STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285256	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KIMBALL COUNTY MANOR	810 EAST 7TH STREET KIMBALL, NE 69145

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F 0676 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 record reviews and interview, the facility failed to evaluate and document potential causal factors and plan to restore or prevent further declines in ADLs (Activities of Daily Living) which were identified on the MDS (Minimal Data Set, a federally mandated comprehensive assessment tool used for care planning) for three current sampled residents (Residents 32, 28 and 30). The facility census was 42 with 12 current sampled residents. Findings are: A. Review of Resident 32's MDS, dated [DATE] revealed that the resident required limited assistance of one staff for eating. Review of the MDS, dated [DATE], revealed that the resident required extensive assistance of one staff for eating. Interview with LPN (Licensed Practical Nurse) - B, MDS Coordinator, on 8/4/20 at 1:15 PM, revealed that there was no documentation of potential causal factors related to the identified decline in eating. Further review revealed no documentation of a plan to restore or to prevent further declines in the resident's ability to eat. B. Review of Resident 28's MDS, dated [DATE], revealed that the resident required extensive assistance of one staff for bed mobility, limited assistance of one staff with ambulation in the room and personal hygiene. Review of the MDS, dated [DATE], revealed that the resident required extensive assist of one staff for bed mobility, ambulated only once or twice with the assistance of one staff and required extensive assistance of one staff for personal hygiene. Interview with LPN - B on 8/4/20 at 1:00 PM revealed that there was no documentation of potential causal factors or a plan to restore or to prevent further declines in the resident's abilities related to bed mobility, ambulation or personal hygiene. C. Review of Resident 30's MDS, dated [DATE], revealed that the resident required limited assistance of one staff for bed mobility, toilet use and personal hygiene. Review of the MDS, dated [DATE], revealed that the resident required extensive assistance of one staff for bed mobility, toilet use and personal hygiene. Interview with LPN - B on 8/4/20 at 1:20 PM revealed that there was no documentation of potential causal factors or a plan to restore or to prevent further declines in the resident's abilities related to bed mobility, toilet use or personal hygiene.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number: 175 NAC 12-006.09D3(2) Based on record reviews and interviews, the facility failed to evaluate and document potential causal factors, plan to restore or to prevent further declines in bladder or bowel function, identified on the MDS (Minimum Data Set, a federally mandated comprehensive assessment tool used for care planning), for three current sampled residents (Residents 32, 28 and 30). The facility census was 42 with 12 current sampled residents. Findings are: A. Review of Resident 32's MDS, dated [DATE], revealed that the resident was occasionally incontinent of bowel (inability to control bowel movements). Review of the MDS, dated [DATE] revealed that the resident was always incontinent of bowel. Interview on 8/4/20 at 1:15 PM with LPN (Licensed Practical Nurse) - B, MDS Coordinator, revealed that there was no documentation of potential causal factors or a plan to restore bowel control. B. Review of Resident 28's MDS, dated [DATE], revealed that the resident was occasionally incontinent of bladder and bowel. Review of the MDS, dated [DATE], revealed that the resident was frequently incontinent of bladder and bowel. Interview on 8/4/20 at 1:00 PM with LPN - B revealed that there was no documentation of potential causal factors or a plan to restore or to prevent further declines in bladder or bowel control. C. Review of Resident 30's MDS, dated [DATE] revealed that the resident was occasionally incontinent of bladder. Review of the MDS, dated [DATE], revealed that the resident was frequently incontinent of bladder. Interview on 8/4/20 at 1:20 PM with LPN - B, revealed that there was no documentation of potential causal factors or a plan to restore or to prevent further declines in bladder control.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number: 175 NAC 12.006.09D8 Based on observations, record reviews and interviews the facility failed to provide encouragement and attempts to eat throughout the meal service for two sampled Residents (Resident 25 and Resident 30) at high risk for continued gradual weight loss. Current sample size was 14. Facility Census was 42. Review of the Vital Results on Resident 25's weights identified the resident's weight had been 106.5 pounds on 03/28/2020 and then on 08/01/2020 Resident 25's weight was 100.5 pounds. This was a loss of 6 pounds over 6 months. Observation on 08/04/2020 at 12:00 p.m. revealed Resident 25 sitting at the dining room table by self and no staff present to provide support, encouragement and conversation throughout Resident 25's meal time. Review of Diet Order copied on 08/04/2020 for Resident 25 revealed Resident was on a Liberal Geriatric CAT diet with no CAT Modification or Modified Utensils. Review of the Face sheet copied on 08-04-20 for Resident 25 revealed Resident 25 had an initial admission date of [DATE] and also had the [DIAGNOSES REDACTED]. Review of the Care Plan, goal dated, 06/11/2020, and printed 08/04/2020, revealed that the resident had altered nutritional status due to disease process. Approaches included Encouragement and prompting during meals and snacks provided because of anticipated weight loss due to COVID-19 guidance, Room tray as needed, Diet per order: Liberal Geriatric CAT, Nutritional risk assessment per protocol, Record intake each meal, Record weight weekly, and Resident prefers small portions and is aware of lower BMI. Weight remains stable with historical weight of this resident. Review of Resident 25's progress note of the Annual Nutritional assessment dated on 6/10/2020 and copied on 08/04/2020 revealed the resident had a significant weight loss at his time and no changes were made to Resident 25's Care Plan. Dietary Aide Progress Note: This is an annual nutrition screening for Evelyn. Evelyn continues to come to the main dining room using her wheeled walker and no assistance. She continues to make her meal choices as well as needs and preferences known to staff. Diet is Liberal Geriatric CAT with no modifications to consistency needed. Intake is fair at 56% with fluid intake at 1006 cc average per day. Weight is 102.4 and showing as a significant loss of 11.5% in 180 days. Evelyn went through a period of time where she was extremely confused and was refusing to eat. The COVID-19 guidance to do room trays also contributed to her confusion. She has recovered and gone back to eating each meal as she used to. It is expected that her weight will stabilize again. Current interventions include encouragement and prompting during meals and snacks provided because of anticipated weight loss due to COVID-19 guidance, room tray as needed, diet per order, resident uses chair cushion from home to assist her to sit more upright during meals, provide cover up each meal as preferred, honor preference for small portions, honor preference not to have juice or milk with meals, nutritional risk assessment per protocol, record intake each meal, record weight weekly. With weight loss explained and addressed, fair intake, and current interventions no further RD recommendations are anticipated. Date/Time: 06/08/2020 13:19. Record review of the Nutritional Risk Assessment,

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 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) dated on 12-12-19 Identified Resident 25 as a high risk with a overall Risk Category score of 8 points. Record review of progress note 08/04/20 02:47 PM Record review progress note - 05/07/2020 15:32 (Recorded as Late Entry on 05/20/2020 15:32) Due to the COVID-19 guidance requiring the resident to endure room confinement, limited activities, and social distancing, weight loss is anticipated. Staff will continue encouragement and prompting during meals as well as offering snacks from the snack cart daily. Written by Certified Dietary Manager. Interview on 08/05/20 11:46 a.m. with RN (Registered Nurse) E revealed that Resident 25 becomes very confused due to dementia and revealed that Resident 25 could recall having eating any of the meals served for the day. RN-E confirmed that Resident 25 does eat snacks but was not clear as on whether or not this was marked on the intake form. RN-E confirm Resident 25 continues to loose weight but has maintained weight at 100 pounds this past month, but over 6 months or more the resident has lost somewhere between 8-10 pounds. Interview on 08/05/2020 11:50 AM RN (Registered Nurse) F revealed that Resident 25 had been eating in the bedroom and this really confused Resident 25, so Resident 25 was not eating well. RN-F reported Resident 25 is eating in the dining room now and it appeared Resident 25 might be eating better. RN-F also confirmed that Resident 25 was also eating or taking snacks however it was unclear if they had been documenting the intake on snacks. Observation on 08/05/20 12:00 PM Resident 25 was sitting alone in the solarium eating lunch. Resident 25 picked at food with fork but did not place food in mouth and just moved food around the plate. There were no staff present to cue or monitor the resident while eating Record review of the Meal Intake, record dated 6-10-2020 through 08/05/2020, revealed it was unclear exactly the amount of the meal that had been eaten by Resident 25 during breakfast, lunch and dinner. Percentage rates ranged from 1% to 25%, 26% to 50%, 51% to 75% and 76% to 100% and there were 9 different occasions where there was no documentation listed. Interview on 08/05/2020 at 2:40 p.m. Dietary Manager verified that Resident 25 had continued to loose weight on a gradual basis and also confirmed there were no staff present with the resident to encourage and assist Resident 25 in eating the meals. Dietary Manager Verified Resident 25 does not sit in the area where assisted residents sit during their meal times. Dietary Manager confirmed that Resident 25 should have had staff providing encouragement to eat and assistance if necessary. Interview on 08/05/202 at 2:45 p.m. Administrator and Director of Nursing confirmed Resident 25 has continued to gradually loose weight and is at risk for further weight loss. The Director of Nursing and Administrator confirmed that staff should be present during meal times to encourage the resident to feed self and provide support. B. Observations on 8/3/20 at 12:30 PM and 1:00 PM revealed Resident 30 resting on the bed with eyes closed. Further observations revealed a covered meal tray on the bedside table. Observations on 8/4/20 at 8:30 AM revealed the resident in bed with eyes closed. Further observations revealed a covered meal tray on the bedside dresser. Observations at 9:00 AM revealed the resident out of the room for a bath. The meal tray remained uncovered on the bedside dresser. Further observations on 9:15 AM revealed the resident awake and seated in the lobby area by the nurse's station. Review of the MDS (Minimum Data Set, a federally mandated comprehensive assessment tool used for care planning), dated 3/19/20, revealed that the resident's weight was 125 pounds. Review of the MDS, dated [DATE], revealed that the resident's weight was 120 pounds. Review of the vital signs record, printed 8/5/20, revealed that the resident's weight on 8/3/20 was 118.3 pounds. Review of the Care Plan, goal date 9/18/20 and printed 8/4/20, revealed that the resident had altered nutritional status due to disease process. Approaches included Med Pass (nutritional supplement) as ordered, encouragement and prompting during meals and snacks provided because of anticipated weight loss due to COVID-19 guidance, room tray as needed or preferred, IB (Instant Breakfast) shake three times a day for weight loss prevention and record intake at every meal. Review of the Nutritional Assessment, dated 6/24/20, revealed that the nutritional risk indicator score was 14 and a score of 8 or more indicated High Risk. Review of the RD (Registered Dietician) Quarterly Assessment, dated 6/24/20, revealed that the resident currently receives Med Pass four ounces three time a day and recommended increasing the supplement to six ounces three times a day due to recent weight loss and continued poor food intakes. Review of the DM (Dietary Manager) Quarterly Nutrition Screening notes, dated 6/19/20, revealed that the resident often refused to eat and meal intakes were less than 25%. Review of the Meal Intake record, dated 7/22/20 through 8/5/20, revealed only six meals documented. Interview on 8/4/20 at 3:00 PM with RN (Registered Nurse) A, Charge Nurse, revealed that the resident is currently taking Med Pass four ounces three times a day. Interview on 8/5/20 at 8:30 AM with the DM confirmed that the resident continues to have gradual weight loss and is at high risk for further weight loss. Further interview revealed that the dietary staff were to document meal intake after each meal. The DM stated that there was no documentation of the resident's intake for the IB shakes or any other food accepted between meals. Further interview confirmed that there was no follow up for the RD recommendation to increase the dose of the Med Pass supplement. The DM stated that weekly weight were routinely reviewed but no further assessments were completed, including the RD, to evaluate dietary approaches since the quarterly assessments in June. Interview on 8/5/20 at 9:00 AM with the DON (Director of Nursing) confirmed that the staff should not leave covered meal trays in the resident's room. The DON confirmed that the staff should wake the resident and set up the meal tray and encourage the resident to eat. Further interview confirmed that the staff should offer meals and snacks at appropriate times such as when the resident was awake to promote nutritional status and prevent further weight loss.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 12-006.12E Based on observation and interview the facility failed to properly store medications for 2 sampled residents (#1, #31) and 11 non-sampled residents (#2, #18, #40, #19, #37, #38, #26, #14, #10, #22, and #16). Census: 42 residents. Sample size: 14 residents. A. On 08/05/20 @ 10:38 AM an observation of the West Hall medication cart revealed one large basin in the bottom drawer contained the following: 1) 7 small plastic vials of Refresh Classic eye drops (no resident name/initials on any vial and no pharmacy label) 2) 5 ziploc baggies containing [MEDICATION NAME][MEDICATION NAME] tablets (a medication used for prevention of nausea and vomiting) for the following residents: a) Resident #2 - 10 tabs b) Resident #18 (2 bags) - 9 tabs and 8 tabs c) Resident #40 - 6 tabs d) Resident #19 - 4 tabs e) Resident #37 - 7 tabs 3) 3 tubs generic Vicks chest rub (a topical rub with medicated vapors) with prescription labels for use on feet for: a) Resident #38 b) Resident #26 c) Resident #14 4) Tub of [MEDICATION NAME] cream (a cream that seals in moisture to heal very dry, sensitive cream) for Resident #31 5) 1 bottle [MEDICATION NAME]-DM syrup (an allergy, cold, and cough remedy) for Resident #10 6) 1 tube [MEDICATION NAME] gel (a topical gel that provides fast and cooling relief froom pain and itching) for Resident #19 7) 1 small bottle [MEDICATION NAME] hydrating cleanser (a face wash) with no resident name and no pharmacy label 8) [MEDICATION NAME] Propionate Nasal Spray (a nasal mist spray used in the treatment of [REDACTED].#14 10) 1 box anti-diarrhea pills for Resident#22 11) [MEDICATION NAME] Propionate nasal spray for Resident #1 12) Box of [MEDICATION NAME] (an allergy, cold, and cough remedy) tabs for Resident #16 13) Dry white powder at bottom of the container On 08/05/2020 at 11:15 AM an interview with the facility Administrator and the Director of Nursing confirmed there was a basin in the bottom of the medication cart with white powder in the bottom of it that held miscellaneous medications of varying routes for different residents, including some medications/treatments with no name or pharmacy label. B. On 8/05/2020 at 11:30 AM observation of the medication storage and stock room revealed 1 vial of [MEDICATION NAME] opened with no open date on the vial or box in which the vial was contained. On 08/05/2020 at 1145 AM an interview with the facility Administrator and Director of Nursing confirmed there was an opened vial of [MEDICATION NAME] with no open date on the vial or on the box in which the vial was contained.
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 Observations and interviews the facility failed to label and date an open back of chicken patties and a bag of pork cutlet patties. these failures had the potential to affect all residents. Facility census was 42. Findings are: Observation on 08/03/20 at 12:21 p.m. upon entering kitchen on the first day and observing the walk in freezer, it was identified there was a bag of chicken patties and a bag of pork cutlets that had been

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) opened and had not been dated or labeled. Staff interview on 08/03/20 at 12:30 p.m. the Certified Dietary Manager-(CDM) verified that the package of pork cutlets and the bag of chicken patties had been opened and they had not been labeled or dated. The CDM confirmed that staff should have labeled and dated both of these items that were located in the walk in freezer. Staff interview on 08/05/20 at 10:00 a.m. the Director of Nursing and the Administrator both verified that the unlabeled packages of pork cutlets and chicken patties should have been labeled and dated upon being opened and placed in the walk in freezer. Review of the 07/21/16 version of the Food Code, based on the United States Food and Drug Administration Food Code and used as an authoritive reference for the food service sanitation practices, revealed the following: 3-201.11 (C) Packaged Food shall be labeled as specified by law, including 21 CFR 101 Food Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers and 9 CFR 381 Subpart Labeling and Containers, and as specified under 3-202.17 and 3-202.18.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Licensure Reference Number 175 NAC 12-006.17 Based on observation and interview the facility failed to prevent cross contamination between 2 residents (#1 and #9). Census: 42 residents. Sample size: 14 residents. On 08/04/20 at 10:56 AM RN-A (Registered Nurse-A)performed hand hygiene and entered the room for Resident #9 with supplies to check the blood sugar level of Resident #9 prior to administering the ordered unsulin. RN-A donned gloves, placed the glucometer strip in the glucometer, punctured the residents finger, and placed a drop of blood onto the strip in the glucometer. The blood sugar result was 263. RN-A read the result out loud to Resident #9, removed the strip from the glucometer, placed the glucometer on the treatment cart outside of the residents room, doffed gloves, and washed hands. RN-A administered insulin to Resident #9 as ordered and performed appropriate hand hygiene. At 11:05 AM RN-A performed hand hygiene, entered the room for Resident #1 with supplies to check the blood sugar level of Resident #1 prior to administering the ordered insulin. RN-A donned gloves, placed glucometer strip in the glucometer, punctured the residents finger, and placed drop of blood onto the strip in the glucometer. The blood sugar result was 189. RN-A read the result aloud for the Resident #1, removed the strip from the glucometer, placed the glucometer on the treatment cart outside of the residents room, doffed gloves, and washed hands. RN-A administered insulin to Resident #1 per insulin order and performed appropriate hand hygiene. The glucometer wasn't cleaned in between uses for Resident #9 and Resident #1. On 08/05/2020 at 11:15 AM and interview with the facility Administrator and the Director of Nursing confirmed that the glucometer was not cleaned properly in between uses in order to prevent cross contamination between the residents.