

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER The Pines at Blue Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 414 North Willson Street Blue Hill, NE 68930	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.19(A)</p> <p>Licensure Reference Number 175 NAC 12-006.19(B)</p> <p>Based on observation, record review, and interview, the facility failed to ensure that rooms were clean and maintained for 5 of 16 residents observed (Residents 33, 10, 15, 2, and 29). The facility census was 38.</p> <p>Findings are:</p> <p>Record review of the facility's undated admission Agreement Attachment 3 titled Resident Rights revealed that the resident has the right to a dignified existence. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life. The resident has the right to a safe, clean, comfortable, and homelike environment. The facility must provide a safe, clean, comfortable, and homelike environment. The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior including adequate and comfortable lighting levels in all areas.</p> <p>A.</p> <p>Observation on 4/14/25 at 7:57 AM in the bathroom of Resident 33 revealed that the bathroom was dark. A dull light on the left side above the sink was on. The light on the right side above the sink was not functioning. The ceiling light was dull.</p> <p>Observation on 4/16/24 at 12:47 PM in the room of Resident 33 with the Facility Administrator (FA) confirmed that the light level in the resident's bathroom was low. The FA confirmed that the light on each side of the sink is now working but dull with the yellowed covers on them. The FA confirmed that the light in the ceiling is not a high enough [NAME] bulb to provide sufficient lighting.</p> <p>B.</p> <p>Observation on 4/14/25 at 8:00 AM in the room of Resident 10 revealed that there was an approximately 1 inch gap between the bedroom carpet and the bathroom vinyl floor per visual measurement. The threshold to cover the gap was missing.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 4/16/25 at 12:48 PM in the room of Resident 10 with the FA confirmed that the gap between the carpet of the resident room and the bathroom floor entry needed to be repaired. The FA confirmed that the threshold was missing and needed to be fixed.</p> <p>C.</p> <p>Observation on 4/14/25 at 8:11 AM in the bathroom of Resident 15 revealed that the water in the sink was not draining as the water was running. The water remained in the sink after the water was shut off.</p> <p>Observation on 4/16/25 at 12:42 PM with the FA confirmed that the bathroom sink of Resident 15 was not draining as it should and that it was in need of repair.</p> <p>D.</p> <p>Observation on 4/14/25 at 9:47 AM in the bathroom of Resident 2 revealed that the bathroom exhaust vent cover was soiled with dark dusty debris. The inside of the toilet bowl was stained with scratches and black marks.</p> <p>Observation on 4/16/25 at 12:51 PM in the room of Resident 2 with the FA confirmed that the bathroom exhaust vent was soiled with gray fuzzy debris and rust-like debris and needed to be cleaned. The FA confirmed that the toilet bowl was scratched and needed to be replaced.</p> <p>E.</p> <p>Observation on 4/14/25 at 1:03 PM in the bathroom of Resident 29 revealed that the bathroom exhaust vent was soiled with fuzzy dark debris.</p> <p>Observation on 4/16/25 at 12:52 PM in the room of Resident 29 with the FA confirmed that the bathroom exhaust vent is soiled with gray fuzzy debris and rust-like debris and needed to be cleaned.</p> <p>Interview on 4/16/25 at 12:53 PM with the FA confirmed that the facility needed to address the cleaning and maintenance issues observed for Residents 33, 10, 15, 2, and 29.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.02(H)</p> <p>Based on record reviews and interviews, the facility failed to ensure that interventions were put into place to prevent further potential abuse or self-harm for 1 (Resident 190) of 1 sampled residents. The facility census was 38.</p> <p>Findings are:</p> <p>Record review of the policy Compliance with Reporting Allegations/Neglect Exploitation dated 10/2023 state the policy of this facility is to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property are reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed time frames. The procedure states the following procedures will be initiated:</p> <p>1. The licensed nurse will;</p> <ul style="list-style-type: none"> -Respond to the needs of the resident and protect him/her from further incident, -Notify the Administrator or designee, -Notify the attending physician, family or legal guardian, and the medical director, -Document actions in the medical record, -Complete an incident report, and -Revise the resident's care plan if the residents medical, nursing, physical, mental or psychosocial needs or preferences change as a result of an incident of abuse. <p>Record review of the Facility Assessment approved and dated 04/08/2025 by the facility administrator revealed on page 7 that the facility provides care for diseases/conditions and physical/cognitive disabilities including psychiatric/mood disorders such as psychosis (hallucinations, and delusions), impaired cognition, mental disorder, depression, bipolar disorder, Schizophrenia, post traumatic stress disorder, anxiety disorder, behavior that needs interventions, etc.</p> <p>Record review of the Medical Diagnoses revealed Resident 190 was diagnosed with schizoaffective disorder (bipolar type; mania and depression), non-suicidal self-harm, generalized anxiety disorder, borderline personality disorder, suicidal ideations, sleep apnea, insomnia, post-traumatic stress disorder, hypothyroidism, morbid obesity, and depression among others.</p> <p>Record review of the admission Minimum Data Set (MDS, a standardized assessment tool used to evaluate the health status of residents nursing homes which provides a comprehensive overview of a resident's functional capabilities and helps identify potential health issues used for care planning.) dated 7.26.2024 for Resident 190 revealed the resident had a Brief Interview for Mental Status (BIMS-used to assess a resident's cognitive function) of 14 meaning the resident was cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During the testing period, Resident 190 was not depressed, sometimes felt lonely or isolated, had a worsening or behavior symptoms compared to the prior assessment but did not wander or reject cares, needed assistance with bathing but was able to most other activities of daily living with supervised assistance or independently, was unable to walk due to safety concerns, was occasionally incontinent of bowel and bladder, and had occasional pain. Medications included Antipsychotics for mood stabilization, antidepressants, and hypoglycemic's to lower blood sugars.</p> <p>Record review of the Incidents by Incident Type dated 04/15/2025 revealed that there were six incidents of self-harm recorded for Resident 190. The dates of the incidents were as follows: 7/30/2024, 7/31/2024, 8/23/2024, 8/29/2024, 9/25/2024, and 10/15/2024.</p> <p>Record review of the Resident Census revealed Resident 190 admitted , transferred and discharged on the following dates;</p> <ul style="list-style-type: none"> -admitted to the facility on [DATE]. -Transferred to the hospital on [DATE] and readmitted to the facility on [DATE]. -Transferred to the hospital on [DATE] and readmitted to the facility on [DATE]. -Transferred to the hospital on [DATE] and readmitted to the facility on [DATE]. -Transferred to the hospital on [DATE] and discharged from facility on 10/29/2024. <p>Record review of the Nursing Progress Notes printed on 04/16/2025 revealed the following:</p> <ul style="list-style-type: none"> -7/30/2024 at 9:00 PM revealed Resident 190 had a self-inflicted laceration 3 centimeters (cm) long by 0.3 cm deep to inside of the left arm. Laceration was not actively bleeding. Resident 190 used the fingernails of two fingers on the right hand to cause the injury. The area was cleaned by the charge nurse and a bandage was applied. The progress notes revealed the incident was reported to the physician on 07/31/2024 at 5:00 AM by faxed communication. -07/31/2024 at 8:47 PM revealed the charge nurse was called to Resident 190's room by a medication aide who revealed Resident 190 was picking on the earlier injury found to the left arm. However, Resident 190 had also self-injured an area of the lower abdomen. Resident 190 was sitting up in bed. The charge nurse noted a laceration to the lower abdomen which was 6 cm by 1.5 cm with slow draining blood. The charge nurse attempted to clean area but Resident 190 would not allow the charge nurse to tend to the wound and continued to pick at wound. At 9:15 PM the charge nurse was able to speak with Resident 190 in the resident's room. After resident refused treatment to new self-inflicted abdominal wound and refused an as needed hydroxyzine from the charge nurse, Resident 190 allowed the charge nurse clean the wounds. The area to the resident's lower abdomen measured 6 cm x 1.5 cm and continued with slow draining of blood. The nurse cleansed the area to the resident's left upper arm, which measured 3 cm in length. When asked why Resident 190 hurt oneself, Resident 190 stated physical pain was better than emotional pain and told the charge nurse(gender) was very sad and wanted to die. The Nursing Assistant had told the charge nurse that Resident 190 was suicidal (wanted to kill self). The charge nurse called the guardian and attending physician for Resident 190. Resident 190 was transferred to a hospital for evaluation and treatment. -08/23/2024 at 7:45 PM revealed the nurse charge was called to Resident 190's room by a nursing <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>assistant and found that Resident 190 had self-inflicted skin abrasion to upper chest with no active bleeding. The areas were measured, cleaned, and covered with a clear dressing. Resident had three areas above chest, one measuring 4 cm x 1.5 cm, 3 cm x 1 cm, and 3 cm x 1 cm. Resident 190 felt anxious at the time and did not think to ask for something for anxiety. The facility started Resident 190 on every 15 minute resident checks. The Director of Nursing (DON) and the Physician were both notified of the incident.</p> <p>-08/29/2024 at 8:01 PM revealed a nursing assistant notified the charge nurse that Resident 190 was cutting their stomach with their nails. When the charge nurse entered the room, Resident 190 was found actively using a piece of plastic to try and cut skin on upper middle abdomen. Resident 190's skin was cut open at the center of upper abdominal region and was bleeding. When the charge nurse asked Resident 190 if (gender) had harmed self, Resident 190 stated, yes and I'm gonna keep doing it. The charge nurse then asked if then asked about Resident 190's feelings and what had made Resident 190 start cutting their skin, Resident 190 had stated, I am just tired of it. Resident 190 was reportedly alert and oriented x 4 with a newly self-inflicted abrasion that was 1 cm in length and 0.3 cm in width. DON, physician, and guardian were notified of incident. Resident 190 was sent to ER via ambulance.</p> <p>-09/25/2024 at 12:00 PM revealed the charge nurse contacted the physician and was told of the injuries to Resident 190's arm which were reportedly significant. The physician called the emergency room and requested Resident 190 be admitted to the psychiatric floor of the hospital.</p> <p>-10/15/2024 at 7:50 PM revealed the charge nurse was notified Resident 190 had a pen-like object in Resident 190's left inner biceps (arm). Resident 190 refused scheduled medications and refused to state what (gender) was doing with the pen-like object. Later in the evening, at 10:30 PM another nursing assistant reportedly found Resident 190 scratching (gender) abdomen with a pen-like object. Resident 190 would not reveal what was being done with the pen once again. A skin assessment was completed of Resident 190 and wound measurements completed. The left medial upper arm wound measured 4 cm x 0.5 cm x 0.5 cm. The abdominal wound was not measured due to the refusal of Resident 190 to allow staff to look at the wound. Resident 190's physician was notified at 11:44 PM and orders were received to send Resident 190 to the emergency room. Law enforcement and Emergency Medical Technicians arrived at the facility and the resident was taken to the hospital.</p> <p>Record review of the Care Plan (a document developed for all nursing home residents to help to address both medical and non-medical concerns) printed on 04/15/2025 for Resident 190 revealed that only two updates were added to the care plan to prevent further harm or injuries after the following incidents: 7/30/2024, 7/31/2024, 8/23/2024, 8/29/2024, 9/25/2024, and 10/15/2024.</p> <p>-There was no update to the care plan for Resident 190 after the incidents on 07/30/2024 and 07/31/2024, after Resident 190 returned to the facility following a hospital stay and readmission to the facility on [DATE].</p> <p>-There was no update to the care plan for Resident 190 after the incident on 08/23/2024.</p> <p>-There was an update to the care plan of Resident 190 added on 08/30/2024, the day after the resident was transferred to the hospital, which stated Resident 190 was to be evaluated by hospital for psychiatric needs.</p> <p>-There was no update to the care plan after Resident 190 was re-admitted on [DATE] following an</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>incident on 8/29/2024 and a hospital stay.</p> <p>-There was no update to the care plan for Resident 190 after the incident on 09/25/2024 after Resident 190 returned to the facility following a hospital stay and readmission to the facility on [DATE].</p> <p>-There was an update to the care plan of Resident 190 added on 10/15/2024, the day before the resident was transferred to the hospital, which stated Resident 190 was to be evaluated for wearing appropriate footwear.</p> <p>-There were no care plan updates that revealed preventative measures related to self-harm either while the resident was in the facility or upon return to the facility from hospital stays.</p> <p>Interview on 04/15/2025 at 3:20 PM with Registered Nurse (RN)-D revealed that care plans are usually updated at the time of the risk meeting and by the care plan coordinator or MDS personnel. RN-D had only been working in the facility about 6 weeks and was still learning the facility processes.</p> <p>Interview on 04/15/2025 at 4:15 PM with the Director of Nursing (DON) who stated that the care plans are updated after incidents and as needed by the DON, MDS coordinator, or nursing staff as needed.</p> <p>Interview on 04/16/2025 at 4:10 PM with the Facility Administrator (FA) confirmed no updates were completed in the care plans to prevent further self-harm because the facility didn't want to change any aspects of what the hospital, where Resident 190 had been admitted and released during each hospital stay, had told the facility to do. The FA further confirmed that the facility assessment stated the facility was able to care for residents with the types of disabilities that Resident 190 was diagnosed with and that the facility had not put their own interventions into place to care and prevent further harm to Resident 190.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>Licensure Reference Number 175 NAC 12-006.10(D)</p> <p>Based on observation, record review and interview; the facility failed to ensure a medication error rate of less than 5%. Observations of 27 medications administered revealed 13 errors for 3 (Residents 194, 13, and 17) of 3 sampled residents, resulting in an error rate of 48.15%. The facility census was 38.</p> <p>Findings are:</p> <p>Record review of the policy Medication Errors dated 08/01/2023 revealed the purpose of the policy is to provide protections for the health, welfare, and rights of each resident ensuring residents receive care and services safely in an environment free of significant medications errors. Under the subheading Policy Explanation and Compliance stated the facility must ensure that it is free of medication error rates of 5% or greater as well as significant medication error events. Paragraph 4 states that medication errors include errors in administration times. Paragraph 7 stated to prevent medication errors and ensure safe medication administration, nurses should verify the following: (a) right medication, dose route, and time of administration.</p> <p>Record Review of the policy Medication Administration dated 04/2025, revealed the policy is to ensure that medications are administered by individuals legally authorized to do so in the state as ordered by the physician and in accordance with professional standards of practice. Furthermore, the policy states under the subheading Policy Explanation and Compliance Guidelines sentence 10 that individuals must ensure that the six rights of medication administration are followed including (e) the right time.</p> <p>A.</p> <p>Record review of Resident 17's Electronic Medication Administration Record (EMAR) revealed an order for Levothyroxine 112 micrograms (mcg) to be given 30 minutes prior to meals in the morning, Omeprazole 40 milligrams (mg) to be given each morning one hour before meals, and cariprazine 1.5 mg daily.</p> <p>Observation on 04/14/2025 at 8:57 AM revealed Medication Aide (MA)-C prepared and administered medications for Resident 17 that included Levothyroxine (a thyroid medication) 112 mcg and Omeprazole (reduces stomach acid) 40 mg while the resident was seated in the dining room eating breakfast. Medications were given whole and mixed with pudding prior to administration. Cariprazine (for schizophrenia) was not available.</p> <p>Interview on 04/14/2025 at 10:00 AM with MA-C confirmed the levothyroxine and the omeprazole were given while Resident 17 was eating breakfast. MA-C further confirmed that the cariprazine was not available and had not been given. The pharmacy had been contacted on 4/13/2025 and MA-C sent another note to the pharmacy 4/14/2025 to request the medication. MA-C then informed the charge nurse that there was still no cariprazine for the resident.</p> <p>B.</p> <p>Record review of the EMAR for Resident 194 revealed that all of the medications for Resident 194</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>were red, which indicated they were overdue. The medications included orders for Eliquis (a blood thinner) 5 mg twice daily, lasix (a diuretic) 80 mg daily, atorvastatin (for high cholesterol) 10 mg daily, and citalopram (antidepressant) 20 mg daily were all due at 8:00 AM. The allopurinol (for gout) 200 mg daily, enalapril 5 mg daily, and metoprolol 100 mg twice daily were due at 9:00 AM.</p> <p>Observation on 04/14/2025 at 9:40 AM revealed MA-C prepared and administered Eliquis, Lasix, allopurinol, atorvastatin, citalopram, enalapril, and metoprolol for Resident 194.</p> <p>Interview on 04/14/2025 at 10:00 AM with MA-C confirmed that all of the medications that were ordered to be given to Resident 194 at 8:00 AM were administered late.</p> <p>C.</p> <p>Record review of Resident 13's EMAR revealed orders for Senna/Docusate (a laxative) 8.6 mg/50 mg 2 tablets every 12 hours, amiodarone (for irregular heartbeat) 200 mg daily, aspirin 81 mg daily, carvedilol (for high blood pressure) 3.125 mg twice daily with food, clopidogrel (a blood thinner) 75 mg daily, spironolactone (a diuretic) 25 mg one half tablet daily, and Flomax 0.8 mg daily.</p> <p>Observation on 04/14/2025 at 11:28 AM as MA-C prepared and administered medications for Resident 13 which were all ordered to be given at 8:00 AM. The resident had eaten very little of the breakfast served at 8:00 AM and was lying in bed at the time of administration.</p> <p>Interview on 4/14/2025 at 11:30 AM with MA-C who confirmed that all of the medications were administered late. MA-C also confirmed that the carvedilol was supposed to be given with food, and the resident had not eaten nor had any type of snack been given to the resident at the time of the medication administration.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Licensure Reference Number 175 NAC 12-006.11(E)</p> <p>Based on observation, interview, and record review; the facility failed to ensure that the facility dishwasher was operating, ensuring facility dishes and utensils were sanitized when washed with the facility dishwasher which had the potential to affect all residents utilizing dishware from the kitchen. The facility also failed to ensure that staff handled foods and assisted residents with meals in a sanitary manner to prevent the potential for cross contamination and foodborne illness. This affected 3 of 20 residents observed (Residents 1, 192, and 11). The facility census was 38.</p> <p>Findings are:</p> <p>A.</p> <p>A record review of an undated facility policy titled Dishwashing: Machine Operation Guideline and Procedure Manual revealed wash temperature must reach a minimum of 120 degrees. If temperatures are not accurate, stop using the dish machine immediately.</p> <p>In an observation on 04/13/2025 at 6:10 PM, it was observed that the facility dishwashing machine temperature during the wash cycle was 98 degrees.</p> <p>In an interview completed on 04/13/2025 at 6:20 PM with the Facility Administrator (FA) the FA confirmed that the facility dishwashing machine was reaching the minimum temperature of 120 degrees. FA stated dietary staff would use the 3-sink sanitization system and they would contact someone to come and examine and fix the dishwasher.</p> <p>In an observation on 04/14/2025 at 7:45 AM, it was observed that the facility dishwashing machine was in operation/being utilized to wash dishes. The temperature during the wash cycle was observed to be 100 degrees.</p> <p>In an interview on 04/14/2025 at 7:45 AM with Cook-B, Cook-B confirmed that they were using the dishwashing machine for the cleaning and sanitization of dishes. The [NAME] also confirmed that the dishwashing machine temperature was not reaching 120 degrees as specified by policy.</p> <p>In an interview completed on 04/14/2025 at 8:15 AM with the FA, the FA confirmed that the dishwasher should not be being used due to not achieving the 120 degrees as specified by policy.</p> <p>B.</p> <p>Record review of the facility policy titled Food Safety Requirements dated 3/26/25 revealed that it is the policy of the facility to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Foods and beverages shall be distributed and served to residents in a manner to prevent contamination. Strategies include: washing hands between contact with residents and use of gloves when touching and assisting with ready-to-eat foods. Staff shall adhere to safe hygienic practices (food safety processes used to prevent the spread of germs and illnesses) to prevent contamination of foods from hands or physical objects. Staff shall wash hands according to facility procedures. Staff shall not touch food with bare hands-use gloves, tongs, deli paper,</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>or spatula.</p> <p>Observation on 4/13/25 at 6:27 PM in the facility dining room revealed that Nurse Aide (NA)-A picked up a piece of cookie from the plate of Resident 1 with their bare hand and fed it to Resident 1. NA-A did not perform hand sanitization (hand washing using soap and water or an alcohol-based hand rub (ABHR) to remove germs for reducing the risk of transmitting infection among patients and health care personnel). NA-A went to another table and picked up the fork from Resident 192. NA-A fed a bite of food to Resident 192 using the fork. NA-A sat next to Resident 192 and rubbed the top of the tire of the resident's wheelchair wheel with their bare right hand as NA-A visited with Resident 192. NA-A handed the fork to Resident 192. Resident 192 used the fork to take a few bites of food. NA-A did not perform hand sanitization. NA-A returned to the table of Resident 1. NA-A picked up a piece of cookie from the plate in front of Resident 1 with the bare right hand and fed the piece of cookie to Resident 1. NA-A did not perform hand sanitization. Resident 11 sat across the table from Resident 1. Resident 11 tried to use a fork to eat the meat on their plate. Resident 11 was unable to cut up the meat. NA-A did not perform hand sanitization. NA-A went to Resident 11 and picked up the fork. NA-A used the fork to cut up the meat on the plate for Resident 11. NA-A explained to Resident 11 where the foods were located on the plate. Resident 11 used the fork to take a bite of food. NA-A did not perform hand sanitization. NA-A returned to Resident 1 and used the bare hands to adjust the clothing protector on Resident 1. NA-A did not perform hand sanitization. NA-A went to Resident 192 and rubbed the resident's shoulder with the bare left hand. NA-A did not perform hand sanitization. NA-A went to Resident 11 and used their bare left hand and picked up the right hand of Resident 11 and removed the fork from Resident 11's hand. NA-A picked up a spoon from the table in front of Resident 11 with their bare hands and placed the spoon in the right hand of Resident 11. NA-A did not perform hand sanitization. NA-A went to the table of Resident 192 and picked up the spoon from the plate of Resident 192 with their bare hand. NA-A fed a spoonful of meat to Resident 192. The time was now 6:30 PM. Resident 8 walked with a walker to the table of Resident 1. NA-A did not perform hand sanitization. NA-A used the bare hands to tuck the front of Resident 8's shirt into their pants and tied the waist string of the pants for Resident 8. NA-A went to the alcohol based hand sanitizer dispenser on the wall and applied sanitizer and rubbed the hands together. NA-A went to Resident 1 and picked up a piece of cookie from the plate in front of Resident 1 with the bare hand and fed it to Resident 1. NA-A picked up another piece of the cookie from the plate in front of Resident 1 with the left bare hand and fed the piece of cookie to Resident 1. NA-A told Resident 1 that was all of the cookie and offered to check and see if the kitchen had any more cookies if the resident wanted more. Resident 1 responded yes that they would like another cookie. NA-A went to the kitchen service window, obtained a plate with a chocolate chip cookie, and carried the plate with the cookie to the table of Resident 1. NA-A sat the plate on the table in front of Resident 1. NA-A picked up the cookie with their bare hands and began to break the cookie into small pieces.</p> <p>Interview on 4/16/25 at 11:25 AM with the Regional Director of Operations (RDO) confirmed that staff assisting residents with meals are expected to perform hand sanitization between residents and after contact with resident items. The RDO confirmed that gloves are to be worn when touching ready to eat foods and not handle foods with the bare hands.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER The Pines at Blue Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 414 North Willson Street Blue Hill, NE 68930	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>B.</p> <p>A review of a facility policy titled Wound Treatment Management dated 11/28/2023 revealed that to promote wound healing the facility will provide treatments in accordance with current standards of practice and physician orders.</p> <p>A review of CDC Guideline for Hand Hygiene in Health Care Settings dated 2007 revealed the use of alcohol-based hand rub or washing with soap and water should be done following the removal of gloves.</p> <p>In an observation completed on 04/15/2025 at 3:50 PM of wound care being provided by Registered Nurse (RN)-D the following was observed:</p> <p>-RN-D donned gloves to both hands and applied a moist piece of gauze to Resident 29's upper right buttock. The RN then removed their gloves and donned another pair of gloves. The RN then proceeded to apply another piece of moist gauze to the resident's left heel and hold that gauze in place with their gloved hand. The RN did not perform hand hygiene between glove changes.</p> <p>-RN-D removed their gloves after holding the moist gauze in place to the resident's heel. The RN then donned new gloves to both hands and obtained a pair of scissors and clean dressing from the bed side table. The RN did not perform hand hygiene between glove changes.</p> <p>-RN-D applied a new clean dressing to the resident's right upper buttock wound with gloved hands. The RN removed the gloves from their hands and donned another pair of gloves on both hands. The RN then obtained a package labeled Kerlex and opened the package with their gloved hands. The RN did not perform hand hygiene between glove changes.</p> <p>In an interview completed on 04/15/2025 at 4:15 PM with RN-D, RN-D confirmed that they did not perform hand hygiene between glove changes during the wound care. The RN stated hand hygiene should have been performed between each glove change by washing hands with soap and water or using alcohol-based hand rub.</p> <p>In an interview completed on 04/15/2025 with the facility Director of Nursing (DON), the DON confirmed that hand hygiene should be performed between glove changes by washing hands with soap and water or using alcohol-based hand rub.</p> <p>Based on record review, interview, and observation; the facility failed to ensure that hand hygiene was performed between residents during medication administration to 3 (Residents 17, 31, and 26) of 3 sampled residents and during wound care for 1 (Resident 29) of 1 sampled resident to prevent the potential for cross contamination and infection. The facility census was 38.</p> <p>Findings are:</p> <p>Record review of CDC Guideline for Hand Hygiene in Health Care Settings dated 2007 revealed the use of alcohol-based hand rub or washing with soap and water should be done between patients when performing cares.</p> <p>A.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER The Pines at Blue Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 414 North Willson Street Blue Hill, NE 68930	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 4/14/2025 at 9:00 AM of Medication Aide (MA) C while passing medications in the dining room. MA-C did not perform hand hygiene as required between Residents 17, 31, and 26 while preparing and administering medications.</p> <p>Interview on 4/14/2025 at 9:20 AM with MA-C confirmed the MA did not perform hand hygiene as required during medication preparation and administration between Residents 17, 31, and 26.</p>		

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NAME OF PROVIDER OR SUPPLIER The Pines at Blue Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 414 North Willson Street Blue Hill, NE 68930	
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<p>F 0923</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have enough outside ventilation via a window or mechanical ventilation, or both.</p> <p>Licensure Reference Number 175 NAC 12-007.04(D)</p> <p>Based on observation, record review, and interview the facility failed to ensure that bathroom exhaust vent fans were functioning for 2 of 16 residents observed (Residents 34 and 10). The facility census was 38.</p> <p>Findings are:</p> <p>Record review of the facility's undated admission Agreement Attachment 3 titled Resident Rights revealed that the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life. The resident has the right to a safe, clean, comfortable, and homelike environment. The facility must provide a safe, clean, comfortable, and homelike environment. The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>A.</p> <p>Observation on 4/14/25 at 8:00 AM in the bathroom of Resident 10 revealed that the bathroom exhaust vent would not pull up a 1-ply square of toilet paper.</p> <p>Observation on 4/16/25 at 12:48 PM in the room of Resident 10 with the Facility Administrator (FA) confirmed that the bathroom exhaust vent would not pull up a 1-ply square of toilet paper. The FA confirmed that the bathroom exhaust vent was not functioning and needed repair.</p> <p>B.</p> <p>Observation on 4/14/25 at 8:04 AM in the bathroom of Resident 34 revealed that the bathroom exhaust vent would not pull up a 1-ply square of toilet paper.</p> <p>Observation on 4/16/25 at 12:46 PM in the room of Resident 34 with the FA confirmed that the bathroom exhaust vent would not pull a 1-ply square of toilet paper. The FA confirmed that the bathroom exhaust vent was not functioning and needed repair.</p> <p>Interview on 4/16/25 at 12:53 PM with the FA confirmed that the facility currently did not have a maintenance director. The FA confirmed that the bathroom exhaust vents are required to be maintained and kept functional.</p>		