

Qtr 3 Federal Fiscal Year 2010 Nebraska Nursing Home Survey Data

Top 20

Total Citations: 295

Total Surveys: 67

Rank	Tag #	Regulation Text	Reg Grouping	# Cites	Frequency of Cite
1	441	Establish and maintain an infection control program	Infection Control	25	37%
2	371	Procure food from sources approved and store, prepare, distribute and serve food under sanitary conditions.	Dietary Services	20	30%
3	281	Services must meet professional standards of quality	Resident Assessment	19	28%
4	309	Highest practicable physical, mental, and psychosocial well-being care.	Quality of Care	12	18%
5	253	Housekeeping & maintenance to maintain sanitary, orderly & comfortable environment.	Quality of Life	11	16%
5	323	Resident environment remains as free from accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents.	Quality of Care	11	16%
6	225	Not employ staff guilty of abuse; ensure all alleged violations reported	Resident Behavior and Facility Practices	10	15%
6	315	No indwelling catheter unless unavoidable; incontinent treatment & services to prevent UTI's & restore function	Quality of Care	10	15%
6	329	Each resident's drug regimen must be free from unnecessary drugs	Quality of Care	10	15%
6	428	The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist and report irregularities to physician, and the director of nursing.	Pharmacy Services	10	15%
7	278	The assessment must accurately reflect the resident's status.	Resident Assessment	9	13%
7	280	CCP developed within 7 days after comprehensive assessment; periodically reviewed and revised.	Resident Assessment	9	13%
8	279	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	Resident Assessment	7	10%
8	514	Maintain clinical records in accordance with accepted professional standards and practices & are complete, accurately documented, readily accessible & systematically organized.	Administration	7	10%
9	166	Prompt efforts to resolve resident grievances, including those with respect to the behavior of other residents.	Resident Rights	6	9%
9	363	Meet the nutritional needs of residents in accordance with RDA	Dietary Services	6	9%
10	157	Facility must immediately inform the resident, their physician and resident's legal representative or an interested family member when there are any changes in a residents condition.	Resident Rights	5	7%
10	226	Develop & implement policies & procedures to prohibit abuse & neglect.	Resident Behavior and Facility Practices	5	7%
10	314	Pressure sore treatment & services.	Quality of Care	5	7%
10	325	Based on a comprehensive assessment, facility must ensure resident maintains acceptable parameters of nutritional status or receives therapeutic diet.	Quality of Care	5	7%

Nursing Home Survey Data (2009-2010)

QTR 3 TOTALS

Month	Annual	Revisit	Complaint	Total
<i>Mar-10</i>	2	0	1	3
<i>April-10</i>	15	0	7	22
<i>May-10</i>	19	0	11	30
<i>June-10</i>	8	1	3	12
TOTALS	36	0	19	67

QTR 3 TOTALS

S & S	Frequency
C	3
D	163
E	80
F	23
G	11
O	15
Total	295

Nursing Home Survey Data (2009-2010)

Quarter 3

Scope and Severity	Tag	Freq.	Scope and Severity	Tag	Freq.
E	156	1	F	156	1
	166	6		363	1
	203	1		371	16
	204	1		441	2
	225	2		445	1
	226	2		497	1
	241	1		499	1
	246	1	Total F Tags		23
	248	1			
	250	1	G	223	1
	253	9		281	1
	272	1		309	3
	278	5		314	2
	279	3		315	1
	280	4		333	1
	281	3		365	1
	309	1		425	1
	315	3	Total G Tags		11
	323	2			
	325	1			
	329	1			
	332	2			
	361	1			
	363	4			
	371	4			
	428	3			
	441	11			
	456	1			
	465	1			
	467	1			
	514	2			
Total E Tags		80	Total Tags		114

Nursing Home Inspection Results by Tag Number, Scope and Severity 2010

Quarter 3

Type	Tag	S/S	Description
A	156	E	Failed to inform the resident and/or responsible party of the potential liability of payment and the right to request a standard claim appeal (demand bill) be submitted to Medicare for 3 residents of 11 sampled.
A	156	F	Failed to ensure that residents were aware of their rights and aware of where to find information pertaining to contacting state agencies. This deficient practice had the potential to affect all residents.
A	157	D	Failed to provide timely notification to physician and/or family of residents change of condition for several days with elevated temperature and respiratory systems for 1 of 13 sampled residents.
A	157	D	Failed to notify the physician regarding a change in blood pressure's as ordered for one resident of 19 sampled.
C	157	D	Failed to notify 1 resident's physician of skin breakdown and/or changes noted on the resident's coccyx on 3/21/10 and 5/13/10. Sample size was 5
C	157	D	Failed to notify the physician of a change of condition for 1 resident of 10 sampled experiencing chest pain.
C	157	D	Failed to notify the residents physician regarding low blood sugar values for one resident of 5 sampled.
C	164	D	Failed to provide personal privacy and or draping to prevent unnecessary exposure of the residents body parts during personal hygiene cares and skilled nursing treatments for 3 residents of 13 sampled.
A	164	D	Failed to ensure privacy was maintained during toileting and personal cares for 1 resident of 9 sampled.
A	164	D	Failed to ensure privacy was maintained during toileting and/or personal cares for 2 of 13 sampled residents.
A	166	E	Failed to ensure that grievances voiced by 11 residents in resident council, who wished to remain anonymous, were addressed and resolved.
A	166	E	Failed to resolve resident complaints/grievances related to call light response time. This had the potential to affect 37 residents identified by the facility as capable of using their call lights.
A	166	E	Failed to resolve resident complaints regarding the length of time required for call lights to be answered. Sample size was 13.
A	166	E	Failed to resolve grievances regarding the length of time required for call lights to be answered and food service complaints. Total sample size was 12.
A	166	E	Failed to resolve grievances related to residents' repeated complaints that dining room chairs were not always pushed up to tables once they were vacated by residents and/or staff making it difficult for residents to maneuver in and out of dining room.
A	166	E	Failed to resolve a grievance voiced by 19 residents that meals were served late.
A	167	C	Failed to post the most recent survey results of the facility to be accessible to the residents without asking for staff to read the results.
A	174	D	Failed to provide 1 resident reasonable access to use a telephone. Sample size was 17.
A	176	D	Failed to assess 2 residents of 20 sampled for self-administration of medications.
A	176	D	Failed to assess the resident for the safe use of a sports cream at the bedside for 1 resident of 13 sampled.
A	176	D	Failed to complete an assessment for self administration of medications for one resident. Sample size was 10.
C	202	D	Failed to obtain physician documentation supporting resident transfer to an assisted living facility for 1 sampled resident of 4 closed records.

Type	Tag	S/S	Description
C	203	D	Failed to ensure that 1 resident was given a 30 day written discharge/transfer notice before being transferred from the facility.
C	203	D	Failed to ensure that 1 resident of 6 sampled received the required written discharge/transfer notice containing the resident's right to appeal the action to the state and the name, address, and telephone of the state long term care ombudsman.
C	203	E	Failed to ensure that 3 residents of 4 closed records reviewed were given the required written discharge/transfer notice before being transferred from the facility.
A	204	D	Failed to establish a discharge plan of care to ensure a safe and orderly discharge for 1 resident that had expressed a desire on admission to return to the resident's prior living arrangements.
C	204	E	Failed to establish a discharge plan of care to ensure a safe and orderly discharge for 3 residents of 4 sampled closed records.
A	221	D	Failed to 1. complete an assessment to ensure that full side rails in place for 1 resident were the least restrictive yet effective device for the resident and 2. ensure that physician orders included the specific device and diagnosis for side rails.
A	221	D	Failed to identify and assess the status of a merry walker as a restraint for 1 resident of 9 sampled.
C	223	G	Failed to protect 2 residents from inappropriate touching/sexual abuse.
A	225	D	Failed to protect residents after an allegation of mistreatment to 1 resident by allowing the employee to continue to work with the residents after the allegation and during the investigation.
C	225	D	Failed to identify a complaint received from a family member regarding 1 closed resident record reviewed as an allegation of neglect, notify the State of the investigation, and forward it to the State per facility policy and State Regulations.
C	225	D	Failed to report to the State Agency and investigate the occurrence of a possible fracture of 1 Resident's finger. Total sample size was 3.
A	225	D	Failed to report 2 incidents of possible abuse and/or neglect to Adult Protective Services [APS] within 24 hours in accordance with state law involving 3 residents. Failed to ensure staff immediately notified administration of allegations of abuse.
A	225	D	Failed to report to the State Agency and investigate the occurrence of a possible fracture of 1 resident's ankle of 10 sampled.
C	225	D	Failed to ensure a process in place to fully investigate and report all alleged violations of abuse/neglect to State Survey and Certification Agency for 1 incident documented in facility files involving a Staff Nurse and 1 resident.
A	225	D	Failed to ensure that all staff immediately notified Administration of allegations of abuse for 1 incident involving 2 staff members.
C	225	D	Failed to report to the State Agency that a resident had been served the wrong diet, choked and died.
C	225	E	Failed to report 3 allegations of possible abuse to APS within 24 hours in accordance with state law involving 5 of 6 sampled residents and failed to submit report of investigation within 5 working days for 2 allegations of possible abuse.
C	225	E	Failed to ensure that all staff immediately notified Administration of allegations of abuse and/or neglect for 3 documented incidents involving 2 of 8 facility staff members interviewed.
A	226	D	Failed to ensure that the staff reported an observed incident of resident to resident verbal abuse and an allegation of resident to resident physical abuse for 1 resident, to the administrative staff per facility policy and procedure.
C	226	D	Failed to maintain verification of nurse aide registry checks for 3 staff members of 5 personnel records reviewed.
C	226	D	Failed to check the Nurse Aide Registry for one Nurse Aide of five newly hired staff.
C	226	E	Failed to: 1) Follow procedures in reporting an allegation of sexual abuse involving 2 residents to facility administration; 2) Provide timely education regarding abuse procedures for new employees 3) Provide ongoing abuse procedures education.
A	226	E	Failed to complete criminal background and registry checks for 1 newly hired employee RN- E.

Type	Tag	S/S	Description
A	241	D	Failed to address the residents by the name the resident wanted to be called for 2 residents of 10 sampled.
A	241	D	Failed to promote dignity during meals for 1 resident by placing the resident in the hallway outside of the assist dining room.
A	241	D	Failed to assure care was provided to residents in a dignified manner as staff members on 2 separate occasions failed to communicate with 1 resident prior to provision of cares which caused the resident to be resistant with cares.
A	241	E	Failed to treat 1 resident of 12 sampled with privacy and dignity during personal cares.
C	242	D	Failed to follow up with resident families to ensure that a choice of mortuary had been identified for 1 resident of 13 sampled and failed to document the choice of a mortuary on resident Admission Face Sheets for 6 residents.
A	246	D	Failed to evaluate and implement interventions to maintain or improve abilities for toileting for 1 resident of 10 sampled.
A	246	D	Failed to ensure that call lights were accessible for two residents and failed to ensure the call light system was in a format that promoted ease of use for one resident with arthritis and 2 confidential interviews. Sample size was 24.
C	246	D	Failed to ensure a soft touch call light was in place for 1 resident and failed to ensure the call light was accessible for 1 resident of 26 sampled.
A	246	E	Failed to ensure that the call light was accessible for 3 current sampled residents of 14.
A	248	D	Failed to provide activities that are meaningful and meet individualized interests and abilities for 3 residents of 20 sampled.
A	248	D	Failed to ensure that 2 residents of 19 sampled were provided with meaningful activities of interest.
A	248	E	Failed to provide activities that are meaningful and meet individualized interests and abilities for 5 of 14 sampled residents.
C	250	E	Failed to provide discharge planning for 3 of 4 closed records reviewed.
A	253	D	Failed to maintain carpet in the lounge area, wooden chairs in the assisted dining room, caulking around the toilets in 2 rooms and caulking around the base in the shower room in clean manor and in good repair.
A	253	D	Failed to ensure that one resident room was free of odor.
A	253	E	Failed to 1.) Maintain facility grounds by ensuring the entry area was free of cigarette butts; 2.) Ensure walls were free from scrapes and gouges; and 3.) Ensure bathroom vents and 1 personal fan was free from build up and debris.
A	253	E	Failed 1)to maintain the doors to the resident rooms, 2) to clean the heater vents in the resident rooms, 3) to fix the walls in the residents room that were marred, 4) to clean around the toilets in the resident bathrooms.
A	253	E	Failed to maintain the doors to the residents' bathrooms and fix a hole in the wall of the dining room.
A	253	E	Failed to maintain the integrity of door frames, window sills, and floor tiles to ensure a clean, well-maintained environment for 12 out of 40 rooms. Failed to eliminate unpleasant odors in one of the hallways. Sample size of 13.
A	253	E	Failed to maintain surfaces on resident bathroom door frames, West hall double doors, and East hall shower room walls in good repair related to missing paint and gouges and marred wood.
A	253	E	Failed to ensure closet doors were functional for 4 non sampled residents.
A	253	E	Failed to maintain the environment related to damaged walls, torn wallpaper, scratched paint, exposed nails, and screws and hooks on walls. This had the potential to affect residents in 14 resident rooms.
A	253	E	Failed to maintain in residents rooms: 1)doors/casings, 2) closet doors, 3) fix walls that were marred, 4) to rid court yard of weeds 5) Clean covered area of debris 6) clean bird droppings 7) fix cement in entry way 8) fix cracks in linoleum in hall.

Type	Tag	S/S	Description
A	253	E	Failed to maintain a clean, odor free environment as evidenced by strong odors of urine present in resident rooms on the first floor of the facility. This affected 10 of 14 resident rooms on the first floor.
A	272	E	Failed to: 1) complete required RAP documentation for 1 resident; and 2) identify unique or causal factors for triggered RAPs for 2 residents of 9 sampled.
A	274	D	Failed to complete a required significant change MDS assessment for 1 of 10 sampled residents.
A	278	D	Failed to ensure the Registered Nurse [RN] Coordinator signed that the MDS were complete after all parties completing portions signed that the assessments were completed for 4 resident's MDS assessments of 22 sampled.
A	278	D	Failed to identify the use of oxygen on MDS assessments for 2 residents of 13 sampled.
A	278	D	Failed to accurately code the MDS for: 1) changes in incontinence for 2 residents; and 2) changes in weight for 1 resident of 9 sampled.
A	278	D	Failed to accurately code the MDS for 1 resident and accurately complete the MDS regarding RN coordinator signatures with date of completion for 2 residents of 15 sampled.
A	278	E	Failed to code the MDS assessments as directed by the RAI manual instructions regarding: 1) coding of resident bladder control for 1 resident; 2) coding the history of resident fractures for 1 resident; 3) coding of medications for 2 residents of 9.
A	278	E	Failed to accurately code the MDS for: 1) use of a psychotropic medication for 1 resident; 2) Restorative Nursing walking programs for 3 residents. and 3) use of side rails for 1 resident of 12 sampled.
A	278	E	Failed to ensure toileting plans were correctly coded for 8 residents and failed to ensure nutritional approaches for 1 resident were accurately assessed and coded.
A	278	E	Failed to ensure that MDS assessments or RAPs were signed within the guidelines of the assessment time frames for 8 of 10 sampled residents.
A	278	E	Failed to ensure that MDS assessments were coded to accurately reflect residents' status regarding: 1) fractures for 1 resident; 2) restorative services for 2 residents and 3) pneumococcal vaccinations for 1 resident. Sample size was 10.
A	279	D	Failed to develop the resident's care plan for 1 resident identified at risk for dehydration. Sample size was 20.
A	279	D	Failed to ensure that a comprehensive care plan was developed for one resident of 19 sampled.
A	279	D	Failed to develop care plan interventions to alleviate insomnia for 1 resident of 13 sampled.
A	279	D	Failed to develop care plan problems and approaches for significant weight changes related to edema and diuresis for 1 resident of 9 sampled.
A	279	E	Failed to develop care plans to address insomnia for 3 residents, weight loss, and the use of routine psychotropic medications for 1 resident, vision problems for 1 resident and issues with a stomach banding for 1 resident of 9 sampled.
A	279	E	Failed to develop and individualize care plans to address incontinence for 6 residents of 10 sampled.
A	279	E	Failed to develop comprehensive care plans that addressed the individual needs of residents and specific interventions for 4 of 13 residents.
A	280	D	Failed to revise the care plan to direct a specific transfer technique and specific instructions for the use of a personal alarm for 1 resident of 9 sampled.
A	280	D	Failed to review and revise care plans to ensure accuracy for 2 residents of 19 sampled.
A	280	D	Failed to clarify approaches on the care plan regarding the use of a personal alarm and frequency to obtain weights for 1 current sampled resident of 13 sampled.
A	280	D	Failed to review and revise the care plan for 1 resident of 15 sampled to reflect the current needs with measurable goals and objectives.

Type	Tag	S/S	Description
R	280	D	Failed to ensure that care plans were reviewed and revised when changes occurred for 2 residents of 6 sampled.
A	280	E	Failed to ensure that comprehensive care plan had been reviewed and revised to reflect current and accurate information for 4 residents of 20 sampled.
A	280	E	Failed to review and revise the Resident Comprehensive Care Plan to reflect accuracy and current needs for 3 residents of 15 sampled residents.
A	280	E	Failed to update the care plans regarding the use of personal alarms for 2 residents and the goal dates for current problems identified for 1 resident of 9 sampled.
A	280	E	Failed to review and revise care plans regarding medications for 1 resident and resorative services for two residents of 10 sampled.
A	281	D	Failed to ensure that physician orders were followed regarding the use of the telephone for 1 of 9 sampled residents.
C	281	D	Failed to ensure that Standards of Practice for documentation in the medical records accurately reflected circumstances 'when falls occurred and injuries were sustained for 3 residents. Failed to provide assessment to prevent futher injuries from occurring
A	281	D	Failed to follow physician orders relating to administration of medication for 1 of 20 sampled residents.
A	281	D	Failed to ensure physician orders for oxygen administration were followed for 2 residents of 10 sampled.
A	281	D	Failed to ensure that physicians' orders were followed for fluid restriction for one resident to treat the medical condition of the resident. Sample of 13.
A	281	D	Failed to follow the physician's orders in obtaining routine blood lab results for 1 resident of 20 sampled.
A	281	D	Failed to ensure that the medication nurse followed the facility policy and procedure and nursing standards of practice to observe the residents swallow their medications for 1 resident of 9 sampled.
A	281	D	Failed to ensure that physician's orders to check blood pressure prior to the administration of medications were followed for 1 resident of 19 sampled.
C	281	D	Failed to provide care in accordance with nursing standards of practice as 1 resident open skin areas were not monitored in accordance with facility policies/procedures, and physician orders were not followed for use of an Aqua K pad for 1 resident.
A	281	D	Failed to ensure medications were administered as the physician prescribed for 1 of 10 sampled residents and 1 non-sampled resident.
C	281	D	Ftaff failed to complete range of motion as ordered, failed to administer insulin as ordered,failed to inform a physician of refusal of insulin and failed to ensure suctioning equipment was available for 3 residents of 14 sampled.
A	281	D	Failed to ensure physician's orders were followed for the collection of laboratory tests for 3 residents of 14 sampled.
C	281	D	Failed to apply dressings to skin tears per the physician order for 1 resident; failed to provide a tube feeding administration per physician order for 1 resident. Sample size was 10.
A	281	D	Failed to ensure that laboratory work was drawn as ordered by the physician for 2 residents of 11 sampled.
R	281	D	Failed to ensure physician orders to check blood pressure prior to the administration of medication were followed for 1 resident and that medication was administered as ordered by the physician for 1 resident. Sample size was 6.
A	281	E	Failed to ensure that: 1) medications provided to 1 resident were provided in accordance with physician's orders; and 2) medications provided to 2 residents were provided in accordance with standards of practice and facility procedure. Sample size was 15
A	281	E	Failed to (1) obtain a physician's order to send medications with a resident upon transfer to another level of care for 1 of 10 records reviewed, (2) failed to obtain a physician's order to change the length of time for an antibiotic to be administered
A	281	E	Failed to follow Physician Orders for 4 of 17 sampled residents.

Type	Tag	S/S	Description
C	281	G	Failed to ensure that medical practitioner's orders were clarified and followed for 1 resident of 6 sampled.
A	309	D	Failed to 1. complete neurological assessments as indicated after falls and 2. assess the resident, provide interventions, and follow up after resident to resident incidents for 1 of 9 sampled residents.
A	309	D	Failed to reassess one resident with increased complaints of pain, failed to evaluate the effectiveness of current interventions for pain and failed to consistently implement the interventions for ongoing complaints of pain.
A	309	D	Failed to implement their bowel management protocol to prevent potential bowel complications for 1 resident of 10 sampled.
A	309	D	Failed to review, revise and implement interventions to protect the skin integrity for 2 residents of 15 sampled.
A	309	D	Failed to develop a plan to manage ongoing disruptive behaviors for 1 resident of 12 sampled.
C	309	D	Failed to implement interventions to prevent the adverse behaviors of one resident from reoccurring. Sample size was 4.
A	309	D	Failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.
C	309	D	Failed to assess risk factors for skin breakdown and contractive development for 1 resident of 4 sampled residents.
C	309	E	Facility failed to monitor and assess 2 residents responses following emergency evacuation procedures.
A	309	G	Failed to implement additional interventions to minimize pain, failed to assess causal factors of pain for 1 and failed to monitor a dialysis access site for 1 resident. Sample size was 15.
A	309	G	Failed to follow policies and procedures for hand hygiene and glove use while providing cares for 2 of 12 sampled residents.
C	309	G	Failed to immediately complete assignments and provide interventions following a choking episode for 1 resident.
A	311	D	Failed to ensure that 1 resident of 15 sampled identified as having swallowing difficulty was provided with assistance in the dining room during mealtime.
A	311	D	Failed to ensure 1 resident of 10 sampled received services to maintain or improve bowel and bladder continence.
A	311	D	Failed to implement an ambulation and exercise program in a timely manner to prevent the potential for decline for one resident of 10 sampled.
A	312	D	Failed to accommodate the needs of the residents by not answering the call lights to the residents satisfaction.
A	312	D	Failed to follow speech therapy recommendations to provide meal assistance to 3 residents of 20 sampled.
A	314	D	Failed to evaluate interventions and revise interventions as necessary to promote improvement for healing of pressure sores for 1 resident of 15 sampled.
A	314	D	Failed to implement interventions to prevent the potential for skin breakdown for 1 resident of 12 sampled previously identified at risk.
A	314	D	Failed to provide necessary treatment/services to promote optimum healing of 1 resident pressure sores who was observed all days of the survey seated in a wheelchair with legs in a dependent position without benefit of repositioning.
A	314	G	Failed to implement new interventions to prevent further pressure ulcer development for 1 resident of 15 sampled.
A	314	G	Failed to provide treatments, reposition the residents and put interventions in place to promote healing for 2 of 13 sampled residents with pressure ulcers.
A	315	D	Failed to ensure that staff performed pericare in a manner to prevent the potential for Urinary Tract Infections (UTI) for one resident of 8 sampled.
C	315	D	Failed to provide perineal cares and cleansing of indwelling catheters in a manner to prevent cross contamination and prevent urinary tract infections for 2 residents of 4 in house residents observed.

Type	Tag	S/S	Description
A	315	D	Failed to ensure the catheter tubing and bag were kept off the floor to prevent a potential urinary infection for 1 of 10 sampled residents. Failed to have a confirmed diagnosis in the use of the catheter for 1 resident.
A	315	D	Failed to provide perineal care In a manner to prevent the potential for a urinary tract Infection for 2 residents of 15 sampled.
A	315	D	Failed to complete an assessment to evaluate bladder incontinence for 1 resident of 13 sampled.
A	315	D	Failed to have a Bladder Assessment completed to ensure that 2 of 10 residents maintained their bladder function at their highest level.
A	315	E	Failed to ensure that perineal cares were provided in a manner to prevent urinary tract infections, or prevent spread of bacteria, for 5 residents of 10 sampled.
A	315	E	Failed to provide thorough perineal care to prevent urinary tract infections and skin breakdown. The sample size was 12.
A	315	E	Failed to provide perineal care in a manner to prevent the potential for a urinary tract infection for 3 residents. Sample size of 15.
A	315	G	Failed to assess decline in urinary incontinence for 2 of 9 sampled residents.
A	318	D	Failed to identify the potential for and implement interventions to prevent a potential decline in Range of Motion (ROM - the distance and direction a joint can move to its full potential) for one resident of 24 sampled.
A	318	D	Failed to have 1 resident assessed and a restorative plan was not developed in an attempt to prevent loss of Rand of Motion (ROM) and contractures. Total sample size was 10.
A	322	D	Failed to ensure that 1 resident's head of the bed was elevated to prevent possible aspiration [food or fluid into the lung] from a resident sample size of 13.
A	322	D	Failed to ensure that 1 resident's head of the bed was elevated to prevent possible aspiration [food or fluids Into the lungs]. Sample size was 15.
C	323	C	Failed to (1) document that the alarms were checked, functional and switched on a regular basis; and (2) implement interventions to prevent falls from occurring for 2 residents of 3 sampled.
A	323	D	Failed to maintain an exit alarm in working order to prevent the potential for elopement and failed to store hazardous chemicals in a manner to prevent the potential for accidental ingestion, inhalation, skin contact etc.
A	323	D	Failed to identify hazards/risks, implement interventions to reduce hazards and risks and monitor effectiveness of interventions for 1 resident relating to the use of an electric mobility wheelchair and failed to monitor and modify safety measures.
A	323	D	Failed to assess for causal factors of falls, make changes in the care and implement interventions to prevent accidents with injuries from occurring for 1 resident of 13 sampled.
A	323	D	Failed to apply footrests on the wheelchair to reduce the risk of injury during transport in the hallways for 1 resident dependent on the Staff for mobility.
C	323	D	Failed to ensure 1 resident of 6 sampled residents was not left unattended during out of facility appointments.
A	323	D	Failed to provide footrests on a wheelchair to ensure safe and comfortable transportation for 1 resident of 13 sampled.
A	323	D	Failed to provide adequate supervision, assess for causal factors and implement interventions to prevent accidents from occurring for 1 resident of 14 residents reviewed.
C	323	D	Failed to supervise 1 resident in the center patio and failed to protect the skin integrity of 1 resident. The survey consisted of 14 sampled.
A	323	E	Failed to control access to hazardous chemicals as the doors of the housekeeping janitorial room and dietary janitorial room which contained cleaning chemicals were unlocked allowing access to 4 residents of 10 sampled who wandered.

Type	Tag	S/S	Description
A	323	E	Failed to ensure bathing fixture temperatures did not exceed 110 degrees Fahrenheit as required for 3 of 3 bathing fixtures and failed to check temperature prior to bathing one of 13 sampled resident.
A	325	D	Failed to revise and implement interventions to prevent 1 resident of 20 sampled from having a significant weight loss.
A	325	D	Failed to provide nutritional interventions in a timely manner to prevent significant, unplanned weight loss from continuing to occur for 1 of 13 residents reviewed.
A	325	D	Failed to provide staff supervision and the necessary diet consistency to prevent weight loss for 1 resident. Resident sample was 15.
A	325	D	Failed to implement interventions for one resident of 10 sampled to prevent weight loss.
A	325	E	Failed to develop and implement a system to record and monitor the intake of dietary supplements for residents identified at nutritional risk. This practice had the potential to affect 8 residents of 12 sampled receiving supplements.
A	327	D	Failed to ensure that 3 residents of 15 sampled received sufficient fluids to meet their assessed hydration needs.
A	327	D	Failed to monitor actual daily fluid intake to ensure adequate hydration and the effectiveness of fluid restrictions ordered for 2 residents of 13 sampled.
R	327	D	Failed to ensure sufficient intake of fluids to maintain adequate hydration for one resident of 6 sampled.
A	329	D	Failed to establish target behaviors and monitor behaviors for 2 residents of 15 sampled.
A	329	D	Failed to question discrepancies regarding medical diagnosis to determine the indications and appropriateness of drug therapy for 1 resident of 9 sampled.
A	329	D	Failed to identify indications for use and monitor the effectiveness of a medication used for sleep for 1 resident of 20 sampled.
A	329	D	Failed to ensure that non-pharmacological interventions were attempted and documented prior to the use of antipsychotic medications for 1 resident of 15 sampled.
A	329	D	Failed to provide non pharmacological interventions for residents with behaviors before providing medication for the behaviors in 3 of 15 sampled residents.
A	329	D	Failed to ensure two gradual dose reductions were attempted within the first year of admission or start of the medication for 2 of 22 sampled residents.
A	329	D	Failed to ensure that non pharmacological interventions were attempted prior to the use of antipsychotic medications for 1 resident of 19 sampled.
A	329	D	Failed to ensure that non pharmacological interventions were attempted prior to the use of psychoactive medications for 2 out of 10 sampled residents.
A	329	D	Failed to provide non pharmacological interventions for 1 resident with behaviors before providing medication for the behaviors in 1 of 15 sampled residents.
A	329	E	Failed to assure 3 of 10 sampled residents were free from unnecessary drugs, as a psychoactive medications were not adequately monitored and/or a gradual dose reduction (GDR) had not been attempted.
C	332	D	Failed to ensure a medication error rate of less than 5%. A total of 40 medications were administered with 3 errors. The error rate was 7.5%. Sample size was 14.
A	332	D	Failed to administer medications for 2 residents at a medication error rate below 5% from a resident sample size of 15.
A	332	E	Failed to administer medications for 3 residents at a medication error rate below 5% from a resident sample size of 14.

Type	Tag	S/S	Description
A	332	E	Failed to ensure that medications were administered to 3 out of 6 residents at a rate of less than 5%. The total number of medications passed was 42 with 5 medication errors, resulting in a medication error rate of approximately 11%.
A	333	D	Failed to administer medication according to the manufacturer's directions for 1 resident of 13 sampled resulting in a significant medication error.
A	333	G	1 resident received 10 medications which were meant for the residents roommate while in the dining room. The medication error resulted in the resident being hospitalized for observation.
A	356	C	Failed to post daily nurse staffing information in a prominent place readily accessible and visible to residents and visitors. Total sample size was 10.
A	361	E	Failed to ensure that the RD reviewed: 1) dietary needs for significant weight loss and skin breakdown 2) skin breakdown 3) a planned weight loss program, 4) nutritional needs for resident with a lap band 5) fluid restriction & low sodium level.
A	363	D	Failed to fortify a meal with additional protein for 1 resident per dietician recommendations of 9 sampled.
A	363	E	Failed to follow the facility menu by: 1) Omitting a food item listed on the menu; 2) Ensure adequate serving sizes were followed; and 3.) Fortifying diets.
A	363	E	Failed to ensure that all residents with diet orders for regular portion sizes received the planned portion size of chicken during one meal observation, and that memory care residents received planned portion size of ground polich sausage during one meal
A	363	E	Failed to follow the menu by omitting sausage from the pre-planned written menu.
A	363	E	Failed to follow the preplanned menu to ensure the correct portion of protein was served to 8 residents that received pureed diets and to 13 residents that received mechanical soft (ground meat) diets.
A	363	F	Failed to serve buttered bread as directed on the menu for 22 of 23 residents on a regular diet.
A	365	D	Failed to serve a mechanical soft diet to one resident as ordered to prevent the potential for aspiration. This had the potential to affect two residents with mechanically altered diets. Sample size was 8.
A	365	D	Failed to prepare and serve food to meet the residents needs for 1 resident. Resident sample size 15.
A	365	D	Failed to ensure that diet orders for 1 resident of 10 sampled were followed.
C	365	G	Failed to serve a mechanical soft diet to 1 resident resulting in the resident choking.
A	367	D	Failed to follow physician's diet orders for 1 resident. Sample size was 10.
A	369	D	Failed to ensure that one Resident was provided adaptive eating utensils as needed. Sample size was 24.
A	371	E	Failed to remove gloves when contaminated while preparing food and failed to ensure fire sprinkler units were free from debris.
A	371	E	Failed to A) ensure dietary staff utilized proper hand wash technique; B) ensure ice water was provided to the residents in a manner to minimize cross-contamination between residents.
A	371	E	Failed to maintain a clean or cleanable area around food preparation. This had the potential to affect all residents. Sample size was 10.
A	371	E	Failed to maintain the temperatures of cold foods at the time of meal service for 5 residents of 11 sampled that received extra protein with meals, as well as residents that chose the alternate entrée offered.
A	371	F	Failed to ensure that potentially hazardous foods were cooled within safe parameters, and were held for service at safe temperatures. Failed to ensure that the air conditioner unit was kept in good repair and that the culinary sink indirectly drained.

Type	Tag	S/S	Description
A	371	F	Failed to change gloves and/or wash hands during the prep of food and to maintain and/or clean the kitchen and/or equipment to prevent contamination of food and failed to have an anti-siphon device on floor sink to prevent contamination of potable water.
A	371	F	Failed to ensure that the kitchen culinary sink was indirectly drained and that potentially hazardous foods were hot held at or above required temperature for safety.
A	371	F	Failed to ensure that potentially hazardous foods on the steam table were held at temperatures to ensure safety, and that the can opener was cleaned.
A	371	F	Failed to ensure ready to eat food was not handled with potentially contaminated bare hands and failed to ensure fire sprinkler units, and light covers were free from debris.
A	371	F	Failed to pass ice water to the residents in a clean manner.
A	371	F	Failed to 1) date bottles of applesauce when transferred from the Original container, 2) ensure staff wore hair restraints in the kitchen food preparation area, 3) discard stained/scratched divided plates, and 4) ensure floor is clean under dish machine.
A	371	F	Failed to ensure that potentially hazardous foods were hot held at or above 135 degrees Fahrenheit (F).
A	371	F	Failed to prepare and distribute food in a manner to prevent the potential for cross contamination and food borne illness. This was related to serving utensils, drinking glasses not clean to sight and touch.
A	371	F	Failed to ensure that potentially hazardous foods were cooled within safe parameters, and that the culinary sink was indirectly drained.
A	371	F	Failed to prepare food under sanitary conditions as evidenced by hand washing practices during 2 food preparation observations.
A	371	F	Failed to A) ensure food available for resident consumption was wholesome and B) ensure that dishes clean dishes were not contaminated and C) ensure food temperatures were within the safe temperature guidelines.
A	371	F	Failed to: 1) replace kitchen sinks with worn finishes; and 2) prevent ceiling vents in the kitchen from collecting dust and debris.
A	371	F	Failed to ensure that potentially hazardous foods were hot held for service at or above 135 degrees Fahrenheit (F) and cold held at or below 41 degrees F.
A	371	F	Failed to ensure ready to eat food was not handled with potentially contaminated gloved hands and failed to ensure fire sprinkler pipe units, and vent covers were free from debris.
A	371	F	Failed to ensure that potentially hazardous foods were cooked and cooled within recommended parameters for safety.
A	387	D	Failed to ensure that 1 resident was seen by a physician every 30 days for the first 90 days after admission and every 60 days after that as per regulatory guidelines.
C	406	D	Failed to provided physical therapy services in a timely manner in accordance with physician's order for 1 resident of 14 sampled.
A	411	D	Failed to ensure that dental services were provided as ordered by one residents dentist and as requested by 1 resident. Sample size was 15.
A	425	D	Failed to obtain routine medications ordered by the medical practitioner for 1 resident of 9 sampled.
C	425	G	Failed to ensure that medications were accurately ordered and acquired for 1 resident of 6 sampled.
A	428	D	Failed to ensure that the Consultant Pharmacist identified irregularities regarding potential medication interactions for 1 resident of 20 sampled.
A	428	D	Failed to ensure psychotropic medication dose reductions were attempted or that clinical rationales for not attempting dose reductions were documented for 3 residents of 10 sampled.
A	428	D	Failed to identify duplicate therapy for 1 resident of 15 sampled.

Type	Tag	S/S	Description
A	428	D	Failed to ensure that medication irregularities were identified for 3 of 22 sampled residents.
A	428	D	Failed to ensure that the consultant pharmacist identified duplicate therapy as an irregularity for 2 residents, and the use of an hypnotic (sleep inducing) medication outside of manufacturers recommendations for one resident. Sample size was 19.
A	428	D	Failed to identify that current electrolyte lab values had been obtained for 1 sampled resident receiving routine diuretic therapy.
A	428	D	Failed to act upon recommendations by the Consultant Pharmacist regarding obtaining a sleep assessment for 1 resident of 15 sampled.
A	428	E	Failed to ensure the consultant pharmacist identified drug regimen irregularities and that the irregularities were reported to the Physician and Director of Nursing for 3 of 10 sampled residents.
A	428	E	Failed to identify and report drug irregularities to the Director of Nurses and the Physician for 3 residents of 10 sampled.
A	428	E	Failed to identify and/or report irregularities regarding psychoactive medication administration to the attending physician and/or Director of Nursing for 5 of 10 residents reviewed.
A	431	D	Failed to ensure the medication label for 1 resident of 9 sampled matched the medication instructions from the physician's order.
A	431	D	Failed to ensure that the narcotic count was reconciled for one resident of 19 sampled.
A	431	D	Failed to ensure that the prescription label accurately reflected the physician's orders for Insulin dosing for 1 current non sampled resident.
A	441	D	Failed to remove gloves and wash hands at appropriate times and contaminated scissors, washcloths and treatment supplies while performing treatments.
A	441	D	Failed to provide hand washing hygiene and gloving procedures to prevent cross-contamination during personal hygiene cares and treatments for 4 residents of 30 sampled.
A	441	D	Failed to follow the facility policy to clean up body excretion spill from 1 resident from a resident sample size of 12.
A	441	D	Failed to follow hand washing hygiene procedures to prevent cross-contamination during personal hygiene cares for 4 residents of 21 sampled.
C	441	D	Failed to utilize isolation procedures, failed to ensure personal equipment used for assessments and gloves were changed to prevent cross contamination for 2 of 6 sampled residents.
A	441	D	Failed to provide hand washing to prevent the transmission of disease for 2 residents from a resident sample size of 15.
A	441	D	Failed to follow facility policy for cares and medication pass for 3 residents of 22 sampled.
AA	441	D	Failed to assure that nursing staff used gloves and handled soiled linens in a manner to prevent the potential spread of infection during suprapubic catheter care for 1 resident.
A	441	D	Failed to assure that staff washed hands as indicated, using proper technique, during resident interaction.
C	441	D	Failed to follow isolation procedures, failed to utilize handwashing and gloving techniques to prevent cross contamination during the provision of care for 2 residents of 14 sampled.
A	441	D	Failed to ensure that nursing personnel performed hand hygiene/glove changing as , required during provision of incontinent cares for 1 resident of 11 sampled.
A	441	D	Failed to ensure that infection control practices were followed during a transfer of 1 resident from a resident sample size of 15.
A	441	E	Failed to follow the policy of keeping hands clean before and during completing cares for 5 residents of 14 sampled.
A	441	E	Failed to follow policies/procedures for hand washing; 3 nursing staff member failed to follow the policy of keeping hands clean before and during completing cares for 3 residents of 10 sampled.

Type	Tag	S/S	Description
A	441	E	Failed to ensure and verify with the physician the precautions needed to prevent the transmission of Clostridium Difficile [C-diff] in 1 resident and to follow the facility policy and procedure to clean up a body excretion spill for one resident of 13.
A	441	E	Failed to administer medications, and failed to clean equipment used for treatments before and after use for 5 residents of 10 sampled.
C	441	E	Failed to provide hand washing hygiene and gloving procedures to prevent cross-contamination during personal hygiene cares, treatments and during the medication pass for 5 residents of 13 sampled.
A	441	E	Failed to ensure that the security belts on 2 of 2 shower chairs were cleaned according to manufacturers recommendations to effectively sanitize between multiple resident use.
A	441	E	Failed to ensure that nursing staff washed hands as indicated during resident interactions in the dining room. Failed to ensure that nursing personnel performed hand hygiene during provision of incontinent cares as needed for 1 resident of 13 sampled.
A	441	E	Failed to ensure that the 1 of 1 operational shower chair was cleaned according to manufacturer's recommendations to effectively sanitize between resident use.
A	441	E	Failed to follow hand washing hygiene procedures to prevent cross-contamination during personal hygiene cares for 2 sampled residents of 10.
C	441	E	Failed to follow policies and procedures for hand hygiene and glove use while providing cares for 2 residents of 7 sampled.
A	441	E	Failed to: 1) disinfect a shower chair in 1 of the 2 bathhouses and 2) the failed to prevent the potential of resident to resident cross contamination during ice pass.
A	441	F	Failed to ensure that staff performed hand hygiene in a manner to prevent the potential for spread of infection during medication administration to two residents and during cares for two residents. Failed to sanitize the whirlpool tub.
A	441	F	Failed to implement the infection control program to prevent potential spread of infection for 4 of 15 sampled residents.
A	444	D	Failed to utilize hand washing and gloving techniques during the provision of cares for 2 residents of 15 sampled.
A	444	D	Failed to ensure that a contaminated oxygen cannula was replaced to reduce the risk of infection for 1 resident of 9 sampled.
A	445	F	Failed to ensure that residents' comingled personal clothing items were laundered using sanitary methods.
A	456	E	Failed to maintain the wheelchair arm pads and wheelchair cushions as a safe and/or cleanable surface for 4 residents of 14 sampled.
A	465	D	Failed to maintain staff bathroom walls, service hall walls and pill crushers in a clean manor and in good repair.
A	465	D	Failed to maintain kitchen in a clean/sanitary manner as vinyl laminate counter tops were chipped and pieces were missing, the laminate surface of 2 doors, edges of cabinets chipped/peeling, lime deposits on hand sink in food prep area.
A	465	E	Failed to ensure that 2 out of 3 whirlpool chair seat belts were free from worn areas.
A	467	E	Failed to ensure that 3 out of 8 sampled resident bathrooms had working ventilation systems.
F	497	F	Failed to assure the provision of a minimum of 12 hours of education that were appropriate to job duties and included meeting the physical, psychosocial and mental needs of the residents residing in the facility.
A	499	F	Facility allowed 1 Medication Aide [MA A] to administer medications without current credentials from 5/27/2009 - 9/29/2009.
A	514	D	Failed to: 1) include the date of a pain assessment for 1 resident and 2) include the staff member signature on assessment for 1 of 9 sampled.
A	514	D	Failed to file completed assessment forms in the resident's medical record for 1 resident of 20 sampled.
A	514	D	Failed to ensure that resident clinical records contained accurate, complete and readily accessible information for 2 residents of 17 sampled.
C	514	D	Failed to ensure that one resident of 6 sampled medication record was accurate.

Type	Tag	S/S	Description
C	514	D	Failed to maintain the medical record in an accurate and chronological manner in 2 residents of 10 sampled resident records reviewed.
A	514	E	Failed to ensure pain and sleep assessments were signed and dated by the person responsible for completing the form for 3 residents and ensure PRN medications included follow up results for 1 resident. Sample size was 15.
A	514	E	Failed to ensure that resident assessment documents were completed, signed, and/or dated for 3 of 9 current sampled residents.
A	O108	O	Failed to review the Nebraska State Patrol Sex Offender Registry for adverse findings for 5 of 5 newly hired employees.
C	O108	O	Facility failed to document a decision to hire a person with a finding on a criminal background for 2 staff members of 5 personnel records reviewed.
A	O109	O	Failed to include required education relating to Resident Rights, emergency procedures that include fire and disaster preparedness plans and nursing directives to respond to medical emergencies during the first two weeks of employment for 5 new staff.
A	O109	O	Failed to ensure that initial orientation requirements were provided within two [2] weeks of hire for 2 out of 2 nursing assistants (Nursing Assistant).
C	O110	O	Failed to: 1) document a description of, education training provided for the staff; and 2) identify the person providing the training for the staff.
A	O128	O	Failed to ensure that the dietary manager had the required qualifications.
A	O165	O	Failed to ensure that the discharge summary information contained all the regulatory requirements for 2 residents of 19 sampled.
C	O196	O	Failed to identify and review causal factors and implement system changes to prevent 1 resident of 6 sampled from receiving a significant medication error.
A	O215	O	Failed to ensure that outdated medications were removed and not available for resident use for 3 residents of 19 sampled.
C	O231	O	Failed to ensure inventory was signed upon discharge of Resident 10. Sample size was 4.
A	O231	O	Failed to complete an inventory of personal effects for 1 of 10 sampled.
A	O231	O	Failed to ensure that the Residents possessions are accounted for upon discharge from the facility, in 4 of 4 medical records of discharge reviewed.
A	O231	O	Failed to complete an inventory of personal effects for 3 of 11 sampled residents.
A	O232	O	Failed to ensure that the Chronological Record included documentation of the resident's dentist per regulatory requirements.
A	O293	O	Failed to separate the heads of the beds occupied by one sampled resident and one non-sampled resident at a minimum of three feet.

Count 295