STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285224	A. BUILDING _____ B. WING _____	07/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SKYVIEW CARE AND REHAB AT BRIDGEPORT	505 O STREET BRIDGEPORT, NE 69336

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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 numbers: 175 NAC 12-006.06 and 175 NAC 12-006.18A (1) Based on interviews, record reviews, and observations, the facility failed to address Resident Council concerns regarding turnover of employees, responses to call light activations, and landscaping concerns of the grounds by reporting back to the council facility efforts to address these concerns and resident input as to whether the issues were satisfactorily resolved. Council attendance and input for the previous three months ranged from 7 to 11 residents. Facility census was 36. Findings are: Interviews with Resident Council members revealed the following: - Resident 20 was interviewed on 7/27/20 at 9:40 a.m. The resident acknowledged being the Vice President of the council and attended regularly. The resident stated the council had brought up concerns about call light response and concerns as to why there was such a large number of employees leaving employment. In addition, the resident stated the facility had not attended to the grounds surrounding the facility and especially in the courtyard where residents like to sit and visit with family members. The resident stated a resident had expressed concerns that the courtyard needed weeding and watering. The resident stated the sprinklers to the facility weren't working and when gazing out across the grounds, the grass is dry and discolored and there are overgrowths of weeds. The resident stated flower beds were not planted and growing weeds in the courtyard. The resident stated the facility has not discussed the issues surrounding long call light responses, landscaping, or employee turnover with the council to express what was being done regarding these concerns. - Resident 17 was interviewed on 7/27/20 at 2:15 p.m. The resident acknowledged being a new admission to the facility and having attended the July meeting of the resident council. The resident recalled a resident expressing concerns about waiting long times for the call light to be answered. The resident also expressed having to wait a long time for the call light to be answered. The resident was asked if the issue had been resolved and the resident expressed sometimes still had to wait up to 20 minutes while on the toilet. Did not feel resolved. - Resident 22 was interviewed on 7/28/20 at 10:00 a.m. The resident acknowledged being the President of the Resident Council and attending meetings. The resident expressed concerns with the council bringing up call light delays at the last two meetings. The resident stated no one reported what the facility was doing regarding the concern to the council and verified the council was not satisfied the issue was resolved. A concern residents expressed through council had been the turnover of employees. The facility had not reported what they were doing about the issue. The resident felt some of the turnover played into the call light delays. - Interview with Resident 15 on 7/30/2020 at 8:45 a.m. revealed the resident regularly attended Resident Council meetings. The resident expressed a concern this resident brought to the council more than once regarding the yard work and landscaping surrounding the building and especially in the resident sitting areas in the courtyard. The resident said there had not been much yard work help in a long time and stated no one in the facility can answer who is responsible to take care of the flowers, gardening, and yardwork. The resident stated the lawn was dry and discolored, weeds have overgrown in the lawn, edging, and flower beds. The resident stated no one in the facility responds to the concern brought up at council. Observations of the facility grounds on 7/27 and 7/28/20 revealed all outside areas of the landscape had large patches of discolored, dry grass. Edges along the sidewalks were overgrown with weeds. Observation of the courtyard with a gazebo and patio used by residents revealed flower beds with no flowers, only growths of weeds. The lawn was discolored and dry with weeds sprouting throughout the grass. On 7/29/20 the sprinkler system was activated and observation on 7/30/20 revealed some improvement in the discoloration of the lawn landscaping. Record review of Resident Council minutes revealed the following: - Meeting 7/17/20 attended by seven residents and the Activity Director revealed in the Old Business concerns expressed by Resident 32 of having to wait 30-40 minutes for someone to answer the call light. Resident 15 expressed concerns about needing help for lawn work. In the New Business, Resident 17 expressed it was taking too long for call lights to be answered. There was nothing in the minutes documenting discussion with residents about the ongoing concerns with lawn care and call light response, reporting what the facility was doing to address the concerns, or identifying if the council felt the concerns were addressed to their satisfaction. - Meeting June 2020- Due to COVID 19 the residents were given concern forms to be addressed as their monthly meeting. 8 residents responded. Old business included a concern by Resident 15 about getting assistance with flower beds and wondering if residents could help. New business recorded Resident 32 reported waiting for 30-40 minutes for call light response. Resident 15 also expressed concerns about turnover of employees and the need for help in the lawn work. Nothing in the meeting minutes addressed what facility was doing about the flower beds brought up at the last meeting. - May 2020 meeting- due to COVID 19 residents were given concern forms. 11 Residents responded In old business the Activity Director did respond to concerns expressed by Resident 22 documenting facility responses to the concerns. New Business revealed concern by Resident 15 regarding needing more help with the flower beds and getting the piano tuned. Interview with the facility Activity Director on 7/28/20 at 2:20 confirmed the Resident Council minutes revealed the council had repeat concerns regarding turnover of staff, call light responses, and landscaping concerns. The Activity Director verified there was no documentation that the council members were provided facility responses to these concerns and whether or not the council felt the resolutions had been done to their satisfaction. Interview with the Administrator on 7/30/2020 at 9:25 a.m. revealed the previous Maintenance Director had left employment in February of 2020 and the position had not been replaced until July of 2020. A corporate consultant in Maintenance helped out and set sprinklers as the Spring season began, but had incorrectly coded the date of the sprinkler system and it did not activate. As the lawn became dry, the Administrator corrected the coding, but when plumbers replaced a water heater, the system was shut down again. The Administrator verified resident council concerns regarding the dry, discolored lawn, and weed growth had not been corrected.
F 0641 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number: 175 NAC 12-006. 09B Based on observations, record reviews and interviews, the facility failed to: 1) accurately code Restorative Nursing programs on MDS (Minimum Data Set, a federally mandated comprehensive assessment tool utilized to develop resident care plans) assessments for 3 sampled residents (Residents 20, 17, and 19); and 2) correct the mis-coding of a ventilator device for one sampled resident (Resident 9). Sample size included 15 current residents. Facility census was 36. Findings are: A. Record review of Resident 20's Admission Record revealed the resident was admitted to the facility on [DATE]. Record review of Resident 20's annual MDS assessment on 6/24/2020 revealed the resident was coded as having no range of motion difficulties and performed dressing activities and bed mobility under the supervision of staff without any weight bearing assistance. The MDS recorded the resident received a Restorative Nursing program for Range of Motion, Dressing, and Bed Mobility on 7 of 7 days of the MDS reference period. Interview with Resident 20 on 7/28/20 at 8:10 a.m. revealed the staff were not providing the resident with any exercise program, range of motion,

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

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F 0641 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	(continued... from page 1) or interventions to improve the resident's dressing or bed mobility performance. The resident stated not being on any formal program for exercise, therapy, or restorative in well over six months. Record review of Resident 20's Care plan with goal target dates of 10/11/20 revealed there was no restorative program developed on the care plan to identify individualized restorative interventions or goals for the resident related to a restorative program. Record review of Resident 20's medical record revealed no documentation outlining a restorative program with individualized interventions and goals, nor was there any licensed nurse review of a restorative program. Record review of a facility Documentation Survey Report for Resident 20 from June 2020 and July 2020 revealed the resident was receiving Restorative Bed Mobility, Restorative Dressing/Grooming, and Restorative Active Range of Motion activities 15 minutes on each shift every day. Interview with Restorative Aide-E on 7/29/20 at 10 a.m. revealed the resident is not on a formal Restorative program due to the resident is essentially independent. The Restorative Aide denied doing any range of motion exercises or activities with the resident to improve dressing or bed mobility. Interview with the facility's RA (Restorative Nursing Aide)-E on 7/29/20 at 10 a.m. RA-E stated that Resident 20 was not on any formal program performed by the Restorative Aide. RA-E stated the resident was essentially independent in transferring self, moving in bed, and dressing self with only some supervisory input from staff. B. Record review of Resident 17's Admission Record revealed the resident was admitted to the facility on [DATE]. Record review of Resident 17 admission MDS assessment on 6/30/2020 revealed the resident was coded as having no range of motion difficulties and performed dressing activities and bed mobility with the assistance of one staff member. The MDS recorded the resident received formal Occupational Therapy on 5 of 7 days of the reference period for a total of 231 minutes and Physical Therapy on 2 of 7 days for a total of 60 minutes Interview with Resident 17 on 7/28/20 at 8:30 a.m. revealed the resident had been in the facility about a month. The resident was asked about exercise programs or therapy and the resident stated receiving formal physical and occupational therapy at the facility to increase her strength and abilities to perform self cares. The resident denied any formal range of motion program, bed mobility training, or dressing improvement activities provided by the nursing staff. Record review of Resident 17's Care plan with goal target dates of 10/11/20 revealed there was no restorative program developed on the care plan to identify individualized restorative interventions or goals for the resident related to a restorative program. Record review of Resident 17's medical record revealed no documentation outlining a restorative program with individualized interventions and goals, nor was there any licensed nurse review of a restorative program. Interview with RA-E on 7/29/20 at 10 a.m. RA-E stated that Resident 17 was not on any formal program performed by the Restorative Aide. RA-E stated the resident was working with Physical and Occupational Therapy. Record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (an regulatory instructional manual on how to accurately code MDS assessments) Version 1.16 from October of 2018 revealed the following regarding MDS coding pertaining to Restorative Nursing Programs: - The following criteria for restorative nursing programs must be met in order to code (section) O0500 (number of days a restorative program occurred.): Measurable objective and interventions must be documented in the care plan and in the medical record . Evidence of periodic evaluation by a licensed nurse must be present in the resident's medical record . A registered nurse or licensed practical (vocational) nurse must supervise the activities in a restorative nursing program . Interview with the DON (Director of Nursing); MDS Coordinator, RN (Registered Nurse)-D; RN-A, and the facility's corporate nurse consultant on 7/30/20 from 1:30 to 1:50 p.m. confirmed the criteria in the Resident Assessment Instrument manual to code Restorative Nursing Programs on MDS assessments for Residents 20 and 17 had not been met and that the item coding these residents received 7 days of a formal Restorative Nursing Program was incorrect. C. On 7/27/20 at 9:37 AM during an interview with Resident 19 a contracture was noted to the resident's right hand along with limited ROM (Range of Motion) on that side. The resident reported that no one performed ROM or did exercises with them on a routine basis. The resident also stated they did not believe they were receiving Hospice care (care designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure). Review of the Annual MDS assessment completed on 6/24/2020 showed that Resident 19 was on Hospice care and a Restorative Nursing program was in place for this resident which included ROM, bed mobility, and dressing seven days a week during the look back period. On 7/27/20 at 10:09 AM, an interview with the facility's DON revealed Resident 19 had not received Hospice care for as long as that nurse had worked in the building. On 7/29/20 at 9:15 AM, an interview with NA-E who was providing Restorative care revealed that this staff member had completed the Restorative program with Resident 19 at about 7:15 AM today due to a leg cramp. NA-E reported having provided ROM to arms, hands, and legs that morning but did not mention assisting the resident with bed mobility or dressing. On 7/29/20 at 2:15 PM, an interview with NA-F revealed that they had been instructed to chart 15 minutes for ROM, Dressing/Grooming, and Bed Mobility when completing NA charting. NA-F reported they were not sure if this should be done on days when the Restorative Aide was working but stated they did mark these services for any resident for whom the computer indicated it should be provided. NA-F was able to state that ROM differed for each individual but usually included moving extremities into more comfortable positions and stretching stiff or painful joints. NA-F stated that day shift was responsible to dress residents which might take more than 15 minutes and that bed mobility included repositioning and/or transfers. However, NA-F was not sure if there were specific things that should be done other than routine care for any specific residents. On 7/30/20 at 8:27 AM, an interview with RN-D who served as the facility's MDS coordinator verified that Resident 19 had not received Hospice care and that this represented an error in the MDS assessment. This error was corrected by RN-D at the time of the interview. On 7/30/20 at 8:37 AM, an interview with RN-D and the DON revealed that NA-E was scheduled to work in the facility 5 days per week and was trained to complete each resident's formal restorative program. Other NAs were trained to provide a Level 2 restorative program during care daily including encouraging resident to do as much as possible for themselves and performing ROM. On 7/30/20 at 8:40 AM, an interview with NA-E revealed they were not working on any residents' restorative programs that day as they had been assigned as the bath aid. NA-E could not identify whether anyone else was doing a formal restorative program that day and did not know if anyone else had been trained to provide a formal restorative program. On 7/30/20 at 10:50 AM, an interview with NA-G who verified they had signed that they had completed Restorative Bed Mobility, Dressing/Grooming, and Active ROM on multiple days including 7/15, 19, 20, and 24-27/2020 for Resident 19. NA-G reported they had been instructed to chart 15 minutes for each area and could identify that for ROM Resident 19 used a carrot (a carrot shaped object which can be inserted into the resident's hand to help stretch the hand to reduce contractures) for 30 minutes and the resident must move their own arms while putting on their shirt. NA-G stated that staff members must move the resident's legs while putting on their pants. For bed mobility, NA-G reported that Resident 19 was encouraged to use a partial rail on the bed to help when staff were repositioning the resident. NA-G verified that some of these things might not take 15 minutes every shift. On 7/30/20 at 1:30 PM, an interview with the DON and RN-D verified that a restorative program must follow RAI guidelines and was being coded incorrectly as much of the time being recorded was actually used to perform ADLs (Activities of Daily Living). Review of the Discharge Summary from PT (Physical Therapy) for Resident 19 showed that their discharge recommendations dated 4/20/2019 were for stretching and positioning with nursing to be done by the RNP (Restorative Nursing Program) while bed mobility was not applicable at the time of discharge. A more recent assessment by PT could not be found in resident's chart. D. On 7/27/20 at 11:48 AM during an initial interview, Resident 9 denied the use of a ventilator or respirator or other respiratory assistive device except O2 which the resident was using during the interview. Review of the Annual MDS assessment completed on 6/2/2020 for Resident 9 showed the use of a ventilator or respirator. On 7/30/20 at 8:27 AM, an interview with RN-D verified that Resident 9 did not use a ventilator or respirator as coded on last MDS this was as error in MDS coding. This error was corrected by RN-D at the time of the interview.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** Licensure Reference Number 175 NAC 12-006.09D7a Based on observations, interviews, and record review, the facility failed to ensure that the oxygen concentrator (a device that concentrates oxygen from the air by selectively removing the nitrogen to create an oxygen rich gas stream) was turned off when not in use for two sampled residents (Residents 2 and 13) to avoid increased risk of fire related to higher O2 (oxygen) concentrations in the residents' rooms. Facility census was 33. Sample size was 15. Findings are: On 7/27/20 at 2:45 PM while Resident 13 was in the dining room playing BINGO, observation showed the O2 concentrator in their room was running with the tubing is laying on the bed. On 7/28/20 at 9:45 AM while Resident 13

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) was in the dining room and had finished breakfast, observation showed the O2 concentrator was running in their room with the tubing laying on the bed as seen the day before. On 7/28/20 at 10:00 AM, Resident 13 was assisted to return to the room by RN (Registered Nurse)-A who left the resident in the wheelchair using portable O2 and did not turn off the concentrator. On 7/28/20 at 10:15 AM during an interview, Resident 13 reported that staff members must make the change between O2 concentrator and portable O2 for them as they cannot reach to do this themself and must use O2 at all times. The Quarterly MDS (Minimum Data Set, a federally mandated comprehensive assessment tool) assessment completed on 6/19/2020 showed that Resident 13 required extensive assist from two people with transfers. On 7/28/20 at 9:45 AM, observation showed Resident 2 sitting in a wheelchair using O2 from a portable tank while the tubing for the O2 concentrator was left hanging from a transfer pole with the concentrator running although the O2 was not being used at that time. On 7/29/20 at 12:27 PM, while Resident 2 was in the dining room for lunch, observation showed that the O2 tubing was left hanging from the bed and the O2 concentrator was running but was not in use. On 7/29/20 at 12:32 PM, observation and interview with the facility's DON (Director of Nursing) verified that the O2 concentrator was running when not in use. The DON verified the need to turn off the O2 concentrator when not in use and agreed that staff members would have assisted the resident to change from using O2 from the concentrator to using O2 from a portable tank. The Quarterly MDS (Minimum Data Set, a federally mandated comprehensive assessment tool) assessment completed on 5/1/2020 showed that Resident 2 required extensive assistance from two people when transferring between the bed and wheelchair.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number: 175 NAC 12-006.09D6 (7) Based on observation, record reviews, and interviews, the facility failed to ensure nursing staff members monitored and documented the use of [MEDICAL CONDITION] (Continuous Positive Airway Pressure, a mechanical device used to treat sleep apnea (periods of no breathing)) equipment for 2 sampled residents (Residents 86 and 17). Sample size included two current residents and one discharged resident. Facility census was 36. Findings are: A. Record review of Resident 86's Admission Record printed on 7/28/20 revealed the resident was admitted to the facility on [DATE]. Among the medical [DIAGNOSES REDACTED]. Interview with Resident 86's POA (Power of Attorney) on 7/28/20 from 3:00 p.m. to 3:15 p.m. revealed family concerns with the facility's monitoring of the resident's [MEDICAL CONDITION] machine. The POA stated the resident developed a fever and due to COVID 19 pandemic concerns the resident was transferred to a quarantined room. The POA stated on 4/30/20 the facility contacted the POA and reported the resident was unresponsive. The POA stated asking the nurse if the resident had been using the [MEDICAL CONDITION] machine at night since this was a similar symptom occurring while the resident was living at home and not using the machine. The staff reported the resident had not used the [MEDICAL CONDITION] since going into quarantine and stated they thought the machine was broken but would check. On 5/2 the facility again reported to the POA that the resident was unresponsive again and decisions were made to transfer the resident to the hospital. The POA reported the resident was admitted to the hospital with [REDACTED]. Record review of Resident 86's closed medical record revealed the following documents and documentation: - Documentation of hospital cardiology Progress Notes on 10/1/9 from the hospital prior to resident admission to the facility revealed the resident was diagnosed with [REDACTED]. - Review of an Inventory of Personal Effects document revealed on admission the resident possessed one [MEDICAL CONDITION] machine. - Review of the resident's Medication Administration Record [REDACTED]. - Review of the resident's care plan documents reviewed on admission 11/22/19, quarterly on 2/20/20, and quarterly on 5/3/20 revealed a Focus problem for: Respiratory: I have altered respiratory status breathing r/t (related to) obstructive sleep apnea and chronic [MEDICAL CONDITION] . Among the actions/interventions to address the problem were instructions initiated on 11/22/19 which read: [MEDICAL CONDITION] at night with 5L (five liters) of oxygen while sleeping. - Faxed communication form dated 2/18/2020 to a physician's assistant revealed the resident's oxygen saturations were good on oxygen at night on (his/her) [MEDICAL CONDITION] . - physician's orders [REDACTED]. One time only for [MEDICAL CONDITION] and lethargic. Electronic record review of facility Progress Notes revealed the following entries were documented regarding Resident 86's condition and [MEDICAL CONDITION] use: - 1/16/20 at 10:14 a.m. the entry recorded a call placed to a Home Care agency in reference to [MEDICAL CONDITION] mask not holding the seal. Advised by (name of staff) that a picture of the [MEDICAL CONDITION] mask needs to be mailed . in order to identify the mask currently being used so it can be sent down with next deliver. - 4/24/20- at 6 a.m. the entry recorded the resident recorded a temperature of 100 and was transferred to an isolation room to implement COVID-19 pandemic policies. Nothing was recorded in the notes regarding whether the [MEDICAL CONDITION] was moved with the resident's transfer. - 4/30/20- at 10 a.m. the entry recorded the resident became unresponsive and the oxygen saturation reading was 77%. Resident improved on oxygen at two liters. The resident tested negative for COVID and was transported back to the previous room out of isolation. The POA was called and suggested that the nonresponsive episodes are caused by resident not wearing [MEDICAL CONDITION] on a regular basis. [MEDICAL CONDITION] checked out and resident placed on it. Resident getting more color in face. [MEDICAL CONDITION] to be in place whenever resident is sleeping in recliner or bed. There was no documentation of [MEDICAL CONDITION] use between 4/24 and 4/30. -5/2/20- at 9:50 p.m. the staff alerted the resident had trouble awakening and the [MEDICAL CONDITION] is not working right. The resident was lethargic with oxygen saturations at 84%. The nurse assessed the connections on [MEDICAL CONDITION] and resident is on it correctly. Oxygen sats continued to drop. The provider was called with an order to send the resident to the emergency room . The POA was notified and agreeable to the transport. Interviews with the DON (Director of Nursing), RN (Registered Nurse)-A, RN-D, and the facility corporate nurse consultant on 7/30/20/20 from 1:30 to 1:50 p.m. confirmed Resident 86 was admitted to the facility with a [DIAGNOSES REDACTED]. The DON verified there were few notes in the progress notes identifying monitoring of the [MEDICAL CONDITION] and that the [MEDICAL CONDITION] was not routinely monitored and recorded on the Treatment or Medication record ensuring the licensed staff monitored to ensure the device was being used. The documentation did not support whether the [MEDICAL CONDITION] was in use or not in use during the time the resident was in isolation when the family reported concerns to facility staff to ensure the [MEDICAL CONDITION] was being utilized by the resident. B. Record review of Resident 17's Admission Record printed on 7/30/2020 revealed the resident was admitted to the facility on [DATE]. Observation of Resident 17's room on 7/27/20 at 2:15 p.m. revealed the resident had a [MEDICAL CONDITION] device atop a stand next to the resident's bed. Interview with Resident 17 on 7/27/20 at 2:16 p.m. confirmed the resident used the [MEDICAL CONDITION] device at night for obstructive sleep apnea. The resident reported this was a chronic condition and that the resident had used the device for a few years. Review of Resident 17's medical records revealed the following: - An admission MDS (Minimum Data Set, a federally mandated comprehensive assessment tool utilized to develop resident care plans) on 6/30/2020 revealed under Special Treatments the resident utilized oxygen and a [MEDICAL CONDITION] device during the previous 7 day look back period. - Review of a Medication Administration Record [REDACTED]. - Review of the resident's care plan with goals through 10/11/20 revealed nothing included in the care plan providing instructions and monitoring related to use of a [MEDICAL CONDITION] device at night. Interviews with the DON, RN-A, RN-D, and the facility corporate nurse consultant on 7/30/20/20 from 1:30 to 1:50 p.m. confirmed Resident 17 was admitted to the facility and utilized a [MEDICAL CONDITION] device at night for sleep apnea. The DON verified there was nothing in the resident's records verifying licensed staff were monitoring the device and ensuring the device was being utilized every night.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.12E1b Based on observation, interviews, and record review, the facility failed to ensure that a count of the narcotics stored in the drug destruction cabinet in the medication store room for one former resident (Resident 34) was made at each change of shift. Facility census was 33. Sample size was 15. Findings are: On 7/30/20 at 10:57 AM during a tour of the medication store room with LPN (Licensed Practical Nurse)-B, observation showed that narcotics waiting for destruction were kept locked in a second box inside the drug destruction cabinet. This section of the cabinet appeared to contain [MEDICATION NAME]es (an opioid pain medicine that is used to treat moderate to severe chronic pain), but LPN-B stated they did not open this area routinely so they would have to search for the key. When asked if these drugs were counted, LPN-B revealed that they did not count them On 7/30/20 at 11:21 AM during an interview with LPN-B and the facility's DON (Director of Nursing) regarding counting narcotics in the drug destruction cabinet, both verified that the check sheet kept in the narcotic count book simply asked whether the lock was present and no count sheets

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F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) for those drugs were located in the narcotic count book. LPN-B verified that no count of the medications in the drug destruction cabinet was made routinely during their shift changes. The DON used the keys being carried by LPN-B as charge nurse to open the lower locked cabinet. The cabinet contained a total of seven [MEDICATION NAME] 12mcg patches for Resident 34 as well as the narcotic count sheets for these medications. There was no evidence that these drugs had been counted since being placed in the drug destruction cabinet. Both the DON and LPN-B verified that narcotics should be counted at every change of shift. Review of the facility's Controlled Substances Policy Statement showed that nursing staff must count controlled medication at the end of each shift with instructions that the nurse coming on duty and the nurse going off duty must make the count together.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC ,[DATE].12E1 Based on observation and interview the facility failed to discard medicated eye drops for one non-sampled resident (Resident 14) in a timely way to ensure efficacy. Facility census was 33. Sample size was 15. Findings are: On [DATE] at 10:57 AM. observation of the medication cart for the 100 and 200 halls with LPN (Licensed Practical Nurse)-B who was working as the charge nurse that day revealed a bottle of [MEDICATION NAME] (a nonsteroidal anti-[MEDICAL CONDITION] drug used to treat moderately severe pain and inflammation) 0.5% eye drops for Resident 14 with a date showing it was opened [DATE]. A second unopened bottle was also seen in the medication cart. When asked about when this medication should be discarded, LPN-B referenced a chart in the narcotic count book but this medication was not listed. LPN-B then asked another nurse to contact the pharmacy regarding how long [MEDICATION NAME] should be used after opening. On [DATE] at 1:36 PM, a follow-up interview with LPN-B revealed that the pharmacy had instructed that [MEDICATION NAME] should be discarded 30 days after opening. LPN-B verified that the bottle opened on [DATE] was expired and had been discarded at that time. LPN-B further verified that the resident was currently using that medication and that another bottle was available in the medication cart.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Licensure Reference Number 175 NAC 12-006.17B Based on observations and interviews the facility failed to 1) correctly store O2 (oxygen) tubing to prevent possible cross-contamination for two sampled residents (Residents 2 and 9) and 2) correctly store a urinal to prevent possible cross-contamination for one sampled resident (Resident 2). Facility census was 33. Sample size was 15. Findings are: A. On 7/27/20 at 9:17 AM, observation showed the tubing on the portable O2 tank for Resident 2 was hanging from the tank and was not covered or contained to prevent possible cross-contamination. On 7/27/20 at 10:46 AM, observation showed the tubing for portable O2 for Resident 9 was hanging from the tank and was not covered or contained to prevent possible cross-contamination. On 7/28/20 at 8:22 AM, observation again showed the tubing for Resident 9's portable O2 was draped across their walker and was not covered or contained. On 7/28/20 at 9:45 AM, the tubing from the O2 concentrator (a device that concentrates oxygen from the air by selectively removing the nitrogen to create an oxygen rich gas stream) was seen hanging from the transfer pole and was not covered or contained when the resident was using a portable tank while sitting in a wheelchair. On 7/29/20 at 7:58 AM, observation showed that the portable O2 tubing for Resident 9 was stretched across the resident's walker and was not covered or contained. On 7/29/20 at 12:27 PM, observation of the O2 tubing for Resident 2 showed it was left hanging from the bed and not placed in the bag attached to the concentrator to prevent possible cross- contamination. On 7/29/20 at 12:32 PM, observation and interview with the facility's DON (Director of Nursing) verified that the O2 tubing from Resident 2's concentrator was left hanging and had not been stored in the bag on the side of the concentrator which had been provided to store tubing when not in use to prevent possible cross-contamination. On 7/29/20 at 2:33 PM, observation and interview with the DON verified that the tubing for the portable O2 tank used by Resident 9 was draped across the walker and was not stored in the bag hanging from the walker which was provided to store the tubing when not in use to prevent possible cross-contamination. B. On 7/27/20 at 10:33 AM, observation showed a urinal hanging in a trashcan next to Resident 2 which contained urine. On 7/27/20 at 12:45 PM, observation found that the urinal remains in the trashcan with urine in it. On 7/27/202 at 2:45 PM, an interview with NA-C revealed that Resident 2 was able to use the urinal independently but needed staff to empty it. On 7/29/20 at 8:59 AM, observation showed a urinal with urine in it is in trashcan next to Resident 2's bed. Resident 2 stated this was where they liked to keep it so they could reach the urinal if necessary. The resident also verified that staff were responsible to empty the urinal. On 7/29/20 at 10:55 AM, the urinal remained in trash can with urine in it as seen earlier. On 7/29/20 at 12:32 PM, observation and interview with the DON verified that the urinal for Resident 2 was being stored in the trash can and that it should be emptied frequently and not be stored with trash to prevent possible cross-contamination. Review of the Quarterly MDS (Minimum Data Set, a federally mandated comprehensive assessment tool) assessment completed on 5/1/2020 showed that Resident 2 required extensive assistance from two people with activities of daily living including toileting. Review of the Annual MDS assessment completed on 6/2/2020 showed that Resident 9 required supervision and set up help with activities of daily living including transfers and mobility.
F 0908 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Keep all essential equipment working safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number: 175 NAC 12-006.18B3 Based on observation, record reviews, and interview, the facility failed to ensure one of two resident transport vans was maintained to: 1) ensure the vehicle's muffler was connected to the exhaust; and 2) ensure brakes on the vehicle were inspected and repaired. The failure could potentially affect resident's being transported to appointments and/or activities in the facility van. Facility census was 36. Findings are: An interview with a source requesting anonymity and requested that the date and time of interview not be recorded revealed concerns with the facility van identified as a 2005 Dodge [MEDICATION NAME] license plate identifier # . The source described knowledge that residents have been transported in the van over the past month and that the van's brakes grind and squeal horribly. In addition, the muffler to the van had been dislodged from the exhaust system. The source reported these problems have been present for the past few months and reported to Administration and they have yet to be repaired. Interviews with staff members who verified transporting residents in the 2005 Dodge [MEDICATION NAME] license # revealed the following: - 7/27/20 at 10:20 a.m. Med Aide-I reported the van had squeaky grinding brakes when stepping on them. Med Aide-I reported the muffler had been dislodged from the exhaust for sometime. Med Aide-I stated the concerns were reported to Administration but could not say when. Med Aide-I stated the employee had not documented the failure in the maintenance log. - 7/27/20 at 10:45 a.m. Med Aide-H reported the van had squeaky grinding brakes when stepping on them. Med Aide-H reported the muffler had been dislodged from the exhaust for sometime. Med Aide-H stated the concerns were reported to Administration but could not say when. Med Aide-H stated the employee had not documented the failure in the maintenance log. - 7/28/20 at 10:15- Med Aide-J reported the van had squeaky grinding brakes when stepping on them. Med Aide-J reported the muffler had been dislodged from the exhaust for sometime. Med Aide-J stated the concerns were reported to Administration but could not say when. Med Aide-J stated the employee had not documented the failure in the maintenance log. An observational inspection of the Dodge [MEDICATION NAME] license # was done with the Administrator on 7/30/2020 beginning at 9:15 a.m. The inspection included a drive around the block of the facility. The Administrator verified the muffler to the van was dislodged from the exhaust system and hanging loose. The Administrator stated having knowledge of this disrepair but had not scheduled an appointment to have the muffler repaired. As the Administrator backed the vehicle out of the parking lot, the brakes emitted a loud grinding and squeaking sound acknowledged by the Administrator. The brakes continued to grind and squeak when activated during the trip around the block. The Administrator verified the brakes needed inspection and repair. Record review of an invoice dated 11/7/19 revealed the 2005 Dodge [MEDICATION NAME] received routine maintenance and this was the last time the vehicle was inspected by a mechanic. Record review of facility maintenance logs revealed none of the staff members who identified issues with the brakes and muffler on the 2005 Dodge [MEDICATION NAME] license # had recorded their concerns in the maintenance log. Record review of transportation logs for the previous 30 days revealed 7 residents were transported for a total of 9 trips between 6/25/20 and 7/24/20. These residents were identified as Residents 16, 34, 12, 8, 35, 3, and 31. There was no record identifying which van any of these

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285224	A. BUILDING _____ B. WING _____	**07/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SKYVIEW CARE AND REHAB AT BRIDGEPORT	**505 O STREET BRIDGEPORT, NE 69336**

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 0908 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) residents were transported in. Review of the records revealed five of the transports were to a facility with round trip mileage of approximately 70 miles while the other four trips were locally to the local hospital. Interview with the Administrator on 7/30/2020 at 9:25 a.m. revealed the Administrator did not recall anyone reporting issues with the 2005 Dodge van. The Administrator verified issues pertaining to maintenance were to be documented in the maintenance log by staff as they occur and verified this had not been done. The Administrator acknowledged the 2005 Dodge [MEDICATION NAME] needed to be taken in for repair of the muffler and brakes.