STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285277	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sutton Community Home, Inc.	1106 North Saunders Avenue Sutton, NE 68979

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.9(D)Based on record reviews and interviews, the facility failed to ensure the Minimum Data Set (MDS - a comprehensive assessment of each resident's functional capabilities used to develop a resident's plan of care) was coded accurately for 1 (Resident 8) of 5 sampled residents for PASARR's (Preadmission Screening and Resident Review -that is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. Level 2 screening is triggered by evidence of a serious mental illness (MI), Intellectual or Developmental Disabilities (IDD) or condition related to Intellectual or Developmental Disabilities (RC) as defined by state and federal). The facility census was 20. Findings are: Record review of Resident 8's annual MDS dated [DATE] revealed the resident was admitted to the facility on [DATE], had a PASARR (Preadmission Screening and Resident Review) Level 1 preliminary screening (federally mandated screening for all residents entering a Medicaid certified nursing facility, designed to identify individuals who might have a Serious Mental Illness or an Intellectual/Developmental Disability), and a Brief Interview for Mental Status (BIMS - a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function) score of 14 indicating cognitively intact, with diagnosis of schizoaffective disorder (a serious mental illness blending psychosis and mood disorder), and bipolar disorder (a serious mental illness causing extreme shifts in mood, energy and activity levels). Record review of Resident 8's Level II PASARR (an in depth person centered evaluation for individuals flagged by the initial Level 1 screening, to assess their need for nursing facility placement and specialized services) dated 10/22/18, revealed Serious Mental Illness (MI). The resident met state medical necessity criteria due to a diagnosis of schizoaffective disorder, needing medication to help manage the symptoms, and had a history of psychiatric hospitalization and seeing a psychiatrist. Record review of Resident 8's Comprehensive Care Plan (CCP - written instructions needed to provide effective and person centered care of the resident that meet professional standards of quality care) focus date revision 8/9/2022 revealed that the resident had a Level 2 PASARR. During an interview on 12/16/2025 at 3:44 PM the Assistant Administrator (AA) - C confirmed that the annual MDS should have been coded as a Level 2 PASARR. During an interview on 12/17/2025 at 1:11 PM the Director of Nursing (DON) confirmed the facility did not have an MDS policy, it was also confirmed that the facility uses the RAI (Resident Assessment Instrument) manual (the official guide for nursing facilities, detailing how to use the RAI process) to ensure accuracy of the MDS.

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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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on record review and interviews, the facility failed to post daily staffing information to include the total number and the actual hours worked by discipline, that are directly responsible for resident care per shift. This had the potential to affect all 20 residents residing in the facility at the time of the survey. The facility census was 20. Findings are: In a record review of the facility Daily Staffing Logs dated 7.3.2025, 7.13.2025, 7.19.2025, 8.24.2025, 8.31.2025, and 9.27.2025, the Daily Staffing Logs did not include the total number of hours by discipline or include total hours worked by shift of the staff responsible for resident care. In a record review of the Daily Staffing Logs revealed: Date 12.15.2025- hours not totaled by shift or for the 24-hour period. No changes to indicate actual hours worked. Certified Nurse Aide (CNA) column indicating hours worked was left blank. Date 12.16.2025- hours not totaled by shift or for the 24-hour period. No changes to indicate actual hours worked. CNA column indicating hours worked was left blank. Date 12.17.2025- hours not totaled by shift for the 24-hour period. One change indicating a call in and the staff member that replaced them. CNA column indicating hours worked was left blank. During an interview on 12.15.2025 at 1:30 PM with the Registered Nurse (RN), it was confirmed the facility Daily Staffing Log is updated by the night shift only and does not include the total number of hours worked by shift of the staff responsible for resident care. During an interview on 12.17.2025 at 12:34 PM with the Assistant Director of Nursing (ADON), it was confirmed the facility does not have a Daily Staff Posting policy. During an interview on 12.17.2025 at 1:25 PM with the ADON, it was confirmed the facility Daily Staff Logs did not separate staff by discipline or include total hours worked by shift of staff responsible for resident care.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Licensure Reference Number 175 NAC 12.006.7(C) Based on interviews and record review, the facility failed to identify hand washing as a systemic issue prior to the survey, and to correct previously cited quality issues. This had the potential to affect all 20 residents residing at the facility at the time of the survey. The facility census was 20.Findings are:In a record review of the facility's Medicare.Gov. Nursing Home Compare website (A public website that provides information to help consumers find and compare the quality of Medicare and/or Medicaid certified nursing homes across the country) on 12.22.2025 at 9:32 AM, revealed prior infection control deficiencies on 6.11.2021, 7.26.2022, 9.14.2023, and 9.12.2024. In a record review of the facility Quality Assurance & Performance Improvement Program (QAPI) dated 8.13.2013 with a revised date of July 2025 revealed a focus area to include monitoring the efficacy and outcomes for the Infection Prevention (IP) program. The guiding principles included: Uses QAPI to make decisions and guide day-to-day operations. Focuses on systems and processes, rather than individuals. Makes decisions based on data, which includes the input of caregivers, residents, health care providers, families, and other stakeholders. Meeting times and scope included reviewing the plan of correction with review of correction compliance and IP data. In a record review of the facility Infection Prevention and Control Risk assessment dated 9/2025 revealed: Staff non-compliance with hand hygiene was rated as having a low probability of occurrence. In a record review of the facility provided active PIP's dated November 2025 revealed Dignity and Wound Assessments and Documentation as the current PIP's. In a record review of the facility QAPI Meeting dated 12.11.2025 revealed Old Business which included: Infection Control; infections and Monthly Infection Surveillance. Nursing; Fall Interventions and Care Planning. Social Services; Grievances, Dignity PIP, Resident Rights and Satisfaction Survey Results. Record review of the facility QAPI Meeting dated 11.13.2025 revealed hand hygiene and handling soiled linen audits with 100% of completed audits in compliance. Record review of the facility QAPI Meeting dated 10.9.2025 revealed hand hygiene and catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) care audits with 100% of completed audits in compliance. Record review of the facility QAPI Meeting dated 9.11.2025 revealed hand hygiene and enhanced barrier precaution (infection control steps to stop germs from spreading beyond standard care) audits with 100% of completed audits in compliance. During an interview on 12.17.2025 at 8:54 AM with the Licensed Practical Nurse-Infection Prevention (LPN-IP) confirmed no active PIP for hand hygiene and the facility only completed hand hygiene audits based on the recommendation from The Nebraska Infection Control Assessment and Promotion Program (Nebraska ICAP) recommendations. Further confirmed that staff will bring issues or concerns to leadership when identified and the committee will change an intervention (action or process of intervening) after a lack of improvement. During an interview on 12.17.2025 at 11:53 AM with the Assistant Director of Nursing (ADON) confirmed QAPI oversight. Further confirmed the current PIP's included dignity and wound documentation and no current hand hygiene PIP. During an interview on 12.18.2025 at 8:19 AM with the Administrator (ADM) confirmed facility had repeat issues with hand hygiene on previous state surveys, and the facility currently does not have an active PIP for hand hygiene and only completed hand hygiene audits. Further confirmed the hand hygiene audit results have always been 100% and the staff are aware they are being monitored, which could improve the outcome of the audits.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.18Based on observations, interviews, and record reviews, the facility staff failed to ensure hand hygiene was performed during meal service, during catheter cares for Resident 15, and during wound care for Resident 7. This practice had the potential to affect all residents in the facility. The facility census was 20 at the time of survey. Findings are: Record review of facility policy titled Service Staff and Serving the Meal, dated 2/9/2010 revealed the Infection Preventionist will provide staff with training on hand hygiene and PPE. Record review of the facility policy titled Hand Hygiene, dated 8/17/25 revealed hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR) and to perform hand hygiene before putting on gloves and after glove removal. A. During an observation on 12/16/2025 at 11:47 AM Dietary Aide (DA) – D served lunch trays in the dining room, holding tray with hands around the bottom of the tray then returned to dining room with same gloves on and no hand hygiene performed. During an interview on 12/16/2025 at 11:55 AM DA – D confirmed that (gender) usually just washes (gender) hands and puts gloves on before serving and then when finished (gender) removes them, it was also confirmed that (gender) goes in and out of resident rooms with the same gloves on. During an interview on 12/17/2025 at 11:20 AM Medication Aide (MA) – E stated that staff is supposed to wash their hands for 20 seconds before putting on gloves and always hand hygiene with glove changes. During an observation on 12/17/2025 at 11:40 AM MA – E did not perform hand hygiene before putting on gloves in the dining room to help serve lunch trays. B. During an observation on 12/17/2025 at 9:11 AM Nursing Assistant (NA) – B completed foley catheter cares and peri cares. Hand hygiene was not performed when changing gloves between tasks. During an interview on 12/17/2025 at 12:25 PM NA – B confirmed that (gender) usually has hand sanitizer with (gender) but was nervous and forget to use it during glove change. During an interview on 12/17/2025 at 12:31 PM Licensed Practical Nurse Infection Preventionist (LPN-IP) confirmed that staff is supposed to perform hand hygiene before gloving, in between glove changes and after removing gloves. It was also confirmed that hand washing audits are completed for all departments. C. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A record review of Resident 7's admission Record dated 12/16/2025 revealed Resident 7 was admitted on [DATE] and had diagnoses of arthritis, high blood pressure, malnutrition, mild intellectual difficulties and a Stage 4 pressure ulcer of the sacral region (a deep injury to tissue caused by prolonged pressure to an area. Stage 4 is full thickness and exposes the underlying muscle, bone, or tendon. The sacral region is the triangular area at the base of the spine, above the buttocks.) A record review of Resident 7's Order Summary dated 12/16/2025 revealed an order for a daily wound dressing change. A record review of the facility's Hand Hygiene (HH-cleaning the hands using either soap and water or an alcohol-based hand rub[ABHR]) policy reviewed/revised 08/17/2025 revealed that HH should be performed under the conditions listed in, but not limited to the attached hand hygiene table, that HH using either ABHR or soap and water should take at least 20 seconds, and that if the task requires use of gloves, HH should be performed prior to putting on gloves, and after removing them. A record review of the undated Hand Hygiene Table copyright 2023 revealed that HH should be performed before applying and after removing PPE, after handling items potentially contaminated with blood or body fluids, and when moving from a contaminated site to a clean site on a resident. A record review of the facility's Personal Protective Equipment (PPE-special equipment, including gloves, gown, masks, and eye protection, worn to prevent exposure to hazards such as infectious materials) policy reviewed/revised 07/25/2025 revealed HH should be performed before putting on and after removing gloves, and that gloves should be changed and HH performed between clean and dirty tasks, when moving from one body part to another, and when heavily contaminated or torn. An observation of Resident 7's dressing change done on 12/17/2025 an 9:32 AM revealed Licensed Practical Nurse (LPN) A and Nurse Aide (NA) B entered Resident 7's room. NA B did not perform HH, went to the PPE holder and took out two gowns. While holding one gown in their hand, the NA put on the second gown and reached up to tie the neck ties of the first gown, causing the second gown to rub on their hair. After handing the gown to LPN A, NA B did not perform HH and put on gloves. LPN A cleaned the overbed table, washed their hands with soap and water for 25 seconds, put on the gown NA B had been holding then put on gloves. An observation 12/17/2025 at 9:40 AM revealed LPN A removed the old dressing, removed their gloves, performed HH, and put on new gloves. The LPN then cleaned the wound and patted it dry, then changed gloves without performing HH and applied the clean dressing. An interview on 12/17/2025 at 9:50 AM with LPN A confirmed the LPN had not performed HH when changing gloves between cleaning the wound and applying the new dressing and should have. An interview on 12/17/2025 at 9:50 AM with NA B confirmed they had not performed HH before putting on gloves when entering the room and should have. The NA further confirmed they should not have been holding the gown up by their head when tying the neck ties on the gown. An interview on 12/17/2025 12:37 PM with the LPN Infection Preventionist (LPN IP) confirmed that staff should perform HH when entering a resident room. LPN IP further confirmed the expectation is that HH should be done before putting on, when changing, and after removing gloves, and that gloves should be changed between removing an old dressing, cleaning the wound, and applying a new dressing.