documentation would be found in the Nurses' Notes. The DON was asked to review the Nurses' Progress Notes to determine when Resident 16's injury of unknown origin occurred. The DON replied it was first noted on [DATE]. The DON stated another staff member remembered seeing it on [DATE]. The DON was asked if this injury of unknown origin had been reported to the State and they replied, No. On [DATE] at 11:50 AM, the ADM was asked to give examples of incidents that must be reported to the State. The ADM replied: abuse, neglect, mistreatment and misappropriation of funds. The ADM also stated reporting to APS, DHHS (Department of Health and Human Services), investigation and calling the family. State Reportable reports provided by the facility since [DATE] were reviewed, and there were no reports for Resident 16. A facility policy, dated ,[DATE], and titled, (Named Facility) Abuse Policy, documented: .An injury should be classified as an injury (of) unknown source when both of the following conditions are met .the source of the injury was not observed by any person or the source of the injury could not be explained by the resident .The injury is suspicious because of the extent of the injury or the location of the injury .the injury is located in an area not generally vulnerable to trauma or the number of injuries observed at one particular

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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) point in time or the incidence of injuries over time .The following is a list (not all inclusive) of indicators of abuse/neglect that may help you determine if abuse/neglect should be suspected .Bruises on the inner arm or thigh . The policy further stated, . (Named facility) has 7 components in place to prevent Abuse/Neglect of our residents . 5. Investigation: (Named facility) has procedures in place to: . Identify staff members responsible for the initial report, investigation of alleged violations and reporting results to proper authorities . The Abuse Policy states, .Points to Remember: .The facility has a responsibility to protect the residents from abuse/neglect .The facility has a responsibility .to immediately report the suspected abuse to the proper authorities . 2. Resident 46's was admitted with [DIAGNOSES REDACTED]. Resident 46 had elected the hospice benefit prior to admission and remained on hospice care. Review of the annual Minimum Data Set (MDS), dated [DATE], revealed Resident 46 score 99 on the Brief Interview for Mental Status (BIMS), indicating the resident was cognitively impaired and was unable to participate in decision making. The MDS also documented Resident 46 required assist of one or two staff for position changes, transfers, and activities of daily living. Review of Resident 46's Weekly Skin Documentation/Care Tracker Back Up Sheet revealed the following: [DATE], Resident 46 had a bruise to the left forehead (site 1) measuring 1.0 x 1.0 (no measurement units specified); and an explanation of the causal factor of bump on lift during transfer; and, a current treatment of [REDACTED]. [DATE], the nurse documented site 2 as a right forehead scab measuring 2.0 x 0.7 (no measurement units specified) with casual factor bumped in bed and current treatment to monitor. [DATE], the nurse documented site 3 as the right lateral (outer) nose measuring 0.8 x 0.3 (no measurement units specified) with causal factors bumped in bed and current treatment to monitor. [DATE], the nurse documented site 4, an abrasion (scrape) on Resident 46's mid nose with measurements of 2.0 x 1.0 (no measurement units specified), with casual factor of bumped in bed and current treatment to monitor. [DATE], the nurse documented site 5, with no type of injury documented, measuring 1.0 x 0.4 (no measurement units specified), with casual factor bumped in bed and current treatment to monitor. [DATE], the nurse documented site 5 on Resident 46's left forehead, a bruise measuring 0.5 x 0.4 (no units of measure specified), no causal factors were identified and current treatment to monitor. [DATE], the nurse documented site 1, a bruise to Resident 46's left forehead measuring 1.0 x 1.0 (no units of measure specified), causal factor of bump on lift during transfer and current treatment to monitor. [DATE], the nurse documented site 2, a scab to Resident 46's right forehead measuring 0.1 x 0.1 (no units of measure specified), no casual factor identified and current treatment to monitor. [DATE], the nurse documented site 3, a scab to Resident 46's right lateral nose measuring 0.5 x 0.4 (no units of measure specified) with no casual factors and current treatment to monitor. [DATE], the nurse documented site 4, and unspecified injury to Resident 46's mid nose measuring 2.0 x 1.0 (no units of measure specified) with no casual factors and current treatment to monitor. [DATE], the nurse documented site 31, the bruise to Resident 46's left forehead measured 1.0 x 1.0 (no units of measure specified) with a causal factor of bumped on lift during transfer and current treatment to monitor weekly. On [DATE], the nurse documented site 2, the right forehead scab was healed. On [DATE], the nurse documented site 3, the scab to the right lateral nose measured 0.1 x 0.1 (no units of measure specified) with no causative factors listed, improving and current treatment to monitor weekly. On [DATE], the nurse documented site 4, the red area to Resident 46's mid nose, with no casual factors and current treatment to monitor weekly. The Director of Nurses (DON) and Administrator, interviewed on [DATE] at 10:45 AM, stated the cause of the injuries was explained by staff. The DON denied investigating the injuries to determine if staff provided care as directed. The DON confirmed the injuries were not investigated as potential abuse. Observation of a handwritten sign taped on the wall in Resident 46's room directed staff, Please put pillow on lift so resident does not bump head. Interview with Registered Nurse (RN)-D on [DATE] at 5:03 PM stated that when one staff member transferred the resident with the mechanical lift, staff was to place a pillow to manage leaning to the right. Observation of Certified Nursing Assistant (CNA)-AA transferring Resident 46 on [DATE] at 10:42 AM was done. CNA-AA performed the transfer without an assistant. Resident 46 was transferred from the wheelchair to the toilet using the mechanical lift. CNA-AA did not place a pillow on the lift as directed by the sign. Review of Resident 46's clinical record revealed on [DATE], the resident was being transported in the wheelchair when Resident 46's fifth finger struck the door frame. The nurse determined the finger was reddened. The clinical record lacked evidence the family/representative or physician was notified of the incident. Interview with the DON on [DATE] at 10:45 AM confirmed since there was no obvious injury, the facility did not provide follow-up assessments and notification of physician or family/representative. The DON stated that an incident report was not required since it was known how the resident received the injury. Interview with the DON on [DATE] at 10:45 AM stated the reporting and investigative tool used by the facility when a resident had an injury was not retained by the facility in the medical record. The document was stored off-site and was not available for review. When asked to provide evidence the injuries were reported, the DON stated that information was not available.
F 0610 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC ,[DATE].02(8) Based on observations, interviews, record reviews and review of policy and procedures, it was determined the facility failed to initiate an investigation for injuries of unknown source for two (Residents 16 and 46) of two sampled residents reviewed for injuries of unknown origin. This affected 2 residents (Resident 16 and Resident 46) of 24 residents. This had the potential to affect all of the residents. It was determined the provider's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment or death to residents. The Immediate Jeopardy was related to State Operations Manual, Appendix PP, 483.12 (freedom from abuse, neglect, and exploitation) at a scope and severity of J. On [DATE] at 4:24 PM, the Administrator, Assistant Administrator, and Director of Nursing, were informed of the Immediate Jeopardy situation. At the time of survey exit, on [DATE] at 1:10 PM, a Removal Plan had not been accepted by the state agency. Findings are: Resident 16 had [DIAGNOSES REDACTED]. Physician orders, dated [DATE], indicated the resident had been prescribed 81 mg (milligrams) of aspirin (a blood thinner) to be taken once a day. A quarterly Minimum Data Set (MDS), dated [DATE], indicated the resident was severely impaired in cognitive skills for daily decision making. The resident required extensive assistance from one staff member with bed mobility, transfers, and personal hygiene. The resident was not steady on their feet and only able to stabilize with staff assistance when moving from a seated to a standing position, moving on and off the toilet, and transferring between surfaces. The resident used a wheelchair for mobility. A care plan, dated [DATE], indicated Resident 16 had a poor memory and used a mechanical lift for transfers. A Nurses' Progress Note dated [DATE] at 10:21 PM, by Registered Nurse (RN)-V indicated at 7:50 PM, they were summoned to the tub room where the resident was receiving a bath. The resident was observed to have a baseball size purple bruise to the left inner thigh. The Progress Note documented, Resident does not remember how (gender) obtained the bruise. A Nurses' Progress Note dated [DATE] at 10:23 PM, by Licensed Practical Nurse (LPN)-W indicated, on [DATE] at 8:00 PM, they were summoned to the resident's room while the resident was being readied for bed. The note indicated the nurse observed a bruise measuring 5 cm (centimeters) by 6.5 cm on the resident's left inner thigh. It was documented the bruise was purple with a raised area in the center and yellowing edges. The note documented the resident didn't know how it happened. The note indicated, at times, the resident became combative with cares and sit to stand lift. A Nurses' Progress Note dated [DATE] at 10:57 PM, by RN- indicated this nurse had not observed any bruises on the resident's arms or hip area; however, the note did not refer to the resident's left inner thigh. The note indicated the resident fought staff as they got the resident up into the s/s (sit to stand, a piece of equipment used for positioning or lifting the resident), the resident stated the machine was hurting them, and the resident's legs were hitting the s/s bar. The note documented, so I think using the total lift would prevent and brusing (sic. bruising). A facility document, dated [DATE], titled, Nursing Home Rounds, indicated a large bruise the size of baseball was located on the resident's left inner thigh and was tender to touch. A physician's signature, dated [DATE], documented a 4 x 4 cm (centimeter) old hematoma was located on the Resident's left thigh. Hot packs had been ordered daily as tolerated. The medical record was reviewed, and it was noted there were no indications a thorough investigation had been conducted regarding this injury of unknown origin. No investigative report could be found in the medical record. No staff interviews, with staff associated with the resident prior to the discovery of the bruise, were documented to determine the injury's root cause. Based on the lack of an investigation, abuse and neglect could not be ruled out as causes for the bruise. On [DATE] at 4:02 PM, the Assistant Administrator (Staff-K), was asked for some examples of injuries of unknown origin, and they replied, Bruising. Staff-K was asked what actions were expected from staff if an injury of unknown origin had been identified. Staff K stated staff were expected to report the injury of unknown origin to the Director of Nurses (DON), to call and report the injury immediately, or within two hours, to the State, and to start an investigation to

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F 0610 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) determine the cause of the injury. Staff K stated staff was expected to fill out a 24-hour Incident Report. On [DATE] at 5:29 PM, the Administrator (ADM) was asked if any investigative reports had been completed for Resident 16 during the month of [DATE]. The ADM stated there were none. On [DATE] at 2:15 PM, the ADM was asked for the phone numbers of some staff who were not scheduled to work during the survey period but had been involved in the incident for interviews. The ADM refused to provide staff phone numbers saying, No, that is inappropriate. On [DATE] at 2:47 PM, the Director of Nurses (DON) was asked what actions were expected from staff when they discovered an injury of unknown origin. The DON stated staff were expected to report injuries of unknown origin to the DON and the ADM. The DON stated injuries of unknown origin should be brought to the attention of the Charge Nurse and APS (Adult Protective Services) should be called about it. The DON stated an internal investigation was expected to be done which would include talking with staff from different shifts about who saw it first and seeing if they can come up with reason for it. The DON was asked who was responsible for completing the Investigative Report. The DON stated the nurse who first discovered the injury of unknown origin was responsible for reporting it and starting an investigation. The DON stated, if the injury of unknown origin was determined to be abuse, APS and the state agency would be notified. The DON stated, otherwise, documentation would be found in the Nurses' Notes. The DON was asked to review the Nurses' Progress Notes to determine when Resident 16's injury of unknown origin occurred. The DON replied it was first noted on [DATE]. The DON stated another staff member remembered seeing it on [DATE]. The DON was asked if a thorough investigation into the event had been conducted. The DON stated they had done their own investigation but replied, I did not document it anywhere. The DON stated they, along with Staff-K and the ADM, had watched the resident during a transfer using the sit-to-stand lift. They determined that was the cause of the bruise. The DON stated they decided not to use the sit-to-stand lift anymore for the resident. The DON was requested to share any investigative documentation that existed. On [DATE] at 11:25 AM, the DON provided two pages from a personal calendar with notes handwritten diagonally across the pages. The DON stated this was the entire investigation for Resident 16's injury of unknown origin. The handwritten notes did not include documentation of a complete investigation that included staff interviews prior to the finding of the bruise to determine its root cause. On [DATE] at 11:50 AM, the ADM was interviewed regarding abuse and was asked to list the elements of a complete investigation. They answered: bios, records, witness interviews and precipitating factors. No mention was made of interviewing other staff members or residents, except witnesses. I would always contact (Staff-K) who heads up investigations. The ADM stated this type of investigation would be given to the DON. The ADM also stated, Who it goes to depends on what department it is in. The ADM said, We have a meeting together and go over everything found and make conclusions. The ADM clarified this was an informal meeting. The ADM stated, They (staff) have their own ways of documenting, the DON is a calendar girl. The ADM further stated If it was not a formal investigation staff could document in their own style The ADM said, If at all possible, I want it in the progress notes. The ADM stated, I have my own way of doing investigations. The ADM stated staff usually met on Wednesdays to discuss incidents like falls and Medicaid issues. The ADM was asked if there was documentation from those meetings. The ADM replied those meetings were just administrative meetings for information gathering and minutes were not kept. The ADM stated investigations into injuries of unknown origin were handled exactly the same way our other investigations are handled. The ADM also mentioned calling the family. On [DATE] at 12:54 PM, Resident 16 was asked if they had a bruise. The resident stated, I told them it wasn't on my arm. It's on my leg! The resident pulled up their left pants leg and a [MEDICAL CONDITION] was observed as well as a 2 inch round, grey/yellow bruise, which was slightly raised in the middle. When Resident 16 was asked if they knew how they got the bruise, the resident stated they did not know how the bruise got there. A facility form, dated [DATE], titled, Weekly Skin Documentation/Care Tracker Back Up Sheet, indicated the bruise on the left inner thigh had healed. On [DATE] at 2:00 PM, RN-BB, stated they had been off for three days, and, on returning to work on [DATE], the DON asked them to assess the resident's bruise. They stated, the DON told me the Resident resisted the lift. On [DATE] at 8:38 AM, Certified Nursing Assistant (CNA)-CC was interviewed. CNA-CC stated they had transferred Resident 16 many times and used the sit-to-stand lift. CNA-CC stated they had never observed the resident to get bumped or hurt with the lift. They stated the resident did not like the lift and sometimes became angry when it was used, but CNA-CC stated the resident only became verbally angry. (Gender) stated that the resident did not strike or swing out with limbs. On [DATE] at 8:44 AM, CNA-DD was interviewed. CNA-DD stated they had never seen the resident get hurt or the inner thighs touch the sit-to-stand lift while using it. CNA-DD stated the only resistance they had seen from the resident was verbal resistance. On [DATE] at 8:52 AM, CNA-EE stated they had often transferred Resident 16 with the sit-to-stand lift and had never seen the resident get hurt using the lift. CNA-DD stated they thought Resident 16 should be using the Hoyer lift as the resident, cannot help with the lifting process at all, and it is hard on (gender). On [DATE] at 9:37 AM, the surveyor observed Resident 16 being transferred to the toilet with the sit-to-stand lift. While the resident only required one staff for transfer assistance, both CNA-CC and CNA-DD were present. The resident's foot was placed correctly on the platform. The resident was correctly secured with the two lift straps. The resident was asked to grip the lift, but the resident was weak and could only lay their hands on the designated area. The resident was safely lifted to the toilet, and when the resident finished on the toilet was lifted back. At no time did the resident's inner thigh touch any part of the lift. On observing the resident's bruise, CNA-CC stated, That bruise is way higher than the lift part. I don't see how it could have caused that bruise. CNA-DD stated, I don't see how in the world the lift could have caused that bruise. She would have had to swing that leg over that piece (part of the lift), or she was twisted. CNA-DD went on to say if the resident had been injured by the lift, the resident would have been more likely to suffer an injury to the outside of the leg - not the inner thigh. An Incident Report Log provided by the facility, dated from February 2020 through [DATE], was reviewed. All 65 incidents recorded on the log were related to falling. No other type of incident, including injuries of unknown origin, was captured on the Facility's Incident Log. No investigations or reports could be found, or were provided, related to Resident 16's injury of unknown origin. A review of records did not contain a thorough investigation of Resident 16's injury of unknown origin. A facility policy, dated ,[DATE], and titled, (Named Facility) Abuse Policy, documented: .An injury should be classified as an injury (of) unknown source when both of the following conditions are met .the source of the injury was not observed by any person or the source of the injury could not be explained by the resident .The injury is suspicious because of the extent of the injury or the location of the injury .the injury is located in an area not generally vulnerable to trauma or the number of injuries observed at one particular point in time or the incidence of injuries over time .The following is a list (not all inclusive) of indicators of abuse/neglect that may help you determine if abuse/neglect should be suspected .Bruises on the inner arm or thigh . The policy further states, .(Named facility) has 7 components in place to prevent Abuse/Neglect of our residents .5. Investigation: (Named facility) has procedures in place to: Investigate different types of incidents Identify staff members responsible for the initial report, investigation of alleged violations and reporting results to proper authorities . The Abuse Policy stated, .Points to Remember: .The facility has a responsibility to protect the residents from abuse/neglect .The facility has a responsibility to identify, to intervene in the abuse and take measures to prevent further occurrences and to immediately report the suspected abuse to the proper authorities . There were no specific investigation instructions or requirements for the topic of Injuries of Unknown Origin. 2. Review of Resident 46's face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Resident 46 had elected the hospice benefit prior to admission and remained on hospice care. Review of the annual Minimum Data Set (MDS), dated [DATE], revealed Resident 46 score 99 on the Brief Interview for Mental Status (BIMS)., indicating the resident is severely cognitively impaired and was unable to participate in decision making. The MDS also documented Resident 46 required the assist of one or two staff for position changes, transfers, and activities of daily living. Review of Resident 46's, Weekly Skin Documentation/Care Tracker Back Up Sheet, revealed the following: [DATE], Resident 46 had a bruise to the left forehead (site 1) measuring 1.0 x 1.0 (no measurement units specified); and an explanation of the causal factor of bump on lift during transfer; and, a current treatment of [REDACTED]. [DATE], the nurse documented site 2 as a right forehead scab measuring 2.0 x 0.7 (no measurement units specified) with casual factor bumped in bed and current treatment to monitor. [DATE], the nurse documented site 3 as the right lateral (outer) nose measuring 0.8 x 0.3 (no measurement units specified) with causal factors bumped in bed and current treatment to monitor. [DATE], the nurse documented site 4, an abrasion (scrape) on Resident 46's mid nose with measurements of 2.0 x 1.0 (no measurement units specified), with casual factor of bumped in bed and current treatment to monitor. [DATE], the nurse documented site 5, with no type of injury documented, measuring 1.0 x 0.4 (no measurement units specified), with casual factor bumped in bed and current treatment to monitor. [DATE], the nurse documented site 5 on Resident 46's left forehead, a bruise measuring 0.5 x 0.4 (no units of

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	285210	A. BUILDING _____ B. WING _____	08/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CROWELL MEMORIAL HOME	245 SOUTH 22ND STREET BLAIR, NE 68008

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 0610 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) measure specified), no causal factors were identified and current treatment to monitor. [DATE], the nurse documented site 1, a bruise to Resident 46's left forehead measuring 1.0 x 1.0 (no units of measure specified), causal factor of bump on lift during transfer and current treatment to monitor. [DATE], the nurse documented site 2, a scab to Resident 46's right forehead measuring 0.1 x 0.1 (no units of measure specified), no casual factor identified and current treatment to monitor. [DATE], the nurse documented site 3, a scab to Resident 46's right lateral nose measuring 0.5 x 0.4 (no units of measure specified) with no casual factors and current treatment to monitor. [DATE], the nurse documented site 4, and unspecified injury to Resident 46's mid nose measuring 2.0 x 1.0 (no units of measure specified) with no casual factors and current treatment to monitor. [DATE], the nurse documented site 1, the bruise to Resident 46's left forehead measured 1.0 x 1.0 (no units of measure specified) with a causal factor of bumped on lift during transfer and current treatment to monitor weekly. On [DATE], the nurse documented site 2, the right forehead scab was healed. On [DATE], the nurse documented site 3, the scab to the right lateral nose measured 0.1 x 0.1 (no units of measure specified) with no causative factors listed, improving and current treatment to monitor weekly. On [DATE], the nurse documented site #4, the red area to Resident 46's mid nose, with no casual factors, and current treatment to monitor weekly. The Director of Nursing (DON) and Administrator (ADM), were interviewed on [DATE] at 10:45 AM. They stated the cause of the injuries was explained by staff. The DON denied investigating the injuries to determine if staff provided care as directed and confirmed the injuries were not investigated as potential abuse. Observation of a sign taped on the wall in Resident 46's room that directed staff, Please put pillow on left so resident does not bump head. An interview with Registered Nurse (RN)-D was done on [DATE] at 5:03 PM. RN-D stated that when one staff member transferred the resident with the mechanical lift, staff was to place a pillow to manage leaning to the right. An observation of Certified Nurse Aide (CNA)-AA transferring Resident 46 was done on [DATE] at 10:42 AM. CNA-AA performed the transfer without an assistant. Resident 46 was transferred from the wheelchair to the toilet using the mechanical lift. CNA-AA did not place a pillow on the lift as directed by the sign taped to the wall in the resident's room. In an interview with the DON on [DATE] at 10:45 AM, the DON stated the reporting and investigative tool used by the facility when a resident had an injury was not retained by the facility. The document was stored off-site and was not available for review. When asked to provide evidence the injuries were investigated, the DON stated that information was not available. The DON confirmed the facility did not have evidence of a thorough investigation including root cause analysis and implementation of preventative measures to prevent further injury to Resident 46. On [DATE] at 1:00 PM the State Agency received an abatement plan via email and approved the abatement. The Immediate Jeopardy was abated to a level G
F 0657 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09C1c Based on record review and staff interviews, the facility failed to revise the care plans for two of 24 residents with pressure ulcers (Residents 28 and 35). Findings are: 1. Resident 35 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. A review of Resident 35's annual Minimum Data Set (MDS) assessment, dated 06/17/20, revealed Resident 35 had unhealed pressure ulcers. Resident 35 was noted to have two Stage IV pressure ulcers that were present on admission. The Admission Nursing Assessment, dated 06/07/19, noted that one wound was on the right hip and one was to the right heel. Review of Resident 35's care plan, most recently updated on 04/01/20, revealed a concern of pressure ulcers. Wounds to the right great toe and lateral foot were not documented. The Weekly Skin Documentation sheets for Resident 35 revealed that wounds were first noted on Resident 35's right great toe and right lateral foot on 06/30/20. An interview was completed with Nurse-A on 08/10/20 at 10:55 AM. After reviewing the medical record, Nurse-A verified the care plan was not updated to show new areas to the right great toe or the right lateral foot. Nurse-A stated if there were new skin areas, the nurse who found it would add it to the care plan. Nurse-A said that new wounds would get written on the 24-hour nursing report that would be reviewed in the daily department head meeting. Nurse-A was responsible for making sure care plans are updated. An interview was completed with Nurse-E on 08/10/20 at 3:04 PM. Nurse-E reported discovering the areas to Resident 35's right great toe and the lateral part of the right foot on 06/30/20. Nurse-E stated that when a new skin wound was found, the Weekly Skin Documentation form was updated. There were no other forms to fill out like incident or adverse event reports. No nurse progress note would be documented. Nurse-E said that the nurses who found a new skin wound, or Nurse-A would update the care plan. 2. Resident 28 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. A review of the admission Minimum Data Set (MDS) assessment, dated 06/02/20, noted that Resident 28 had two or more falls with no injury. Review of Resident 28's care plan noted a problem related to falls dated 06/15/20. The last update was done on 07/15/20. Review of Resident 28's nursing progress notes revealed falls on 05/18/20, 05/21/20, 07/05/20, 07/07/20, 07/09/20, 7/11/20, 07/16/20 and 07/27/20. On 08/06/20 at 10:30 AM, an interview was completed with Nurse-A. Nurse-A was identified as the staff member who wrote care plans and who made sure revisions were done. Nurse-A said that nurses can also make their own revisions. Nurse-A verified the care plan listed three falls and that Resident 28 had experienced five falls. After reviewing the medical record, Nurse-A verified there were more falls and the care plan had not been updated since 07/15/20. Nurse-A reported getting copies of incident reports that would prompt a care plan update. Sometimes they get lost in the shuffle. Nurse-A said the reports were probably given to (gender), but the care plan didn't get updated.
F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09D2 Based on observations, record review and staff interviews, the facility failed to follow the physician's orders [REDACTED]. Findings are: Resident 35 was admitted to the facility on [DATE]. Diagnoses included dementia, pressure ulcer and stroke. A review of Resident 35's annual Minimum Data Set (MDS) assessment, dated 06/17/20, revealed Resident 35 had unhealed pressure ulcers. Resident 35 was noted to have two Stage IV pressure ulcers that were present on admission. 1a. Review of the Weekly Skin Documentation/Care Tracker Back Up Sheet for Resident 35 revealed wound measurements. None of the measurements indicated the type of wound that was present. On 06/09/20, the right heel wound measured 5.2cm (centimeters) x 3cm x 0.2cm. Weekly measurements were done on 06/15/20 and no other measurements were done until 06/30/20, when the right heel wound was noted to be 5.3cm x 8cm. On 07/07/20, the right heel was noted to have a wrap that must stay in place and no measurement was documented. On 07/14/20 and 07/28/20, Nurse F documented unable to measure the right heel. The latest measurement on the right heel was completed on 08/04/20 noting 8cm x 6cm x 0.8cm. On each measurement, staging was left blank. On 06/30/20, a wound was noted to the right great toe measuring 8cm x 1cm. Measurements for wounds were completed on 07/14/20, but the right great toe was not documented. On 07/28/20, the right great toe wound measured 0.5cm x 0.2cm. The latest measurement was dated 08/04/20 and measured 1cm x 0.5cm. On 06/30/20, a wound to the right outer foot was noted measuring 2cm x 1.3cm. On 07/28/20, the wound measured 3.5cm x 3cm x 0.2cm. The latest measurement was dated 08/04/20 and was listed as 3.6cm x 3cm x 0.2cm. An interview was completed with the DON on 08/10/20 at 9:17 AM. The DON reported the wound clinic would complete measurements on Resident 35's wounds and nurses' would document those measurements on the Weekly Skin Documentation sheet. The DON stated Resident 35 went to the wound clinic every week. After reviewing progress notes, the DON said (gender) did not see any wound measurements from the wound clinic back to the first of July. The DON was asked for documentation of wound evaluations from the wound clinic. The only document supplied was a wound culture report. On 08/10/20 at 10:35 AM, an interview was completed with Nurse-I. Nurse-I stated sometimes the wound clinic did wound measurements, but wounds were measured at the facility every Tuesday. Nurse-I completed the wound measurements on 08/04/20. Nurse I also stated Resident 35 had the heel wound on admission and all of the foot wounds were Stage II or Stage III. Nurse-I said they didn't write any staging on the weekly measurement sheet. Nurse-I said the heel wound was a pressure ulcer and the other two foot ulcers were from pressure and bad circulation. An interview was completed with Nurse-A on 08/10/20 at 10:55 AM. After reviewing the medical record, Nurse-A said, I haven't seen any notes from the wound clinic on what's going on with his toe. There is no diagnosis. Nurse-A was not aware of the area on the right lateral foot. Nurse-A verified the care plan was not updated to show new areas to the right great toe or the right lateral foot. If there are new skin areas, the nurse who found it would add it to the care plan. Nurse-A said new wounds would get written on the 24-hour nursing report, that would be reviewed in the daily department head meeting. Nurse-A was responsible for making sure care plans are updated. On 08/10/20 at 11:47 AM, an interview was completed with Nurse-J. Nurse-J was a nurse with the wound clinic and familiar with Resident 35. Nurse-J said the clinic did not send wound descriptions or measurements unless it was a new wound. Nurse-J said their documentation

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F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) noted the right great toe and lateral side of the foot started on 07/01/20. Nurse-J said they first saw the lateral foot and great toe on 07/08/20 and were told the areas had been there about a week, so it was dated 07/01/20. Nurse-J said the physician documented the wounds as pressure but did not stage them. Nurse-J said the current staging was Stage III for the outer foot and Stage IV for the heel. Resident 35 went to the wound clinic every two weeks. Nurse-J verified staff were present in the clinic until 5 PM each day and a physician was on call after hours and can be reached by calling the hospital. An interview was completed with Nurse-F on 08/10/20 at 2:46 PM. Nurse-F reported measuring Resident 35's wounds on 07/14/20. Nurse-F was aware of the areas to Resident 35's toe and the lateral right foot. When asked about not documenting a measurement for the great toe on 07/14/20, Nurse-F said, I must have just missed measuring it. Nurse-F said nurses should be filling out the wound staging. Nurse-F acknowledged writing unable to measure the right heel on the Weekly Skin Documentation sheet on 07/14/20 and 07/28/20. Nurse-F said it took two staff to lift the right foot to be able to see and measure the wound. Nurse-F said the nursing assistants were busy, but Nurse-F liked to get the dressing changes done in the morning because it's so busy in the afternoon. A follow up interview was completed with Nurse-E on 08/10/20 at 3:04 PM. Nurse-E reported discovering the areas to Resident 35's right great toe and the lateral part of the right foot on 06/30/20. Nurse-E stated the 8cm measurement to the right toe was probably inaccurate. I measured the whole area of (gender) toe that was red; probably more than I should. Nurse-E stated when a new skin wound was found, the Weekly Skin Documentation form was updated. There were no other forms to fill out like incident or adverse event reports. No nurse progress note would be completed. During an interview with the DON on 08/10/20 at 3:30 PM, the process after finding a new skin would was discussed. The DON said the nurse would assess and measure the new area and document on a nursing progress note and on the Weekly Skin Documentation sheet. At 4:49 PM, the DON confirmed there was no policy or written process on what to do when new skin issues were found. 1.b Review of Resident 35's physician's orders [REDACTED]. On 08/06/20 at 1:07 PM, Nurse-E was observed to be on the phone discussing Plurogel. During an interview at 1:08 PM, Nurse-E said that the order for Plurogel was faxed in on 08/05/20, but that it hadn't been received and the person that was spoken to at the pharmacy assumed the wound clinic had sent the Plurogel. Wound care for Resident 35 was observed on 08/06/20 at 1:52 PM. Resident 35's right foot was wrapped in a bath towel. Nurse-E unwrapped the right foot. Resident 35's right great toe was noted to have a blackened scab. An open wound was noted at the base of the right 5th toe extending under the foot and the entire right heel was noted to be an open wound with serosanguinous drainage. No care was provided to the right foot and the towel was replaced around the foot. On 08/06/20 at 2:08 PM, an interview was completed with Nurse-E. Nurse-E stated Resident 35 was not supposed to have a dressing applied to the right foot; but should have gel applied. Nurse-E reported Plurogel had not been received from the pharmacy. On observation, the towel was still around Resident 35's foot. On 08/06/20 at 6:25 PM, an observation of Resident 35's right foot wound was completed with Director of Nurses (DON). Resident 35's foot remained wrapped with a bath towel. When uncovered, the right heel has noted to have drainage in a circular area approximately 5cm (centimeters) in diameter and soaked through the towel. Review of Progress Notes for Resident 35 revealed a note dated 08/07/20 at 8:15 AM. Nurse-O wrote the wound clinic had been called about wound care, as Plurogel was not available. Nurse-O was instructed to go back to the previous dressing change order until Plurogel was available. Plurogel was to be applied, then covered with gauze. On 08/10/20 at 9:04 AM, a follow up interview was completed with Nurse-E. Nurse-E stated on 08/06/20, the pharmacy staff called around 3:30 PM and said the Plurogel wouldn't be in until 08/10/20. Nurse-E acknowledged the physician was not notified and, In retrospect, I should have called the wound clinic and let them know. An interview was completed with the DON on 08/10/20 at 9:17 AM. When asked about notifying the wound clinic on 08/06/20 about the unavailability of Plurogel, the DON said the wound clinic did not have any after-hours staff so the call couldn't be made until 08/07/20.
F 0689 **Level of harm -** Immediate jeopardy **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 observations, interviews, record reviews and review of policy and procedures, it was determined the facility failed to provide adequate supervision for two residents who left the building unsupervised for two of 24 sampled residents (Resident 24 and Resident 28) reviewed for adequate supervision. This affected 2 residents (Resident 24 and Resident 28) of 24 residents. This had the potential to affect all 4 of the residents who wander. Four residents were at risk for elopement. It was determined the provider's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment or death to residents. The Immediate Jeopardy was related to State Operations Manual, Appendix PP, 483.25 (quality of care) at a scope and severity of J. On 08/11/20 at 4:24 PM, the Administrator, Assistant Administrator, and Director of Nursing were informed of the Immediate Jeopardy situation. At the time of survey exit, on 08/17/20 at 1:10 PM, a Removal Plan had not been accepted by the state agency. Findings are: 1. Resident 24 had [DIAGNOSES REDACTED]. physician's orders [REDACTED]. A Quarterly Minimum Data Set (MDS), dated [DATE], indicated the resident was severely impaired in cognitive skills for daily decision making. The resident required supervision for walking and locomotion off the unit. The resident used a walker for a mobility. A care plan, dated 06/01/20, documented a Category of Cognitive Loss/Dementia. A care plan approach dated 06/01/20 documented, Wander-guard placed on resident. Check function per MAR (Medication Administration Record). The Care Plan Category of Activities indicated it was important for the resident to be outside when the weather was nice to get fresh air, and an approach date of 06/01/20, documented, .Assist to go outdoors as weather permits . A late entry Nurse's Progress Note, dated 07/09/20 at 8:53 PM, indicated at 6:30 PM the resident had been found in the facility parking lot walking with (gender) walker. The care plan documented, on 07/09/20, the resident's Wandering Assessment score was 7 (definite risk for elopement). Resident wandered into the facility parking lot and care plan approach, dated 07/09/20, documented, Discuss the need for additional alarms on exit doors of building. A Nurse's Progress Note, dated 07/10/20 at 1:00 PM, indicated the resident did not remember going outside by (gender) the day before. A Nurse's Progress Note, dated 07/21/20 at 8:47 PM, indicated the resident had been found, at 8:40 PM, walking with (gender) walker in the parking lot after exiting the facility through a door on the south side of the building. A Nurse's Progress Note, dated 07/24/20 at 10:29 PM, indicated the resident continued to be confused, frequently mentioned going home, and would attempt to leave the facility if not redirected. On 08/06/20 at 5:27 PM, the Administrator (ADM) was asked if an investigation or incident report had been completed for Resident 24 during July 2020, and (gender) said, No. The ADM stated incident reports were not kept on the premises. On 08/10/20 at 9:54 AM, the Director of Nurses (DON) stated Resident 24 had been found outside the facility building on 07/09/20 and 07/21/20, but Staff C stated the resident had not eloped because they were still on facility grounds. Staff C stated both times the resident exited the building, they were on the south side of the facility, the same place. The DON was asked what new interventions had been put into place after the resident left the building on 07/09/20, and the DON stated they had discussed the need for additional alarms. The DON was asked if the installation of alarms had been followed up on, and the DON said, We are still in discussion on that since that area is now the grey zone. On 08/10/20 at 10:36 AM, Maintenance (Staff-FF) was asked if the facility had a system to ensure the Wanderguard system was intact, and they said, No, not really. Staff FF stated the resident had exited from the south wing of the building and the Wanderguard alarm on the wall near the fire doors should have initiated an alarm to alert staff the resident had passed it. Staff FF clarified the Wanderguard system would have only set off an alarm; the Wanderguard system would not lock the door, and the resident could have, just gone through it. Staff FF stated the resident would then have had to pass through the grey unit to reach the doors that exited to the outside. Staff FF was asked if there were alarms on the outside doors of the south/grey unit, and Staff FF said, No. Staff FF added the outside doors only opened one way so once someone was on the outside, they would not be able to get back in without assistance. Several staff members, who were not in the facility at the time of the survey, were noted, in Nurses' Progress Notes, to have been involved in the resident's care around the time of the discovery. On 08/10/20 at 2:17 PM, the DON was asked how long the resident had been outside on 07/09/20 before being found and (gender) said, I do not know. The DON was asked how long the resident had been outside on 07/21/20 before being found and she said, I have no idea. On 08/11/20 at 11:00 AM, it was observed the parking lot on the south side of the facility was intersected by a street that was a main access to facility. It was used to drive around the facility, access other facility parking areas and provided access to a small residential area adjacent to the facility. It was observed the city street that bisected the facility's south parking lot was frequented with vehicles. It was also observed, the South Wing had four doors, with outside access, that did not have any alarms on them. Two doors, at the end of each of the Red

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	285210	A. BUILDING _____ B. WING _____	08/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CROWELL MEMORIAL HOME	245 SOUTH 22ND STREET BLAIR, NE 68008

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 0689 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 6) and Grey Zones, emptied into stairwells before exiting the building. Neither of the doors to the stairwells or the doors to the outside were fitted with alarms. Additionally, a door by the nurses' station and a door in the therapy room had direct access to outside the building and did not have alarms. On 08/17/20 at 2:34 PM, it was observed the four doors on the south wing directly off of the hall had magnetic alarms installed that sounded for as long as the door was open. But, the two doors off the stairwells that exited the building did not have alarms. On 08/17/20 at 2:34 PM, Certified Nursing Assistant (CNA)-GG stated they were concerned because, if they were in a room at one end of the unit, they would not be able to hear the new alarms that had been installed. They stated they were also concerned as the alarms only sounded the few seconds the door was opened. CNA-GG stated they were concerned as one of the residents on the hall, really wanted to get out. An Incident Report Log provided by the facility, dated from February 2020 through July 2020, was reviewed. All 65 incidents recorded on the log were related to falling. No other type of incident, including elopements, was captured on the Facility's Incident Log. No investigations or reports could be found, or were provided, related to Resident 24's two episodes of elopement. A facility policy, dated 07/18 and titled, Wandering Residents, documented: Every effort will be made to prevent wandering episodes .Interventions into elopement episodes will be entered onto the resident's care plan . Surveyor: Campbell, Patrick 2. Resident 28 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of Resident 28's admission Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate impairment. Locomotion did not occur during the review period. Review of nursing progress notes for Resident 28 revealed that on 05/14/20 at 10:13 PM, Nurse-P wrote, Resident propels self in wheelchair and wheels self throughout facility. Will not confine self to room. Attempts to leave facility numerous times through any doors that (gender) sees. Has a WanderGuard (electronic device to alert if a resident attempts to go to a restricted area) on wrist. Very confused. Talks of going home and going to grocery store. Staff attempts to explain why (gender) cant (sic) go home and why (gender) is here and (gender) disagrees. Doesn't know where (gender) is. Review of the facility Wandering risk document for Resident 28, dated 05/14/20, noted a score of 8. The document noted a score of 3 or above indicated an elopement risk. Review of nursing progress notes dated 05/25/20 at 10:45 AM, noted Resident 28 was readmitted from a hospital stay. On 05/25/20 at 11:15 AM, Nurse-N noted that the WanderGuard was placed back on Resident 28. No documentation was provided to show when the WanderGuard was removed after 05/25/20. On 07/14/20, an updated Wandering risk screening was completed for Resident 28, resulting in a score of 7. Review of the Medication Administration Record [REDACTED]. For the Month of June 2020, the WanderGuard was initialed as in place 64 times and the initials had parenthesis around them 26 times. From 07/01/20 to 07/10/20, 21 entries were initialed and 9 had parenthesis. On 08/05/20 at 2:45 PM, Nurse-D verified that initials with parentheses meant a task wasn't done. Nurse-D verified on days in June and July prior to July 11, their initials had parenthesis. Nurse-D also verified that Resident 28 did not have a WanderGuard on during those times. Nurse-D could not explain why the documentation would show the WanderGuard was on and off on various shifts since it would not be removed and replaced routinely. Review of a nurse progress note, dated 07/11/20 at 9:08 PM by Nurse-D, revealed that Resident 28 had been found outside the facility on the sidewalk at 8:20 PM. Resident 28 had a skin tear to the elbow. On 08/05/20 at 5:37 PM, an interview was completed with a family member of Resident 28. The family member was aware of the elopement and was told Resident 28 went outside looking for a truck. The family member said they were told a WanderGuard was placed on Resident 28 after the incident. On 08/06/20 at 8:45 AM, an interview was completed with Medication Aide (MA)-Q. MA-Q reported being familiar with Resident 28. MA-Q said that Resident 28 was very mobile and would go up and down the halls. MA-Q had not seen Resident 28 attempt to elope; but was aware that Resident 28 had eloped in the past. MA-Q also reported being aware that Resident 28 had removed the WanderGuard in the past. Review of physician's orders [REDACTED]. No documentation was found to indicate functioning or placement was monitored. An interview was completed with Nurse-D on 08/06/20 at 2:25 PM. Nurse-D reported being familiar with Resident 28. Nurse-D reported she was the charge nurse on 07/11/20. She was called by Nursing Assistants (NA)-H and NA-R to report Resident 28 had been found outside. Nurse-D said they thought Resident 28 went out a door just outside of the unit where Resident 28's room was located. Resident 28 was found laying on the sidewalk about 10 feet from the door. Nurse-D thought Resident 28 stepped off the sidewalk and fell . Nurse-D also indicated NA-H stated Resident 28 had been seen about 20 minutes before being found and that Resident 28 had a history of [REDACTED]. Nurse-D further reported Resident 28 did not have a WanderGuard on because there was an order to use it if appropriate. Nurse-D said Resident 28 had not been feeling well since going to the hospital in May, but was feeling better. Prior to the elopement, Nurse-D did not feel like Resident 28 was well enough to wander. Resident 28 required a mechanical lift to transfer and hadn't been observed walking but did walk independently until the fall outside. Nurse-D initiated an order on 07/11/20 to apply the WanderGuard and to check it every shift. That order could not be located on any monitoring documents. Nurse-D reported the order should have appeared on the MAR indicated [REDACTED]. On 08/06/20 at 2:39 PM, an interview was completed with NA-H. NA-H reported providing care for Resident 28 on 07/11/20. NA-H reported not seeing Resident 28 in (gender) room. NA-H started looking for Resident 28. Resident 28 was found outside on the ground. NA-H stated Resident 28 had been left in the room recliner 15-20 minutes before and had walked out to the courtyard and fell . NA-H said Resident 28 did not have a WanderGuard on. NA-H said Resident 28 previously had a WanderGuard, but it had been removed when Resident 28 went to the hospital. On 08/06/20 at 3:10 PM, an observation was completed of the area were Resident 28 had been found. Multiple doors opened into a courtyard. Resident 28 was found near one of the doors. The area Resident 28 was found in was approximately 30 feet from (gender) room. There were no alarms on the door. The courtyard that Resident 28 was found in exited to the street. An investigation for Resident 28 signed by the Director of Nurses (DON) dated 07/11/20 was reviewed. The investigation presented was a one-page document printed on the front and back sides. During interview on 08/06/20 at 3:53 PM, the DON verified the two-page document was the entire investigation. There were no witness statements or other documents. The DON said they determined the root cause was Resident 28 had dementia and walked out the door. The DON also said they did not consider this incident an elopement because Resident 28 did not leave the facility property. The DON also stated Resident 28 had not previously used a WanderGuard. To complete the investigation, the DON stated the incident report completed at the time of the elopement would be reviewed. No other data sources were utilized including witness interviews. When asked for a copy of the incident report, the DON stated they were not kept at the facility and would not be retrievable. During a follow up interview on 08/06/20 at 5:16 PM, the DON stated there had been no other elopements since January 2020. On 08/11/20 at 2:00 PM, another interview was completed with DON. The DON reported the facility had a Falls Committee that meets and would have discussed Resident 28's fall, but the committee does not document minutes or create progress notes in the medical record. The DON verified they have an investigation sheet, but that it only addressed falls and the only reason there was an investigation for this incident was because Resident 28 fell . If the incident requires State reporting, those documents are filled out, but there are no internal documents. The DON also stated, If a fall isn't witnessed, (they) wouldn't get any statements (from staff present). Interviews would not be completed with anyone who did not see a fall. On 8/20/2020 at 1:00 PM the State Agency received an abatement plan via email and approved the abatement. The Immediate Jeopardy was abated to a level G
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** Licensure Reference Number 175 NAC 12-006.04B, 12-006.04B2, 12-006.02Ba Based on record review and interview, the facility failed to ensure licensed nurses and certified nurse aides (CNAs) had specific competencies to provide care for the residents. This affected five out of five licensed nurses (RN-D, RN-V, LPN-E, LPN-F, LPN-NN) and five out of five CNAs (CNA-OO, CNA-PP, CNA-QQ, CNA-CC, CNA-S) reviewed for competencies. Findings are: Training records for five licensed nurses were reviewed, which included Registered Nurse (RN)-D, RN-V, Licensed Practical Nurse (LPN)-E, LPN-F and LPN-NN. No evidence of competency assessment could be identified. Training records for five CNAs were reviewed, which included CNA-OO, CNA-PP, CNA-QQ, CNA-CC and CNA-S. No evidence of competency assessment could be identified. On 08/06/20 at 5:21 PM, the Nursing Home Administrator (NHA) stated all training and competencies were the responsibility of the Director of Nursing (DON). On 08/06/20 at 5:23 PM, the Assistant Administrator (K) stated the DON handled all training and competencies. On 08/06/20 at 5:26 PM, the DON stated a competency program was something that was being worked on and we need to do more of them.

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F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09D Based on record review and staff interviews, the facility failed to identify targeted behaviors (reason for the psychoactive medication) and monitor for those behaviors for two of six residents (Residents 35 and 46) reviewed for unnecessary medications. Findings are: 1. Resident 35 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of physician's orders [REDACTED]. A review of Resident 35's annual Minimum Data Set (MDS) assessment, dated 06/17/20, revealed Resident 35 had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, indicating severe impairment. Resident 35 had no physical or verbal behaviors directed at others and no behaviors that were directed at others. A review of Resident 35's care plan revealed a concern related to dementia. No target behaviors to be monitored were listed. On 08/10/20 at 2:00 PM, an interview was conducted with the Director of Nurses (DON). The DON confirmed if Resident 35 had any negative behaviors, the nurse would document them, but would not document the absence of behaviors. On 08/11/20 at 3:01 PM, an interview was completed with the Social Services (SS) Director/Minimum Data Set (MDS) Nurse-A. SS-A said Resident 35 was admitted on an antipsychotic. After reviewing the medical record, SS-A said the physician had diagnosed Resident 35 with dementia with behaviors but did not list any exhibited behaviors. SS-A also said the only behavior they had seen from Resident 35 was repeated mumbling. SS-A stated negative behaviors aren't routinely tracked and the nurses would document only if behaviors were exhibited. SS-A confirmed the staff don't have any reference for behaviors to monitor for. A follow up interview was completed with the DON on 08/12/20 at 3:12 PM. The DON stated nursing assistants fill out behavior monitoring sheets routinely every day and nurses would complete a nursing progress note only if negative behaviors were displayed. A follow up interview was completed with SS-A on 08/12/20 at 3:28 PM. SS-A confirmed there was only one entry documented for behaviors for Resident 35 for June and July and the documentation was no behaviors occurred. An interview was completed with Nurse-L on 08/12/20 at 3:38 PM. Nurse-L was familiar with Resident 35. Nurse-L said Resident 35 mumbled or chanted but was not combative and didn't yell. Resident 35 will say no appropriately and would mumble louder if aggravated but exhibited no other negative behaviors. 2. Review of Resident 46's face sheet revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Resident 46 had elected the hospice benefit prior to admission and remained on hospice care. Review of the annual Minimum Data Set (MDS), dated [DATE], revealed Resident 46 scored 99 on the Brief Interview for Mental Status (BIMS), indicating the resident was cognitively impaired and is unable to participate in decision making. The MDS also documented Resident 46 took an antianxiety medication ([MEDICATION NAME]) daily. The admission orders [REDACTED]. Review of Resident 46's care plan revealed the lack of targeted behaviors (reason for the resident to take the antianxiety) or document episodes of anxiety. The hospice care plan indicated Resident 46's experienced restlessness when the resident needed to toilet. One entry in the clinical record, dated 04/29/20 at 4:42 AM by Pool Aide, indicated Resident 46 was rejecting care, the resident was toileted, and restlessness was eased. Interview with the Director of Nursing (DON) and the Administrator on 08/10/20 at 2:00 PM revealed the resident often had behaviors including is grabby and rejected care. The DON if the resident were to have behaviors, the behaviors would be documented I the progress notes. The DON confirmed there was no routine behavior documentation to demonstrate the resident's continued need for the medication. Interview with Consulting Pharmacist J, on 08/12/20 at 5:39 PM, revealed the pharmacist reviewed the clinical record for evidence of behaviors. The pharmacist stated they were not aware of documentation done routinely for the presence or absence of behavior symptoms to be considered for the resident's continued need for the antianxiety medication. The facility's lack of assessing the resident's signs and/or symptoms of anxiety. The facility failed to care planning to assist the resident in times of demonstrated signs/symptoms. The facility failed to document the non-pharmacological interventions attempted. There was also no documentation of the resident's reaction to the interventions. This placed the resident at risk of receiving unnecessary medications.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Licensure Reference Number 175 NAC 12-006.11A Based on observations, facility policy review and staff interviews, the facility failed to store foods in accordance with professional standards for food service safety. Bulk food items were undated; and leftover food was not labeled and discarded after it was spoiled. Findings are: Review of an undated policy, titled Food Storage, noted that broken lots of bulk foods should be accurately labeled. There was no specific guidance on dating open items or how long they could be kept before being discarded. On 08/05/20 at 8:25 AM, an observation of the dry storage area of the kitchen revealed the following food items that were opened and undated: icing mix, five bags of cereal, a bag of chocolate cake mix, two bags of cheese puffs and a bag of graham cracker crumbs. An interview was completed with Dietary Manager-B on 08/05/20 08:31 AM. Dietary Manager-B said all dry goods should be dated when they are opened and would be kept for three days. On 08/06/20 at 7:55 AM, a second observation of the kitchen was completed. Three bags of pasta, one bag of rice and a container of graham cracker crumbs were opened and undated. On 08/11/20 at 9:47 AM, an observation of the 2nd floor nourishment room and an interview were completed with Nurse-G. Nurse-G said all food items that were in the unit's nourishment refrigerator should be dated when opened and if the items belonged to a resident, the item should also have the resident's name on it. Two plastic containers with clear snap on lids, that appeared to have leftover foods, were noted in the refrigerator. Neither were dated and one had no resident's name on it. One container had the name of Resident 45. The food inside was covered with a grey substance that Nurse-G identified as mold. Nurse-G reported that dietary staff were responsible for disposing of foods from the nourishment refrigerators. On 08/12/20 at 11:01 AM, an interview was completed with Dietary Manager-B. Dietary Manager-B said nursing staff came down and get supplies for the nourishment refrigerators, but the kitchen staff do not go into the refrigerators and would not clean them out.
F 0835 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** Licensure Reference Number 175 NAC 12-006.02 Based on observations, interviews, record review and facility policy review, the facility's Administration failed to manage the facility in a way to ensure the facility was in substantial compliance with federal regulatory requirements. It was determined the provider's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment or death to residents. Findings are: Failure to provide oversight resulted in an Immediate Jeopardy (IJ) during the Recertification and Complaint survey under F610 for failing to initiate investigations for injuries of unknown source. The Immediate Jeopardy was related to State Operations Manual, Appendix PP, 483.12 (freedom from abuse, neglect, and exploitation) at a scope and severity of J. Failure to provide oversight resulted in a second IJ situation during the survey under F689 for failing to provide adequate supervision for two residents who left the building unsupervised. The Immediate Jeopardy was related to State Operations Manual, Appendix PP, 483.25 (quality of care) at a scope and severity of J. The Administrator, interviewed on 08/17/20 at 9:15 AM, acknowledged the Administrator was responsible for the effective and efficient day-to-day operations of the facility, and for the provision of resident care. On 8/20/2020 at 1:00 PM the State Agency received an abatement plan via email and approved the abatement. The Immediate Jeopardy was abated to a level G
F 0838 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.**

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F 0838 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 8) Based on record review and interview, the facility failed to review and update the Facility Assessment, as necessary, and at least annually. Findings are: Review of the Facility Assessment revealed a document that was not dated. On 08/06/20 at 5:21 PM, the Nursing Home Administrator (ADM) was interviewed. The ADM stated the last review of the Facility Assessment was not known. On 08/06/20 at 5:23 PM, Assistant Administrator-K was interviewed. The Assistant Administrator-K stated the Director of Nursing (DON) was working on it (facility assessment) but did not believe it been reviewed since it was originally completed in 2017. On 08/06/20 at 5:28 PM, the DON was interviewed. The DON stated, I can't recall the last time it was reviewed.
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** Licensure Reference Number 175 NAC 12-006.17A Based on observations, interviews, record reviews and review of policy and procedures, it was determined the facility failed to implement use of proper PPE (Personal Protective Equipment) for one resident (Resident 35) who regularly received medical treatments outside the facility; and failed to ensure persons entering the facility were screened for COVID-19. Findings are: 1. Resident 35 had [DIAGNOSES REDACTED]. The Infection Preventionist (IP) confirmed the resident left the facility for appointments at a local wound care clinic on the following days: 04/27/20, 06/02/20, 06/19/20, 06/25/20, 07/01/20, 07/08/20, 07/14/20, 07/21/20, 07/28/20, and 08/05/20. On 08/06/20 at 1:00 PM, the IP was asked if Resident 35 should be treated with transmission-based precautions and PPE, as if in the gray unit (Rooms designated by the State for residents being transferred into the facility from outside facilities (but have no known exposure to COVID-19) to be kept in this zone for 14 days and if remain asymptomatic at the end of the 14 days will be moved out of this zone.), as the resident left the facility to receive medical treatments in the community. The IP stated the resident did not wait in a waiting room at the appointments and only saw the medical team. The facility did not think the resident needed to be in the grey zone or be cared for with the gray zone associated PPE. The IP stated, as the resident was not out in the community, the facility did not think it necessary to take any further precautions. The IP confirmed proper PPE for use in the gray zone consisted of gown, gloves, N95 masks, and a face shield. On 08/10/20 at 4:40 PM, Registered Nurse (RN)-II from the wound care clinic the resident visited for appointments, was asked if the resident ever had to wait in the waiting room prior to an appointment or had potential contact with persons non-medical while at the facility. RN-II stated they tried to minimize the time more than one person would be in the waiting room at a time. They stated only two patients were scheduled at a time and the staff was good at being on time. However, they stated there were no guarantees that a person would have the waiting room to themselves. RN-II added the waiting room was small and they could not say two patients would not cross paths in the halls or touch the same surfaces. On 08/12/20 at 09:00 AM, Resident 35 was observed in their room. Their room was not designated a gray zone room and did not have PPE stationed outside the door with signage to use. Staff were observed throughout the survey caring for the resident without utilizing face shields or gowns. A facility policy, dated 07/31/20, and titled, Isolation Precautions, documented: .Gray Zone: Transition (sic.) Zone - Consists of New and Readmitting Residents transferring from outside the facility but with no known exposure COVID-19 . 2. On 08/13/20 at 7:35 AM, a surveyor entered the facility through an unlocked door. No staff was present in the lobby to screen for COVID-19. The surveyor waited approximately 30 seconds and then left the lobby to find staff. The Office Manager (Staff)-JJ, in the business office, was found and asked if anyone was doing screenings. They stated they would call the Director of Nurses (DON). Staff JJ was asked if the front desk was monitored when the doors were unlocked. They stated the doors would be monitored once the front desk clerk arrived for work. On 08/13/20 at 1:27 PM, the IP was asked if the unlocked, front facility doors were monitored to screen those entering. The IP stated the front desk clerk typically would start the screening process for those entering the building. The IP stated the desk clerk hours may have been recently changed from 7:30 AM to 8:00 AM. The IP stated the front desk clerk would call the DON or themselves to complete the screening. The IP stated staff knew to go downstairs to screen, if no one was at the front desk to screen. The IP stated someone from the Business Office was usually at the facility at 6:30 AM and could find someone to assist with screening if needed. Based on this information, it was possible someone could enter facilities unlocked doors, pass by an unmonitored front desk, and have access to the facility without being properly screened for COVID-19. A facility policy, dated 03/18/20, titled Coronavirus Surveillance, documented: .Heightened surveillance activities will be implemented to limit the transmission of COVID-19. These include, but are not limited to, screening visitors, staff and residents .
F 0947 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.** Licensure Reference Number 175 NAC 12-006.04B2a Based on interviews and record reviews, the facility failed to ensure Certified Nurse Aides (CNAs) received no less than 12 hours of required annual in-service training, including resident abuse prevention and dementia management training; and failed to have a process for tracking who attended the training. This affected five of five sampled CNAs who had their personnel files reviewed (CNAs: OO, PP, QQ, CC and S). Finding are: The training for five facility employed CNAs were requested for review: CNAs OO, PP, QQ, CC and S. Inservice training records for the five CNAs were reviewed. Four of five CNAs had not attended dementia management training. None of the CNAs had attended or been provided with abuse prevention training. The CNAs were not provided with the required 12 hours of annual in-service training. On 08/06/20 at 5:21 PM, the Nursing Home Administrator (NHA) stated all training was the responsibility of the Director of Nursing (DON). On 08/06/20 at 5:23 PM, the Assistant Administrator-K stated the DON handled all trainings. On 08/06/20 at 5:26 PN, the DON stated that an in-service and training program was being worked on and we need to do more of them. The DON didn't have a system for tracking who attended inservices. Attendance logs were kept, but it didn't indicate who attended the inservice.