STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285159	A. BUILDING _____ B. WING _____	**03/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PLUM CREEK CARE CENTER	**1505 NORTH ADAMS STREET LEXINGTON, NE 68850**

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F 0561 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** Licensure Reference Number 175NAC 12-006.05(4) Based on record review and interview the facility failed to ensure that the bathing preference for number of baths per week was followed for 1 resident (Resident 24). The facility census was 33. Findings are: Interview with Resident 24 on 3/10/20 at 1:23 PM confirmed that the resident preference was to receive 3 baths per week and that the resident had not been receiving 3 baths per week. Record review of the care plan (a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) revealed that the resident needed extensive assist with bathing and that the resident takes a shower 3 times a week. Record review of the task care record for January 2020 for Resident 24 revealed that the resident received no baths between 1/1/20 and 1/7/20. Record review of the task care record for February 2020 for Resident 24 revealed that the resident received no baths between 2/12/20 and 2/29/20. Interview on 3/10/20 at 1:37 PM with the facility Minimum Data Set Assessment Coordinator (MDSC) (a nurse responsible for using the mandatory comprehensive assessment tool to provide for resident care planning) confirmed that the care plan for Resident 24 documented the resident's preference was to have 3 baths per week. The MDSC confirmed that the review of the bathing task record for January 2020 revealed that Resident 24 received no baths between 1/1/20 and 1/7/20. The MDSC confirmed that the review of the bathing task record for February 2020 for Resident 24 revealed that the resident received no baths between 2/11/20 and 2/29/20. The MDSC confirmed that this did not meet the resident preference of 3 baths per week.
F 0657 **Level of harm** - Minimal harm or potential for actual 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 12-006.09C1c Based on observations, interviews, and record reviews; the facility failed to review and revise the care plan (a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) for a resident with a respiratory condition and precautions for RSV (Respiratory Syncytial (sin-SISH-uhl) Virus (a common respiratory virus that usually causes mild, cold-like symptoms. Most people recover in a week or two, but RSV can be serious, especially for infants and older adults) for 1 resident (Resident 32); failed to revise the resident care plan to include the nursing restorative program (person-centered nursing care and exercises designed to improve or maintain the functional ability of residents, so they can achieve their highest level of well-being possible) for 1 resident (Resident 24); and failed to revise the resident care plan to remove the nursing restorative program for 1 resident (Resident 2). This affected 3 of 18 sampled residents. The facility identified a census of 33 at the time of survey. Findings are: A. Review of Resident 32's annual MDS (Minimum Data Set-a comprehensive assessment tool used to develop a resident's care plan) dated 2/20/2020 revealed an admission date of [DATE]. Resident 32 had a BIMS (Brief Interview for Mental Status) score of 13 which indicated Resident 32 was cognitively intact. Resident 32 required extensive assistance of 2 staff for bed mobility, transfer, locomotion, dressing, and toilet use. Interview with Resident 32 on 03/04/20 at 1:47 PM revealed they were in isolation for a contagious lung infection. Observation of Resident 32's room on 3/05/20 at 10:51 AM revealed the door was closed. PPE (Personal Protective Equipment-gowns, gloves, face masks, shoe covers worn to protect the wearer from potential infection) was observed on a cart outside the room door. There was a sign on the door for visitors to check at the nurses' station before entering the room. Review of Resident 32's Progress Notes dated [DATE] at 18:25 (6:25 PM) revealed the following: Physician Visit Note Text: Res (Resident) returned from the doctor with order for Z-pak (antibiotic), respiratory isolation for 7-10 days. Dr. stated res has RSV [MEDICAL CONDITION]. Res (Resident) in room (with) meal tray. Review of Resident 32's Care Plan dated [DATE] revealed no documentation of interventions for the respiratory condition or precautions to prevent transmission. Interview with the DON (Director of Nursing) on 3/10/20 at 9:07 AM confirmed Resident 32's care plan had no documentation of interventions for the respiratory condition, isolation or infection. The DON reviewed the care plan and confirmed the interventions were not on the care plan and they should have been. Review of the facility policy Care Planning with a revision date of (NAME)2019 revealed the following: After the care conference, if there are any revisions needed, they are made in the EHR (Electronic Health Record) care plan. Care plans should be updated between care conferences to reflect current care needs of the individual resident as changes occur. Interview with MA-E (Medication Aide) on 3/10/20 at 10:19 AM revealed they got the information they needed to care for the residents from the Care Plan. B. Interview on 3/09/20 at 12:03 PM with Resident 24 in the dining room revealed that the resident recently completed occupational therapy (therapy to enable people to participate in the activities of everyday life) and that nursing staff received instructions to provide restorative nursing exercises (person-centered nursing care designed to improve or maintain the functional ability of residents, so that they can achieve their highest level of well-being possible) to the resident. Resident 24 revealed that the restorative nursing exercises had not been provided by staff. Interview on 3/10/20 at 9:52 AM with Certified Occupational Therapy Assistant G (COTA-G) revealed that occupational therapy worked with Resident 24 recently. COTA-G revealed that upon discharge from therapy a Rehabilitation Restorative Care Plan (written recommendations from therapy provided to nursing for a nursing restorative program) for Resident 24 was provided to the Director of Nursing (DON) for implementation by the nursing restorative aide. Record review of the Rehabilitation Restorative Care Plan for Resident 24 revealed the written recommendations for the nursing restorative program exercises of the resident's arms and legs for coordination and functional capacity 5 times a week. The goals written on the plan were to maintain strength and activity tolerance for the resident. Record review of the facility policy titled Restorative Nursing Program Policy dated May 2019 revealed Step 7. Each resident who participates in the Restorative nursing program will have an individual program with individual goals, these goals and interventions will be stated in the resident's plan of care. Step 8. Measureable objectives and interventions must be documented in the resident's care plan and medical record. Evidence of periodic evaluation by the licensed nurse must be present in the medical record. Record review of the care plan (a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) for Resident 24 revealed that the care plan did not contain the section for the restorative nursing exercises program. Interview on 3/10/20 at 11:35 AM with the facility Minimum Data Set Assessment Coordinator (MDSC) (a nurse responsible for using the mandatory comprehensive assessment tool to provide for resident care planning) confirmed that the care plan for Resident 24 did not contain a care plan section for the recommended nursing restorative program. The MDSC confirmed that

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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) the care plan should have been updated to include the restorative nursing program and interventions. C. Record review of the care plan for Resident 2 revealed the care plan (a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) intervention to continue working with restorative therapy for active range of motion (AROM) (the resident performs the exercise without assistance from another body part, person or device) and passive range of motion (PROM) (staff physically moves or stretches a part of the body) of both upper and lower extremities (arms and legs) initiated on 9/13/16. Interview on 3/09/20 at 12:02 PM with Resident 2 outside of the facility dining room revealed that the resident did not participate in a restorative exercise program. Interview on 3/10/20 at 10:01 AM with the facility MDSC confirmed that Resident 2 was not on a restorative program. Record review of the facility policy titled Care Planning dated (NAME)2019 revealed Step 10. Care plans should be updated between care conferences to reflect the current care needs of the individual resident as changes occur. Interview on 3/10/20 at 11:35 AM with the facility Minimum Data Set Assessment Coordinator (MDSC) (a nurse responsible for using the mandatory comprehensive assessment tool to provide for resident care planning) confirmed that the care plan for Resident 2 contained an intervention for continued working with restorative therapy for active range of motion and passive range of motion of both upper and lower arms and legs initiated on 9/13/16 and that the resident was not receiving restorative therapy. The MDSC confirmed that the care plan should have been updated to remove the restorative therapy intervention from the care plan.
F 0676 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09D1b Based on observation, interview and record review; the facility staff failed to implement a restorative program based on therapy recommendations after therapy services ended for 2 residents (Residents 5 and 24). This affected 2 of 3 sampled residents. The facility identified a census of 33 at the time of survey. Findings are: A. Review of Resident 5's Admission MDS (Minimum Data Set-a comprehensive assessment tool used to develop a resident's care plan) dated 12/12/2019 revealed an admission date of [DATE]. Resident 5 had a BIMS (Brief Interview for Mental Status) score of 15 which indicated Resident 5 was cognitively intact. Resident 5 required extensive assistance of 2 staff for bed mobility, transfer, and toilet use. Walking in room and corridor did not occur. Resident 5 required limited assistance of 1 staff for locomotion on the unit and extensive assistance of 1 staff person for personal hygiene and bathing. Interview with Resident 5 on 3/04/20 at 11:19 AM revealed they had reached their limit (no longer qualified) with therapy so they were no longer receiving therapy services. Resident 5 revealed they were not offered a nursing restorative program. Resident 5 revealed they had been living at the assisted living and able to care for themselves there prior to moving to the skilled facility. Resident 5 revealed the staff had to use a sit to stand lift to transfer Resident 5. Observation of Resident 5 on 3/05/20 at 2:00 PM revealed they were in a wheelchair wheeling themselves down the hall. Observation of Resident 5 on 3/09/20 at 10:40 AM revealed NA-H (Nurse Aide) and NA-I used the sit to stand lift to assist Resident 5 to stand up and transfer into the bathroom. Review of Resident 5's Care Plan dated 12/5/2019 revealed a goal of I want to be able to meet Assisted Living Requirements. Staff will assist me to gain back my independence. Therapy services as ordered to assist me in reaching my highest practicable level. Review of Resident 5's Therapy Discharge Notice dated 1/14/2020 revealed the following: D/C (discontinue) secondary to limited progress d/t (due to) left shoulder injury. Last date of therapy services for PT (Physical Therapy) and OT (Occupational Therapy) was 1/16/2020. Review of Resident 5's Medical Record revealed no documentation Resident 5 was receiving nursing restorative services. Interview with the DON (Director of Nursing) on 3/05/20 at 3:19 PM confirmed Resident 5 was not receiving any nursing restorative services. Interview with the DON on 3/10/20 at 9:07 AM revealed the procedure to set up residents for a restorative program after Medicare A services ended was to set up as a task PRN (on an as needed basis). The DON revealed the facility did not have a formal nursing restorative program. Interview with COTA-G (Certified Occupational Therapy Assistant) on 3/10/20 at 9:51 AM revealed they had to discontinue Resident 5's Medicare A therapy services as they no longer qualified to receive the skilled services because Resident 5 was waiting for shoulder replacement surgery. COTA-G revealed Resident 5 had a bad shoulder and they could not do a push up out of the wheelchair to stand due to shoulder pain. COTA-G revealed therapy staff were going to re-start skilled therapy services after Resident 5 had their shoulder replacement surgery. COTA-G revealed they did make some nursing restorative recommendations for Resident 5 to continue after the skilled therapy services ended. Review of the Restorative Care Plan received from COTA-G revealed the following recommendations: Bilateral lower extremity exercises in all planes, kicks, marches, etc. Squeezes with ball between knees. Frequency: 5 times a week 2 set of 20 reps (repetitions). Goals: Maintain strength needed for sit to stand lift. Interview with MA-E (Medication Aide), identified as the restorative aide on 3/10/20 at 10:19 AM revealed if a resident was receiving nursing restorative care it would be documented under the PRN (as needed) on the electronic health record. MA-E revealed they tried to complete nursing restorative care when they could. Review of the facility policy Restorative Nursing Program Policy with a revision date of May 2019 revealed the following: Restorative nursing program refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. Restorative nursing actively focuses on achieving and maintaining optimal physical, mental and psychosocial well-being. Generally restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech therapy. Restorative nursing includes but is not limited to skill practice in walking, dressing, grooming, eating, swallowing, transferring, amputation care, splint care, communication, PROM/AROM (Passive Range of Motion/Active Range of Motion), scheduled toileting, bladder training, or bed mobility. Residents who have completed a formal therapy program will be assessed for a restorative program or when a significant change in condition warrants. B. Record review of the facility policy titled Restorative Nursing Program Policy dated May 2019 revealed that restorative nursing program refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. Restorative nursing actively focuses on achieving and maintaining optimal physical, mental and psychosocial well-being. Generally restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech therapy. Interview on 3/09/20 at 11:47 AM with physical therapy assistant J (PTA-J) revealed that therapies were not currently working with Resident 24. PTA-J revealed that Resident 24 was on occupational therapy (therapy to enable people to participate in the activities of everyday life) but had been discharged . PTA-J revealed that therapies do not perform any restorative exercises with residents and that restorative exercises are performed by the nursing staff. Interview on 3/09/20 at 3:31 PM with Nursing Assistant C (NA-C) revealed that the nursing assistant does not perform restorative exercises for residents. NA-C revealed that therapy does range of motion exercises with residents. Interview on 3/09/20 at 12:03 PM with Resident 24 in the dining room revealed that the resident recently completed occupational therapy and that the nursing staff received instructions to provide restorative nursing exercises (person-centered nursing care designed to improve or maintain the functional ability of residents, so that they can achieve their highest level of well-being possible) to the resident. Resident 24 revealed that the restorative nursing exercises had not been provided by staff. Interview on 3/10/20 at 9:52 AM with Certified Occupational Therapy Assistant G (COTA-G) revealed that occupational therapy worked with Resident 24 recently. COTA-G revealed that upon discharge from therapy a Rehabilitation Restorative Care Plan (written recommendations provided to nursing for a nursing restorative program) for Resident 24 was provided to the Director of Nursing (DON) for implementation by the nursing restorative aide. COTA-G revealed that the nursing staff do not have time to do the restorative therapy with residents. Record review of the Rehabilitation Restorative Care Plan for Resident 24 revealed the written recommendations for the nursing restorative program exercises of the resident's arms, shoulders, and legs for coordination and functional capacity 5 times a week. The goals written on the plan were to maintain strength and activity tolerance for the resident. Record review of the task care record for (NAME)2020 for Resident 24 revealed that the task record contained a task directing nursing staff to perform the restorative exercises for the resident. The task record contained no documentation that the restorative exercises were provided to Resident 24. Interview on 3/10/20 at 12:09 PM with the facility Director of Nursing (DON) confirmed that all nursing staff had been trained on performing restorative nursing exercises. The DON revealed that there currently was not a specific restorative aide for the facility. Interview on 3/10/20 at 1:23 PM with Resident 24 confirmed that the resident desired to have the restorative exercises and that the staff did not do them as they state they do not have the time. Interview on 3/10/20 at 11:35 AM with the facility Minimum Data Set Assessment Coordinator (MDSC) (a

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F 0676 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) nurse responsible for using the mandatory comprehensive assessment tool to provide for resident care planning) confirmed that the task care record for Resident 24 contained the task for the performance of the nursing restorative program for Resident 24 and that the task had not been performed by staff.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** Licensure Reference Number 175NAC 12-006.09D2 Based on observation, record review, and interview the facility failed to ensure that documentation of assessments and monitoring of skin conditions were completed in the resident medical record to ensure wound healing for 1 resident (Resident 2). The facility census was 33. Findings are: Record review of the facility policy titled Skin Program Policy dated (NAME)2019 revealed Step 6. When a bruise or skin tear are noted, a thorough assessment or a comprehensive wound assessment sheet should be completed and documented in a progress note. These areas will be monitored on the Treatment Administration Record (TAR) (a legal record of the administration of scheduled treatments or performance of other scheduled medical tasks for a resident by a health care professional such as a licensed nurse) until healed. Step 8. Completed comprehensive skin assessments and record of any resident training will be placed in the medical record. Interview on 3/10/20 at 8:41 AM with the facility Director of Nursing (DON) revealed that for non-pressure skin condition wounds (scratches, scrapes, skin tears, cuts, bruises, burns, rashes on the skin not caused by prolonged pressure against the skin) identified on the resident's skin, the expectation is for staff to follow the policy titled Skin Program Policy. Upon identification of a non-pressure skin condition wound the nurse would assess the wound. The nurse would then be expected to notify the physician (usually by fax). The nurse would document the findings of the initial wound assessment into a progress note in the medical record. The nurse would add the skin condition wound to the Treatment and Administration Record (TAR) for scheduled monitoring until the wound is healed. The nurse would be expected to document the findings of the wound monitoring in a progress note. The DON revealed that the facility had room to improve wound documentation and monitoring. Observation on 3/05/20 at 11:29 AM revealed that Resident 2 was seated in the motorized wheelchair in the resident's room. Multiple scattered horizontal scratches were noted on the left forearm and the left upper arm of Resident 2. The resident revealed that the scratches were from the resident's wrist watch. Interview on 3/05/20 at 1:32 PM with Nursing Assistant I (NA-I) revealed that Resident 2 had scratches present on the resident's left arm and that the resident often scratched at the resident's arms. Record review of the progress notes for the past year in the medical record for Resident 2 revealed no progress note identifying the scratches on the resident's left arm. Record review of the TAR for December 2019, January 2020, February 2020, and (NAME)2020 for Resident 2 revealed that no TAR entry was present to perform monitoring of the scratches on the resident's left arm. 03/10/20 11:04 AM Interview with the DON confirmed that no progress notes were in the medical record for the scratches on the upper and lower left arm of Resident 2 and that progress notes should have been made as well as a TAR entry for weekly monitoring of the scratches until healed.
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 12-006.09D2b Based on observation, interview, and record review; the facility staff failed to perform pressure ulcer care to prevent cross contamination, potential infection and promote healing for Resident 10. This affected 1 of 3 sampled residents. The facility identified a census of 33 at the time of survey. Findings are: Review of Resident 10's annual MDS (Minimum Data Set-a comprehensive assessment tool used to develop a resident's care plan) dated 1/13/2020 revealed an admission date of [DATE]. Resident 10 had no BIMS (Brief Interview for Mental Status) score as Resident 10 was rarely/never understood. Staff assessment for mental status indicated Resident 10 had short term and long term memory problems and severely impaired cognitive skills for decision making. Resident 10 required extensive assistive of 2 staff for dressing and bed mobility and was dependent upon 2 staff for transfer, toilet use, and personal hygiene. Resident 10 had 1 Stage 4 (Full thickness tissue loss with exposed bone, tendon or muscle) pressure ulcer present at admission. Review of Resident 10's Weekly Wound Form dated 12/3/2019 revealed Resident 10 had a Stage IV pressure ulcer to the coccyx (tailbone) measuring 4 cm (centimeters) wide by 5.5 cm long by 1.8 cm deep. Review of Resident 10's Weekly Wound Form dated 3/4/2020 revealed Resident 10 had a Stage IV pressure ulcer to the coccyx that measured 3.2 cm wide by 3.8 cm long by 1.6 cm deep. Observation of Resident 10 on 3/05/20 at 2:20 PM revealed LPN-D (Licensed Practical Nurse) completed a dressing change for Resident 10's pressure ulcer with the assistance of MA-F (Medication Aide). Both LPN-D and MA-F washed hands. MA-F donned gloves. LPN-D put a hand towel on a table. LPN-D then put a pile of gloves on the towel and laid out 3 packages of gauze sponges, a Maxsorb II (silver alginate) dressing, an adhesive bordered gauze dressing, and a collagen (protein) powder. MA-F got behind the bed after LPN-D put the bed up by handling the bed control as Resident 10 was lying in the bed. LPN-D donned gloves and removed the old dressing. Resident 10 had a deep open area on the coccyx. LPN-D removed the gloves, used hand sanitizer for hand hygiene then opened the dressing packages. LPN-D cleaned the scissors with an alcohol wipe. LPN-D picked up the Maxsorb dressing with their bare hands and handled both sides of the dressing. LPN-D then cut the dressing with the scissors then laid the dressing on the towel. LPN-D then opened 2 packages of gauze sponges and squirted saline (solution) into them then laid the packages on the towel. LPN-D then washed their hands and donned clean gloves. LPN-D cleaned the wound bed with the wet gauze sponges then cleaned the perimeter (outside edge) of the wound. LPN-D then applied skin prep (liquid skin adhesive) to the perimeter of the wound. LPN-D then packed the wound with the collagen powder using the same gloved hands. LPN-D poured the collagen powder onto a gloved hand and pushed it directly into the wound. LPN-D then picked up the Maxsorb dressing they had handled with their bare hands and covered the wound with it then applied the adhesive bordered gauze over the Maxsorb dressing. LPN-D then removed the gloves and did not perform any hand hygiene. LPN-D then took a pen out of their pocket and marked the dressing with the pen and put the pen back in their pocket. LPN-D did not do any hand hygiene or clean the pen. LPN-D then fastened Resident 10's brief. Review of Resident 10's Care Plan dated 10/3/2018 revealed Resident 10 had a pressure wound to the coccyx with a goal of I want my wound to continue to heal. Team to complete treatments as ordered. Interview with the DON (Director of Nursing) on 3/10/20 at 9:07 AM revealed it was their expectation that the nurse should have changed gloves and performed hand hygiene when they removed the dressing and after cleaning the wound before applying the clean dressing. If staff were applying a dressing on a wound they were not allowed to handle it with their bare hands. They should have donned clean gloves to handle the dressings. Review of the facility policy Dressings Clean/Aseptic with a revision date of (NAME)2019 revealed the following: The purpose of this procedure is to provide guidelines for the application of dry, clean dressings. Wash hands. Put on clean gloves remove soiled dressing(s). Remove gloves and discard .wash hands or use alcohol gel. Put on clean gloves. Open dry, clean dressings by pulling corners of the exterior wrapping outward, touching only the exterior surface. Pour prescribed cleansing solution on the dry, clean gauze if used. Cleanse the wound .clean from the least contaminated area to the most contaminated area. If gauze or other permeable material is used to clean the wound, remove gloves, perform hand hygiene and put on a new pair of non-sterile gloves. Apply the ordered dressing and secure with non-[MEDICATION NAME] tape or adhesive. Remove gloves and discard in bag. Wash hands.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** Licensure Reference Number 175NAC 12-006.09D4 Based on observation, record review, and interview the facility failed to ensure that the risks and benefits of contracture management (the provision of physical therapy, occupational therapy, or restorative nursing therapy to increase the range of motion and strengthen the muscles and/or the use of a splint or other device to prevent the continued decrease of function of a contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints that prevents normal movement of a joint or other body part that can be caused by not using the muscles)) were provided to 1 resident (Resident 2). The facility census was 33. Findings are: Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) for Resident 2 dated 12/17/19 revealed that the resident had a Brief Interview for Mental Status (BIMS) (a brief screening tool that aids in detecting cognitive impairment) score of 15 indicating that Resident 2 was cognitively intact. BIMS scores range from 0 (severely impaired cognition) to 15 (intact cognition). Observation on 3/05/20 at 11:29

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F 0688 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) AM revealed that Resident 2 was seated in the motorized wheelchair in the resident's room. The resident's right hand was bent at the wrist with the fingers curled tightly into the palm of the hand (contracture). Interview on 3/05/20 at 11:29 AM with Resident 2 confirmed that the use of the resident's right arm was limited due to a previous illness that affected the resident's brain. The resident confirmed that the right wrist contracture was a result of the limited use of the right arm. Record review of the progress notes in the medical record for Resident 2 revealed that no documented discussion of contracture management risks and benefits was provided to Resident 2. Interview on 3/10/20 10:01 AM with the facility Minimum Data Set Assessment Coordinator (MDSC) (a nurse responsible for using the MDS to provide for resident care planning) confirmed that Resident 2 had a contracture of the right wrist and hand that was present upon admission to the facility. The MDSC confirmed that the contracture was not on the care plan for Resident 2 and that the contracture should have been on the care plan with any interventions to prevent further increase of the contracture. The MDSC revealed that no documentation of any physician or facility discussions on contracture management with Resident 2 was found in Resident 2's medical record. Interview on 3/10/20 at 1:18 PM with Resident 2 revealed that the facility staff had not discussed contracture management with the resident until this morning. Resident 2 revealed that the resident was not sure what the benefits of contracture management may be.

F 0755

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

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 12-006.12A Based on observation, interview, and record review; the facility staff failed to administer medications within the scheduled time frame for 28 of 33 residents (Residents 21, 29, 30, 3, 7, 20, 15, 22, 34, 5, 6, 16, 13, 27, 12, 14, 9, 17, 10, 26, 31, 11, 23, 24, 184, 2, 32, and 28). The facility identified a census of 33 at the time of survey. Findings are: A. Observation of RN-A (Registered Nurse) on 3/05/20 at 11:49 AM revealed RN-A administered carvedelol 6.25 mg (milligrams) and [MEDICATION NAME] 20 mg to Resident 23. Review of the facility Medication Audit Report dated 3/5/2020 revealed Resident 23's carvedelol 6.25 mg and [MEDICATION NAME] 20 mg Schedule Date was 10:00 AM and the Administration Time was 11:49 AM which indicated they were administered 1 hour and 49 minutes after their scheduled time to be administered. Review of Resident 23's MAR (Medication Administration Record) for (NAME)2020 revealed the carvedelol and [MEDICATION NAME] medications were scheduled to be administered at 10:00 AM and again at 8:00 PM. B. Observation of RN-A on 3/5/20 at 12:40 PM revealed they administered Resident 184 [MEDICATION NAME] 25 mg and [MEDICATION NAME] 30 mg 1 inhalation. Review of the facility Medication Audit Report dated 3/5/2020 revealed Resident 184's [MEDICATION NAME] and [MEDICATION NAME] Schedule Date was 10:00 AM and the Administration Time was 12:40 PM which indicated they were administered 2 hours and 40 minutes after their scheduled time to be administered. Review of Resident 184's MAR for (NAME)2020 revealed the administration time on the MAR indicated [REDACTED]. C. Observation of LPN-D on 3/05/20 at 12:45 PM revealed they administered 2 units of [MEDICATION NAME]subcutaneous to Resident 27. Review of the facility Medication Audit Report dated 3/5/2020 revealed Resident 27's [MEDICATION NAME] Schedule Date was 11:30 AM and the Administration Time was 12:45 PM which indicated it was administered 1 hour and 15 minutes after the scheduled time to be administered. Review of Resident 27's MAR for (NAME)2020 revealed the administration time on the MAR indicated [REDACTED]. D. Observation of LPN-D on 3/05/20 at 12:50 PM revealed LPN-D administered 17 units of [MED] [MED] subcutaneous to Resident 23. Review of the facility Medication Audit Report dated 3/5/2020 revealed Resident 17's [MED] Schedule Date was 11:30 AM and the Administration Time was 12:50 PM which indicated it was administered 1 hour and 20 minutes after the scheduled time to be administered. Review of Resident 17's MAR for (NAME)2020 revealed the administration time on the MAR for the [MED] was 11:30 AM which indicated the [MED] [MED] was administered 1 hours and 20 minutes after the scheduled administration time. E. Observation of MA-E (Medication Aide) on 3/09/20 at 11:27 AM revealed they administered [MEDICATION NAME] 1 capsule, [MEDICATION NAME] 125 mcg QD (every day), [MEDICATION NAME] 1 drop both eyes BID (twice a day), FeSO4 325 mg 1 PO QD, [MEDICATION NAME] 50 mg BID, [MEDICATION NAME] 17 GM (grams), Multivitamin 1 tablet, Pantoprazole 40 mg BID, and [MEDICATION NAME] 20 mg Q (every) AM to Resident 28. Review of the facility Medication Audit Report dated 3/5/2020 revealed Resident 28's [MEDICATION NAME] 1 capsule, [MEDICATION NAME] 125 mcg QD, [MEDICATION NAME] 1 drop both eyes BID, FeSO4 325 mg 1 PO QD, [MEDICATION NAME] 50 mg BID, [MEDICATION NAME] 17 GM, Multivitamin 1 tablet, Pantoprazole 40 mg BID, and [MEDICATION NAME] 20 mg Q AM Schedule Date was 10:00 AM and the Administration Time the last medication was given was 11:27 AM which indicated they were administered 1 hour and 27 minutes after their scheduled time to be administered. Review of Resident 28's MAR for (NAME)2020 revealed the administration time on the MAR indicated [REDACTED]. Interview with LPN-D on 3/05/20 at 12:19 PM revealed they still had 6 more resident to administer [MED] to. At 12:34 PM LPN-D reported they still had 4 more residents to administer [MED] to. Interview with RN-A on 3/05/20 at 12:36 PM revealed they still had 10 AM and 11 AM medications to administer to the residents. Review of the facility Medication Admin Audit Report for 3/5/2020 for 6 AM to 6 PM revealed the following residents' medications were not given in accordance with the facility policy that medications were to be administered within an hour before or an hour after the scheduled date or were given late: Resident 21 Vitamin D3 Capsule ([MEDICATION NAME]) Give 2000 unit by mouth one time a day Scheduled date: 3/5/2020 09:00 (9 AM) Administration Time: 3/5/2020 11:19 by LPN-D [MEDICATION NAME] Tablet (Solifenacin [MEDICATION NAME]) Give 5 mg by mouth one time a day Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 11:19 by LPN-D Multi-Vitamin Tablet (Multiple Vitamin) Give 1 tablet by mouth one time a day Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 11:19 by LPN-D Tums Tablet Chewable (Calcium [MEDICATION NAME] Antacid) Give 750 mg by mouth one time a day Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 11:19 by LPN-D [MEDICATION NAME] Capsule 100 MG Give 1 capsule by mouth three times a day Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 11:19 by LPN-D [MEDICATION NAME] ER Tablet Extended Release 24 Hour Give 50 mg by mouth one time a day Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 11:19 by LPN-D [MEDICATION NAME] Capsule 300 MG Give 300 mg by mouth one time a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:19 by LPN-D [MEDICATION NAME] Capsule 100 MG Give 1 capsule by mouth three times a day Scheduled date: 3/5/2020 15:00 (3 PM) Administration Time: 3/5/2020 17:46 (5:46 PM) by LPN-D Resident 29 [MEDICATION NAME] Capsule Delayed Release 40 MG Give 1 capsule by mouth in the morning Scheduled date: 3/5/2020 07:30 Administration Time: 3/5/2020 08:50 by RN-A [MED] [MEDICATION NAME] Solution Inject as per sliding scale subcutaneous before meals Scheduled date: 3/5/2020 07:30 Administration Time: 3/5/2020 09:21 by LPN-D [MED] [MEDICATION NAME] Solution Inject as per sliding scale subcutaneous before meals Scheduled date: 3/05/2020 11:30 Administration Time: 3/5/2020 13:22 (1:22 PM) by LPN-D [MEDICATION NAME] HCl Tablet Give 37.5 mg by mouth every 8 hours Scheduled date: 3/5/2020 1400 (2 PM) Administration Time: 3/5/2020 1511 (3:11 PM) by RN-A Resident 30 [MEDICATION NAME] Acid Tablet Give 1000 mg by mouth one time a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:17 by RN-A Multi-Vitamin Tablet (Multiple Vitamin) Give 1 tablet by mouth one time a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:17 by RN-A Calcium [MEDICATION NAME]-Vitamin D Tablet 600-400 MG-UNIT Give 1 tablet by mouth two times a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:17 by RN-A IBU Tablet 800 MG ([MEDICATION NAME]) Give 1 tablet by mouth three times a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:19 by RN-A Potassium Chloride ER Tablet Extended Release 20 MEQ Give 1 tablet by mouth in the morning Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:16 by RN-A [MEDICATION NAME] Powder (Polyethylene [MEDICATION NAME] 3350) Give 17 gram by mouth one time a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:17 by RN-A Aspirin Tablet Give 325 mg by mouth one time a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:17 by RN-A IBU Tablet 800 MG ([MEDICATION NAME]) Give 1 tablet by mouth three times a day Scheduled date: 3/05/2020 15:00 Administration Time: 3/05/2020 16:26 (4:26 PM) by RN-A Resident 3 [MEDICATION NAME] Tablet 40 MG Give 40 mg by mouth one time a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:20 by RN-A [MEDICATION NAME] Tablet 325 (65 Fe) MG Give 1 tablet by mouth in the morning Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:20 by RN-A [MED] Tablet 2.5 MG ([MED]) Give 2.5 mg by mouth two times a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:20 by RN-A [MEDICATION NAME] HCl Tablet Give 5 mg by mouth one time a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:20 by RN-A Aspirin Tablet 81 MG Give 81 mg by mouth one time a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:20 by RN-A [MEDICATION NAME] Tablet 25 MG Give 25 mg by mouth one time a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:42 by RN-A [MEDICATION NAME] Propionate Suspension 2 spray in each nostril one time a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:42 by RN-A Entresto Tablet 49-51 MG (Sacubitril-[MEDICATION NAME]) Give 2 tablet by mouth two times a day Scheduled date: 3/5/2020 10:00 Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285159	A. BUILDING _____ B. WING _____	**03/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PLUM CREEK CARE CENTER	**1505 NORTH ADAMS STREET LEXINGTON, NE 68850**

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 0755

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 4)

Time:3/5/2020 11:42 by RN-A Thera-M Tablet (Multiple Vitamins-Minerals) Give 1 tablet by mouth one time a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:43 by RN-A Resident 7 Dantrolene Sodium Capsule 25 MG Give 25 mg by mouth three times a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:12 by RN-A Resident 20 [MEDICATION NAME] Capsule Give 400 mg by mouth three times a day Scheduled date: 3/5/2020 15:00 Administration Time: 3/5/2020 17:46 by LPN-D [MEDICATION NAME] Tablet Give 650 mg by mouth two times a day Scheduled date: 3/5/2020 15:00 Administration Time: 3/5/2020 17:46 by LPN-D [MEDICATION NAME] Tablet (Oral Electrolytes) Give 2 tablet by mouth three times a day Scheduled date: 3/5/2020 15:00 Administration Time: 3/5/2020 17:46 by LPN-D Resident 15 [MEDICATION NAME] HFA Aerosol Solution 108 (90 Base) MCG/ACT ([MEDICATION NAME] HFA) 1 puff inhale orally four times a day Scheduled date:
3/5/2020 11:00 Administration Time: 3/5/2020 12:12 by RN-A Resident 22 Actos Tablet 30 MG (Pioglitazone HCl) Give 1 tablet by mouth in the morning Scheduled date: 3/5/2020 07:30 Administration Time: 3/5/2020 08:58 by RN-A Entresto Tablet 24-26 MG (Sacubitril-[MEDICATION NAME]) Give 1 tablet by mouth two times a day Scheduled date: 3/5/2020 07:30 Administration Time: 3/5/2020 08:58 by RN-A [MEDICATION NAME] HCl Tablet 1000 MG Give 1 tablet by mouth two times a day
Scheduled date: 3/5/2020 07:30 Administration Time: 3/5/2020 08:58 by RN-A [MEDICATION NAME] 250 MG ([MEDICATION NAME] HCl) Give 250 mg by mouth in the morning Scheduled date: 3/5/2020 07:30 Administration Time: 3/5/2020 08:58 by RN-A Multi-Vitamin Tablet (Multiple Vitamin) Give 1 tablet by mouth one time a day Scheduled date: 3/5/2020 07:30 Administration Time: 3/5/2020 08:58 by RN-A Tylenol Extra Strength Tablet 500 MG ([MEDICATION NAME]) Give 2 tablet by mouth four times a day Scheduled date: 3/5/2020 11:00 Administration Time: 3/5/2020 12:35 by RN-A Resident 34 [MEDICATION NAME] Tablet Give 20 mg by mouth two times a day Scheduled date: 3/05/2020 15:00 Administration Time 3/05/2020 17:47 by LPN-D Resident 5 [MED] HCl Capsule Give 0.8 mg by mouth one time a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:20 by LPN-D Potassium Chloride ER Tablet Extended Release Give 20 mEq by mouth one time a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:20 by LPN-D [MEDICATION NAME] Capsule ([MEDICATION
NAME] Product) Give 1 capsule by mouth one time a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:20 by LPN-D Aspirin EC Low Dose Tablet Delayed Release 81 MG (Aspirin) Give 1 tablet by mouth one time a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:20 by LPN-D [MEDICATION NAME] Sodium Capsule Give 100 mg by mouth two
times a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:20 by LPN-D [MEDICATION NAME] Tablet Give 25
mg by mouth two times a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:20 by LPN-D
Multi-Vitamin/Minerals Tablet (Multiple Vitamins-Minerals) Give 1 tablet by mouth one time a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:20 by LPN-D [MEDICATION NAME] Tablet 325 (65 Fe) MG Give 1 tablet by mouth one time a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:20 by LPN-D [MEDICATION NAME] Capsule Delayed
Release Particles ([MED] HCl) Give 60 mg by mouth one time a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:20 by LPN-D [MEDICATION NAME] HCl Tablet Give 500 mg by mouth two times a day Scheduled date: 3/5/2020 10:00
Administration Time: 3/5/2020 11:20 by LPN-D [MEDICATION NAME] Fiber Packet ([MEDICATION NAME]) Give 1 packet by mouth one time a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:20 by LPN-D Resident 6 [MEDICATION NAME]
Tablet Give 1000 mg by mouth four times a day Scheduled date: 3/5/2020 07:00 Administration Time: 3/5/2020 08:12 by RN-A [MEDICATION NAME] Sodium Tablet 50 MCG Give 50 mcg by mouth one time a day Scheduled date: 3/5/2020 07:00 Administration
Time: 3/5/2020 08:12 by RN-A [MEDICATION NAME] Tablet 1 MG ([MEDICATION NAME]) Give 1 mg by mouth one time a day Scheduled date: 3/5/2020 08:00 Administration Time: 3/5/2020 09:06 by RN-A Vitamin D3 Tablet ([MEDICATION NAME]) Give 2000 unit by
mouth one time a day Scheduled date: 3/5/2020 08:00 Administration Time: 3/5/2020 09:06 by RN-A Sennosides Tablet 8.6 MG Give 1 tablet by mouth in the morning Scheduled date: 3/5/2020 08:00 Administration Time: 3/5/2020 09:06 by RN-A Resident 16 [MEDICATION NAME] HCl Solution 1 % Instill 1 drop in both eyes three times a day Scheduled date: 3/5/2020 09:00
Administration Time: 3/5/2020 10:15 by RN-A [MEDICATION NAME] HCl Solution 1 % Instill 1 drop in both eyes three times a day Scheduled date: 3/5/2020 15:00 Administration Time: 3/5/2020 16:07 by RN-A Resident 13 [MEDICATION NAME] Sodium Tablet 200 MCG Give 1 tablet by mouth one time a day Scheduled date: 3/5/2020 07:00 Administration Time: 3/5/2020 08:13 by RN-A [MEDICATION NAME] Tablet ([MEDICATION NAME]) Give 40 mg by mouth in the morning Scheduled date: 3/5/2020 07:00
Administration Time: 3/5/2020 08:13 by RN-A [MEDICATION NAME] HCl Tablet 100 MG Give 1 tablet by mouth in the morning Scheduled date: 3/5/2020 07:00 Administration Time: 3/5/2020 08:13 by RN-A [MEDICATION NAME] Capsule Give 650 mg by mouth
every 6 hours Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 12:13 by RN-A Resident 27 [MEDICATION NAME]
Tablet ([MEDICATION NAME]) Give 325 mg by mouth one time a day Scheduled date: 3/05/2020 10:00 Administration Time: 3/5/2020 11:06 by RN-A Folic Acid Tablet 1 MG Give 1 mg by mouth one time a day Scheduled date: 3/05/2020 10:00 Administration Time: 3/5/2020 11:06 by RN-A [MEDICATION NAME] HCl Tablet 200 MG Give 200 mg by mouth in the morning Scheduled date: 3/05/2020 10:00 Administration Time: 3/5/2020 11:06 by RN-A [MEDICATION NAME] Tablet 10 MG ([MEDICATION
NAME]) Give 10 mg by mouth in the morning Scheduled date: 3/05/2020 10:00 Administration Time: 3/5/2020 11:05 by RN-A Magnesium Capsule Give 400 mg by mouth one time a day Scheduled date: 3/05/2020 10:00 Administration Time: 3/5/2020 11:06 by RN-A [MEDICATION NAME] Tablet 50 MG ([MEDICATION NAME] HCl) Give 50 mg by mouth one time a day Scheduled date:
3/05/2020 10:00 Administration Time: 3/5/2020 11:06 by RN-A [MEDICATION NAME] Tablet 3.125 MG (Carvedilol) Give 3.125 mg
by mouth two times a day Scheduled date: 3/05/2020 10:00 Administration Time: 3/5/2020 11:12 by RN-A [MEDICATION NAME]
Solution 100 UNIT/ML ([MED] [MEDICATION NAME]) Inject as per sliding scale subcutaneous before meals Scheduled date: 3/5/2020 11:30 Administration Time: 3/5/2020 12:45 by LPN-D Artificial Tears Solution 0.4 % (Hypromellose) Instill 1 drop in both eyes four times a day Scheduled date: 3/5/2020 15:00 Administration Time: 3/5/2020 16:30 by RN-A Myrbetriq Tablet Extended Release 24 Hour 25 MG (Mirabegron ER) Give 25 mg by mouth one time a day Scheduled date: 3/5/2020 15:00 Administration Time: 3/5/2020 16:30 by RN-A Resident 12 [MEDICATION NAME] HCl ER Coated Beads Capsule Extended Release
24 Hour 240 MG Give 240 mg orally one time a day Scheduled date: 3/5/2020 15:00 Administration Time: 3/5/2020 16:41 by RN-A Resident 14 NAME] Tablet Delayed Release 40 MG Give 40 mg by mouth one time a day Scheduled date: 3/5/2020 07:30 Administration Time: 3/5/2020 09:54 by LPN-D Artificial Tears Solution 1-0.3 % ([MEDICATION NAME]-[MEDICATION NAME])
Instill 1 drop in both eyes two times a day Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 11:18 by LPN-D [MEDICATION NAME] Tablet 1000 UNIT Give 2 tablet by mouth one time a day Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 11:18 by LPN-D Aspirin Tablet 81 MG Give 1 tablet by mouth one time a day Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 11:18 by LPN-D [MEDICATION NAME] Tablet 5 MG Give 5 mg by mouth one time a day Scheduled
date: 3/5/2020 09:00 Administration Time: 3/5/2020 11:18 by LPN-D [MED] HCl Capsule 0.4 MG Give 1 capsule by mouth one time a day Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 11:18 by LPN-D [MEDICATION NAME] Oxalate Tablet 10 MG Give 10 mg by mouth one time a day Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 11:18 by LPN-D [MEDICATION NAME] Tablet 500 MG Give 1 tablet by mouth three times a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:18 by LPN-D [MEDICATION NAME] Tablet 500 MG Give 1 tablet by mouth three times a day Scheduled date: 3/5/2020 15:00 Administration Time: 3/5/2020 17:45 by LPN-D Resident 9 [MEDICATION NAME] HCl Tablet 50 MG Give 50 mg by
mouth three times a day Scheduled date: 3/5/2020 15:00 Administration Time: 3/5/2020 16:39 by RN-A [MED] Capsule (Lactobacillus) Give 1 mg by mouth three times a day Scheduled date: 3/5/2020 15:00 Administration Time: 3/5/2020 16:39 by RN-A Resident 17 Lactobacillus Rhamnosus (GG) Capsule Give 1 capsule by mouth two times a day Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 10:50 by RN-A [MEDICATION NAME] ER Tablet Extended Release 24 Hour Give 50 mg by
mouth one time a day Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 10:51 by RN-A Calcium-Vitamin D3 Tablet 600-400 MG-UNIT (Calcium Carb-[MEDICATION NAME]) Give 1 tablet by mouth one time a day Scheduled date: 3/5/2020 15:00 Administration Time: 3/5/2020 16:42 by RN-A Resident 10 [MEDICATION NAME] Tablet 325 (65 Fe) MG Give 325 tablet by mouth two times a day Scheduled date: 3/5/2020 15:00 Administration Time: 3/5/2020 16:18 by RN-A [MEDICATION NAME] Tablet 50 MG
([MEDICATION NAME] HCl) Give 1 tablet by mouth three times a day Scheduled date: 3/5/2020 15:00 Administration Time: 3/5/2020 16:18 by RN-A Resident 26 [MEDICATION NAME] Capsule 1.25 MG (UT) Give 1 capsule by mouth in the morning Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 11:19 by LPN-D [MEDICATION NAME] Tablet 325 (65 Fe) MG Give 1 tablet by mouth in the morning Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 11:18 by LPN-D Memantine HCl
Tablet 5 MG Give 1 tablet by mouth two times a day Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 11:18 by LPN-D [MEDICATION NAME] HCl ER Tablet Extended Release 24 Hour 37.5 MG Give 1 tablet by mouth in the morning Scheduled
date: 3/5/2020 09:00 Administration Time: 3/5/2020 11:19 by LPN-D Incruse Ellipta Aerosol Powder Breath Activated 62.5 MCG/INH (Umeclidinium [MEDICATION NAME]) 1 puff inhale orally in the morning Scheduled date: 3/5/2020 09:00 Administration
Time: 3/5/2020 11:18 by LPN-D Aspirin Children's Tablet Chewable 81 MG (Aspirin) Give 1 tablet by mouth in the morning Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 11:18 by LPN-D [MEDICATION NAME] 500/200 D-3 Tablet 500-200

	MG-UNIT (Calcium [MEDICATION NAME]-Vitamin D) Give 1 tablet by mouth in the morning Scheduled date: 3/5/2020 09:00

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285159	A. BUILDING _____ B. WING _____	**03/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PLUM CREEK CARE CENTER	**1505 NORTH ADAMS STREET LEXINGTON, NE 68850**

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 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) Administration Time: 3/5/2020 11:19 by LPN-D Magnesium Oxide Tablet 400 MG Give 1 tablet by mouth two times a day Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 11:18 by LPN-D Folic Acid Tablet Give 0.4 mg by mouth in the morning Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 11:18 by LPN-D Potassium Chloride ER Tablet Extended Release 20 MEQ Give 1 tablet by mouth in the morning Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 11:18 by LPN-D Resident 31 [MEDICATION NAME] Solution 250 MG/5 ML Give 5 ml via [DEVICE] three times a day Scheduled date: 3/5/2020 15:00 Administration Time: 3/5/2020 16:21 by LPN-D [MEDICATION NAME] Syrup Give 400 mg via [DEVICE] three times a day Scheduled date: 3/5/2020 15:00 Administration Time: 3/5/2020 16:21 by LPN-D [MEDICATION NAME] Tablet 10 MG Give 1 tablet via GTube three times a day Scheduled date: 3/5/2020 15:00 Administration Time: 3/5/2020 16:21 by LPN-D Resident 11 [MEDICATION NAME] Tablet Delayed Release 20 MG (NAME]) Give 1 tablet by mouth in the morning Scheduled date: 3/5/2020 07:30 Administration Time: 3/5/2020 08:56 by LPN-D [MEDICATION NAME] Tablet 50 MG ([MEDICATION NAME] HCl) Give 1 tablet by mouth three times a day Scheduled date: 3/5/2020 15:00 Administration Time: 3/5/2020 17:44 by LPN-D Resident 23 [MEDICATION NAME] Capsule 100 MG ([MEDICATION NAME] Sodium) Give 2 tablet by mouth in the morning Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:44 by RN-A Vitamin D3 Tablet 2000 UNIT ([MEDICATION NAME]) Give 2000 unit by mouth one time a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:45 by RN-A Artificial Tears Solution 1.4 % ([MEDICATION NAME] Alcohol) Instill 1 drop in both eyes two times a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:44 by RN-A Aspirin Tablet 81 MG Give 81 mg by mouth in the morning Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:44 by RN-A [MEDICATION NAME] Tablet 1 MG ([MEDICATION NAME]) Give 1 tablet by mouth in the morning Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:44 by RN-A [MEDICATION NAME] Tablet 5 MG Give 5 mg by mouth one time a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:45 by RN-A [MEDICATION NAME] Capsule 50 MG (Pregabalin) Give 1 capsule by mouth two times a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/05/2020 11:45 by RN-A [MEDICATION NAME] Tablet 6.25 MG (Carvedilol) Give 6.25 mg by mouth two times a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:48 by RN-A [MEDICATION NAME] Tablet 20 MG Give 20 mg by mouth two times a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 11:49 by RN-A [MED] Solution ([MED] [MEDICATION NAME] (Human)) Inject 17 unit subcutaneous two times a day Give at noon and supper Scheduled date: 3/5/2020 11:30 Administration Time: 3/5/2020 12:50 by LPN-D Resident 24 Artificial Tears Solution 0.4 % (Hypromellose) Instill 1 drop in both eyes three times a day Scheduled date: 3/5/2020 15:00 Administration Time: 3/5/2020 16:08 by RN-A [MEDICATION NAME] Tablet Give 50 mg by mouth three times a day Scheduled date: 3/5/2020 15:00 Administration Time: 3/5/2020 16:08 by RN-A [MEDICATION NAME] Tablet ([MEDICATION NAME]) Give 40 mg by mouth two times a day Scheduled date: 3/5/2020 15:00 Administration Time: 3/5/2020 16:08 by RN-A [MEDICATION NAME] Sodium Capsule Give 100 mg by mouth three times a day Scheduled date: 3/5/2020 15:00 Administration Time: 3/5/2020 16:08 by RN-A Resident 184 [MEDICATION NAME] Tablet Give 12.5 mg by mouth two times a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 12:40 by RN-A [MEDICATION NAME] HandiHaler Capsule 18 MCG ([MEDICATION NAME]) 1 capsule inhale orally one time a day Scheduled date: 3/5/2020 10:00 Administration Time: 3/5/2020 12:40 by RN-A Resident 2 [MEDICATION NAME] Capsule 0.4 MG ([MED] HCl) Give 1 capsule by mouth one time a day Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 10:10 by RN-A Multi-Vitamin/Minerals Tablet (Multiple Vitamins-Minerals) Give 1 tablet by mouth one time a day Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 10:10 by RN-A Questran Packet ([MEDICATION NAME]) Give 2 packet by mouth one time a day Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 10:10 by RN-A [MEDICATION NAME] Tablet 20 MG Give 1 tablet by mouth in the morning Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 10:14 by RN-A [MEDICATION NAME] Tablet 25 MG (Carvedilol) Give 1 tablet by mouth two times a day Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 10:15 by RN-A Resident 32 [MEDICATION NAME] Tablet (Oral Electrolytes) Give 1 tablet by mouth three times a day Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 10:05 by LPN-D [MEDICATION NAME] Tablet 6.25 MG (Carvedilol) Give 1 tablet by mouth two times a day Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 10:04 by LPN-D Potassium Chloride ER Tablet Extended Release 20 MEQ Give 1 tablet by mouth two times a day Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 10:05 by LPN-D [MEDICATION NAME] HCl Tablet 25 MG Give 1 tablet by mouth in the morning Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 10:05 by LPN-D [MEDICATION NAME] Powder (Polyethylene [MEDICATION NAME] 3350) Give 0.5 dose by mouth in the morning Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 10:05 by LPN-D [MEDICATION NAME] Capsule (Multiple Vitamins-Minerals) Give 1 capsule by mouth two times a day Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 10:05 by LPN-D [MEDICATION NAME] Tablet 5 MG Give 1 tablet by mouth three times a day Scheduled date: 3/5/2020 09:00 Administration Time: 3/5/2020 10:04 by LPN-D [MEDICATION NAME] Tablet (Oral Electrolytes) Give 1 tablet by mouth three times a day Scheduled date: 3/5/2020 15:00 Administration Time: 3/5/2020 17:45 by LPN-D [MEDICATION NAME] Tablet 5 MG Give 1 tablet by mouth three times a day Scheduled date: 3/5/2020 15:00 Administration Time: 3/5/2020 17:45 by LPN-D Interview with the DON (Director of Nursing) on 3/10/20 at 9:07 AM revealed if the resident is asleep they do not expect the staff to wake them up; however, the DON agreed that the scheduled time frames had to be abided by. Review of the facility policy Medication Pass Policy with a revision date of (NAME)2019 revealed the following: Medications must be administered in a timely manner and in accordance with the physician's written/verbal orders. Medications must be administered within one hour before or after time indicated when using unit dose.

F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09D Based on observation, interview and record review; the facility staff failed to ensure adverse side effects did not occur from use of medications for 1 resident (Resident 10). This affected 1 of 6 sampled residents. The facility identified a census of 33 at the time of survey. Findings are: Review of Resident 10's annual MDS (Minimum Data Set-a comprehensive assessment tool used to develop a resident's care plan) dated 1/13/2020 revealed an admission date of [DATE]. Resident 10 had no BIMS (Brief Interview for Mental Status) score as Resident 10 was rarely/never understood. Staff assessment for mental status indicated Resident 10 had short term and long term memory problems and severely impaired cognitive skills for decision making. Resident 10 required extensive assistive of 2 staff for dressing and bed mobility and was dependent upon 2 staff for transfer, toilet use, and personal hygiene. Antipsychotic (medication used to treat behavior disorders), antidepressant (medication used to treat depression), and opioid (pain medication) were used 7 days of the 7 day MDS look back period. Constipation (a condition in which you may have fewer than three bowel movements a week, stools that are hard, dry, or lumpy, and stools that are difficult or painful to pass) was marked no. Review of Resident 10's POC (Point of Care) Response History Bowel Elimination Size of BM (Bowel Movement) for the past 30 days (2/13/2020-3/10/2020) revealed the following documentation: Resident 10 had a large BM 2/13/2020; Resident 10 had a large BM [DATE] which was 5 days with no BM; Resident 10 had a small BM on 2/26/20 which was 8 days with no BM; Resident 10 had a large BM on 2/29/20 which was 3 days with no BM and a large BM on 3/1/20; Resident 20 had a small BM on 3/2/20 and then no BM had been documented since then which was 8 days with no BM with the last day of the report being 3/10/2020. Review of Resident 10's POC Response History Bowel Elimination Consistency of BM for the past 30 days (2/13/2020-3/10/2020) revealed the following documentation: constipated/hard was marked on 2/13/20, 2/18/20, 2/26/20, and hard was marked on 3/1/20 and 3/2/20. Observation of Resident 10 on 3/5/2020 at 12:29 PM revealed an unidentified staff person was attempting to get Resident 10 to eat and Resident 10 refused by clamping their mouth shut and shaking their head when the staff person approached Resident 10 with a spoon of food. Review of Resident 10's MAR (Medication Administration Record) for February and (NAME)2020 revealed orders for [MEDICATION NAME] Capsule 100 MG (milligrams)([MEDICATION NAME] Sodium))(cathartic-medication used to promote bowel evacuation) Give 100 mg by mouth two times a day for Constipation Active 2/7/2020; [MEDICATION NAME] Tablet 100 MG (quetiapine [MEDICATION NAME])(antipsychotic) Give 1 tablet by mouth at bedtime Active 9/20/2019; [MEDICATION NAME] Tablet 50 MG ([MEDICATION NAME] HCl)(opioid) Give 1 tablet by mouth three times a day for pain Active 11/19/2019; [MEDICATION NAME] Tablet 50 MG (quetiapine [MEDICATION NAME]) Give 1 tablet by mouth in the morning Active 10/22/2019; and [MEDICATION NAME] (antidepressant) Give 15 mg by mouth at bedtime for depression Active 11/30/2016. Resident 10 also had orders on the MAR for [MEDICATION NAME] Suppository 10 MG ([MEDICATION NAME])(cathartic) Insert 1 application rectally every 24 hours as needed for Constipation Active 6/2/2016 and Milk of Magnesia Concentrate Suspension (Magnesium [MEDICATION NAME]) (cathartic) Give 30 ml by mouth every 24 hours as needed for Constipation per standing order Active 4/22/2018 but there was no documentation the [MEDICATION NAME] or milk of magnesia were administered to Resident 10. Review of Resident 10's MAR for February and (NAME)2020 revealed the nursing staff were to monitor Resident 10 for the following: Monitor for side effects of antidepressant. Common side effects are: constipation and Antipsychotic medication: monitor for constipation. Review of Resident 10's Progress Notes revealed documentation Resident 10's cathartic orders were changed when Resident 10 went to the medical provider on February 7 for a routine 2

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	285159	A. BUILDING _____ B. WING _____	03/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PLUM CREEK CARE CENTER	1505 NORTH ADAMS STREET LEXINGTON, NE 68850

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 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 6) month follow up. There was no documentation the medical provider was notified when Resident 10 was exhibiting episodes of constipation. The nurses documented Resident 10 was having no s/s of adverse side effects from the medication. Review of Resident 10's Care Plan dated 8/14/2019 revealed the following: I receive antipsychotic medication. I want to be free of side effects and stable in my illness Date Initiated: 08/14/2019. Staff will observe for side effects of this medication such as constipation. Interview with MA-E on 3/10/20 at 10:19 AM revealed they were to monitor the residents for adverse medication side effects that were listed with the medication. Review of the Nursing2018 Drug Handbook revealed the following nursing considerations for [MEDICATION NAME] ([MEDICATION NAME]): Monitor bowel and bladder function. Anticipate need for stimulant laxative. Quetiapine ([MEDICATION NAME]) Adverse Reaction: constipation. [MEDICATION NAME] ([MEDICATION NAME]) Adverse Reaction: constipation. Interview with the DON (Director of Nursing) on 3/10/20 at 12:01 PM confirmed there were long stretches Resident 10 was going without a BM. The DON revealed the nursing staff should have given Resident 10 the Milk of Magnesia and the [MEDICATION NAME] suppository when needed. The DON revealed the facility did not have a specific bowel protocol. The DON revealed the only documentation Resident 10's cathartic orders were changed was on 2/7/2020 when the medical provider changed the orders to discontinue the [MEDICATION NAME] (a cathartic) and increase the [MEDICATION NAME] to 100 mg BID. Review of the facility policy Bowel Disorders Clinical Protocol dated (NAME)2019 revealed the following: As part of the initial assessment, the staff and physician will help identify individuals with previously identified lower gastrointestinal tract conditions and symptoms. This should include a review of gastrointestinal problems during any recent hospitalization s .etc. The staff and physician will monitor the individuals' response to interventions and overall progress; for example, overall degree of comfort of distress, frequency and consistency of bowel movements and the frequency, severity, and duration of abdominal pain, etc.
F 0804 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** LICENSURE REFERENCE NUMBER 175 NAC 12-006.11D Based on observation, interviews, and record review, the facility failed to provide foods which was palatable and according to resident preferences. This had the potential to affect all residents who ate food from the kitchen. The facility census was 33 at the time of the survey. Findings are: On 3/4/2020 at 12:05 PM an observation of the staff delivering the prepared food to the residents revealed the staff did not offer the residents condiments of salt or pepper. On 3/5/2020 at 12:05 PM an observation of the DC-M (Dietary Cook) revealed that when the food was prepared on the plate the recipe was followed and no gravy was placed on the potatoes. Gravy was applied to the meat only. On 3/5/2020 at 12:10 PM an observation of the staff delivering the serving tray to Resident 21 revealed that the staff person did not offer the resident any condiments of salt or pepper. On 3/5/2020 at 12: 15 PM an interview with Resident 21 revealed, when asked how the meal was, stated the meat and vegetables were good. The carrots were not mushy or overcook. The resident stated further that the potatoes were stiff and could use some butter or gravy. On 3/5/2020 at 12:15 PM an interview with the DM (Dietary Manger) revealed that the DM did not like the recipe because it did not call for placing gravy on the potatoes. DM confirmed that the residents should be asked if they would like condiments placed on their food such as salt, pepper and/or gravies. On 3/5/2020 at 12:45 PM the test tray arrived to be sampled with gravy on both the meat and potatoes. The temperatures were checked with the potatoes being 186 degrees Fahrenheit; Salisbury Steak 165.6 degrees Fahrenheit; Carrots 167 degrees Fahrenheit; and the Fruit Cocktail 38.2 degrees Fahrenheit. The potatoes were dry, thick and pasty. The potatoes required more gravy or butter to moisten them and there was none on the tray. The meat was very good with a good taste and flavor. Except for the potatoes the meal looked appetizing. There was also no salt or pepper on the serving tray. Record review of the State Operations Manual Appendix PP (Rev. 168, Issued: 03-08-17, Implementation: 03-08-17) Section 483.60(d) Food and drink; Sub-section 483.60(d) (2): Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Food-palatability was referred to the taste and/or flavor of the food.
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 12-006.11E Based on observation, record review and interview the facility failed to serve meals in a manner to prevent foodborne illness by reusing contaminated serving trays that had been sat on residents tables and serving food with the hand on the eating surface of the plates and glasses. This had the potential to affect all residents who ate in the dining room. The facility census was 33 at the time of the survey. Findings are: A. An observation on 3/04/20 at 12:13 PM of MA-L (Medication Aide) revealed that MA-L sat the tray on the table beside Resident 21 and served the items from the serving tray to Resident 21. MA-L placed MA-L's open hand over the top of the serving dish for the dessert which caused MA-L to contaminate the outside top of the dish. Sitting the serving tray on the table caused the tray to become contaminated. When MA-L took the contaminated tray back to the serving area the contaminated tray was passed through the serving area window through which the trays of food were passed for other residents. An observation on 3/04/20 at 12:17 PM of NA-H (Nursing Aide) when Resident 33 was given the items off the tray, NA-H placed NA-H's open hand over the top of the coleslaw and dessert which contaminated the outside of the dishes. An observation on 3/04/20 at 12:17 PM of DA-K (Dietary Aide) receiving the contaminated trays back from the dining room that were being passed over food prepared to go out into the dining room. The contaminated tray was then set up for the next resident without sanitizing or cleaning the tray off between residents. An interview on 3/09/20 at 11:42 AM with the DM (Dietary Manager) regarding use of the serving trays in the dining room revealed that the trays are to be sanitized between uses and placed on the cart outside the kitchen area by the serving window. The trays are never taken back into the kitchen and reused without cleaning and sterilizing. An interview on 3/09/20 at 1:36 PM with DM (Dietary Manager) revealed that staff are not to touch the glasses on the top with the hands and condiments such as salt, pepper and gravies are to be offered. Record review of the Nebraska Food Code, Effective date 7/21/16, 81-2,272.10* (Replaces 2013 Food Code 3-301.11 (B), (C), (D) and (E) Preventing Contamination from Hands) * revealed: (3) Except when washing fruits and vegetables, food employees shall minimize bare hand and arm contact with exposed food. Record review of the Nebraska Food Code, Effective date 7/21/16, 81-2,272.10* (Replaces 2013 Food Code 1-201.10 Statement of Application and Listing of Terms)* revealed: Food-contact surface means: (1) A surface of EQUIPMENT of a UTENSIL, with which FOOD normally comes into contact; or (2) A surface of EQUIPMENT or a UTENSIL, from which FOOD may drain, drip, or splash; (a) Into a FOOD, or (b) Onto a surface normally in contact with FOOD. B. Record review of the Nebraska Food Code, Effective date 7/21/16, 81-2,272.10* (Replaces 2013 Food Code 3-301.11 (B), (C), (D) and (E) Preventing Contamination from Hands) * revealed: (3) Except when washing fruits and vegetables, food employees shall minimize bare hand and arm contact with exposed food. Observation on 3/04/20 at 12:03 PM revealed that Bus Driver N (BD-N) served the meal to Resident 4 with the thumb on the eating surface of the plate. Observation on 3/04/20 at 12:03 PM revealed that the facility Social Services Director (SSD) served the meal to Resident 24 with the thumb on the eating surface of the plate. Observation on 3/04/20 at 12:03 PM revealed that Medication Aide L (MA-L) served the meal to Resident 21 with the thumb on the eating surface of the plate. Observation on 3/04/20 at 12:07 PM revealed that BD-N sat the tray on the table beside Resident 19 and placed the plate of food in front of Resident 19 with the thumb on the eating surface of the plate. BD-N returned to the kitchen service window and placed the tray on the service window counter. Observation on 3/04/20 at 12:10 PM revealed that Nursing Assistant I (NA-I) served the meal to Resident 2 with the thumb on the eating surface of the plate. Observation on 3/04/20 at 12:10 PM revealed that the facility Activity Director (AD) sat a tray of food on the table beside Resident 26 and served the food to Resident 26. The AD returned to the kitchen service window counter and placed the tray on the top of a tray sitting on the counter of the service window. Observation on 3/04/20 at 12:10 PM revealed that MA-L served the meal to Resident 23 with the thumb on the eating surface of the plate. MA-L picked up the bowl of salad from the tray with the hand over the top of the bowl and placed it in front of the resident. MA-L picked up the bowl of apple crisp with the hand over the top of the bowl and placed it in front of the resident. MA-L returned to the kitchen service window counter with the tray and placed the tray underneath a tray sitting on counter of the service window. Observation on 3/04/20 at 12:15 PM revealed that BD-N held the plate of Resident 10 in place on the table with the left index and middle finger on the top of the plate eating surface while using a fork held in the right hand to mix the resident's potatoes and gravy together.

F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.**

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.17 LICENSURE REFERENCE NUMBER 175 NAC 12-006.17D LICENSURE REFERENCE NUMBER 175 NAC 12-006.18 Based on observation, interview, and record review; the facility staff failed to clean equipment used for the residents per the disinfectant recommendations for the lift which had the potential to affect 7 of 7 sampled residents (Residents 21, 30, 10, 31, 23, 2, and 32) and the facility failed to ensure that staff performed hand hygiene between residents during medication administration for 3 of 10 residents (Residents 27, 7, and 4). The facility identified a census of 33 at the time of survey. Findings are: A. Interview with Resident 32 on 03/04/20 at 1:47 PM revealed they were in isolation for a contagious lung infection. Observation of NA-C (Nurse Aide) on 3/04/20 at 2:58 PM revealed they donned gloves, a gown and a mask then wheeled the Hoyer (full) lift into Resident 23's room. Observation of NA-C on 3/04/20 at 3:18 PM revealed they wheeled the Hoyer lift into the hall out of Resident 23's room, pulled a wipe out of a tub of MicroKill Plus wipes and wiped the lift surfaces that had been handled (the rings, bars, controls). It was dry in seconds. The label on the MicroKill Plus wipe container read 2 minute kill time. An unidentified staff person then took the lift down the hall. Review of the MicroKill label provided by the facility Administrator revealed the following Directions for Use: Disinfection: Thoroughly wet pre-cleaned, hard, non-porous surface with a wipe, keep wet for 2 minutes (5 minutes if fungus is suspected), and allow to air dry. Use as many wipes as needed for the treated surface to remain wet for the entire contact time. Review of the facility policy Cleaning Resident Equipment with a revision date of (NAME)2019 revealed the following: Purpose: to ensure all resident equipment is sanitized using EPA (Environmental Protection Agency) approved guidelines to assist in the prevention and spread of infection. The mechanical lift/stand handles will be cleaned with a hand wipe or disinfectant after each resident use. Interview with the DON (Director of Nursing) on 3/10/20 at 9:31 AM confirmed the staff were to follow the directions on the disinfectant label for disinfecting the lift. Interview with the DON on 3/10/20 at 1:34 PM revealed the facility had 1 full lift they used for all of the residents. Review of the list residents who used the Hoyer full lift received from the DON revealed the following: Residents 21, 30, 10, 31, 23, 2, and 32 used the lift. B. Observation of MA-B (Medication Aide) on 3/04/20 at 2:36 PM revealed they took medication to Resident 12. MA-B gave Resident 12 a glass of water in a disposable glass. Resident 12 handled the glass while they drank the water, then MA-B handled the glass when they obtained it from Resident 12 and discarded it. MA-B did not perform any hand hygiene. MA-B then went to the medication cart and handled the mouse, the keyboard, and the keys to the medication cart. At 2:41 PM MA-B then picked up a plastic medication cup off of a stack of cups on the medication cart and proceeded to pour Resident 27's medications into the cup. MA-B then retrieved a bottle of eye drops out of the drawer. MA-B had not performed any hand hygiene after handling the glass Resident 12 drank from. MA-B then proceeded to don gloves and administer eye drops to Resident 27 by touching their eye. MA-B then removed the gloves, threw them in the trash, opened the medication cart with the keys, put the eye drops back in the box then put the box back into the medication cart by opening the drawer. MA-B then handled the mouse and the keyboard to chart. MA-B did not perform any hand hygiene after removing the gloves. At 2:44 PM MA-B then went into Resident 30's room. MA-B went to the sink and washed their hands for 10 seconds then turned the faucet off with the hand that MA-B had just washed then got paper towels and dried their hands. MA-B then went back out to the medication cart, lifted the screen of the tablet computer, and touched the mouse and the keyboard. At 2:45 PM MA-B then took a plastic medication cup off of a stack of medication cups on the medication cart and poured a pill for Resident 7 into the cup. MA-B then took the medication to Resident 7. Resident 7 asked MA-B to rinse their sports bottle in the sink and fill it half way with water which MA-B did then gave it back to Resident 7 who handled it. MA-B then administered the pill to Resident 7 by pouring it into their mouth from the medication cup. MA-B then discarded the cup and used hand gel from the dispenser in the room. MA-B said the hand gel was thick so MA-B washed the hand gel off in the sink in Resident 7's room for 20 seconds using soap and water. MA-B used a paper towel to turn the water off then went back out to the cart and touched the mouse and the keyboard that was already contaminated. At 2:49 PM MA-B then took a nose spray to Resident 4. MA-B donned gloves and gave Resident 4 one spray into each nostril. MA-B then removed the gloves and gave Resident 4 a glass of supplement to drink. MA-B and Resident 4 both handled the glass. MA-B then took the glass from Resident 4 and threw it away after Resident 4 had handled it. MA-B did not do any hand hygiene and went back out to the medication cart and touched the mouse and the keyboard and opened the drawer on the medication cart to put the nose spray away. C. Observation of MA-E on 3/09/20 at 11:18 AM revealed they set up medications for Resident 28. MA-E took 2 plastic medication cups from a stack of medication cups on the medication cart and pushed a [MEDICATION NAME] pill, FeSO4 pill, [MEDICATION NAME] pill, Pantoprazole pill, and [MEDICATION NAME] pill from the bubble cards into their bare hand and dropped them into the medication cups. MA-E then went and got the medication room keys from an unidentified nurse and went into the medication room by handling the door knob. MA-E then took the keys back to the nurse and took the medication cups with the pills in them into Resident 28's room and put them on the table. MA-B had not done any hand hygiene after they handled the keys and the medication room door handle. MA-B spilled the pills and picked them up with their bare hands and put them back into the cup. MA-B then administered the pills to Resident 28 who took them by mouth. Interview with the DON on 3/10/20 at 9:07 AM revealed the nursing staff were expected to wash their hands between residents. The staff were not allowed to touch the pills with their bare hands. Review of the facility Medication Pass Policy with a revision date of (NAME)2019 revealed the following: Wash hands between each resident. May use hand sanitizer. Review of the facility Medication Administration and Ordering Policy with a revision date of (NAME)2019 revealed the following: Policy: Never handle medications with bare hands. Review of the facility policy Handwashing/Hygiene with a revision date of January 2020 revealed the following: Policy: Handwashing, being the single most effective way of controlling the spread of infection, will be performed by staff routinely and thoroughly to protect residents from the spread of infection. Hand hygiene needs to be completed before and after direct physical contact with the resident, before donning and after removal of gloves and other PPE (e.g. gown, facemask, etc.), when hands are obviously soiled, before and during medication pass, and after contact with soiled patient equipment or utensils including handling soiled or used linens, dressings, bedpans, catheters and urinals, blood pressure cuffs, etc. Employees must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water if hands are visibly soiled. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% [MEDICATION NAME]. Hand hygiene is always the final step after removing and disposing of personal protective equipment. The use of gloves does not replace handwashing/hand hygiene.