Sector Statements		MEDICAID SERVICES				OMB NO	
	OF DEFIC ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	• •	PLE CONSTRUCT G		(X3) DATE COMP	SURVEY LETED
		285104	B. WING			06/2	29/2020
NAME OF PI	ROVIDER OR SUPPLIER		200	STREET ADDRE	ESS, CITY, STATE, ZIP CODE		
PRESTICE	CARE CENTER OF PL	ATTSMOUTH		602 SOUTH 18	TH STREET		
REGHOL	CARE CENTER OF TE			PLATTSMOU	TH, NE 68048		
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F 880	Continued From page	e 4	F8	80			
	IN THE LARS ADDRESS OF THE	cility Administrator. During		hand hyg	ziene.		
	Key and the second s	w of the CSIS sheets for					
		M, N and O dated 6/28/20		Educatio	n was provided to all		
	and 6/29/20 was com				eping staff on cleaning high-		
		ed there should have been			ch as light switches, call light	100	
	follow up evaluations				os, and toilets/sinks to ensure	9	
	temperatures and wa			sanitary	conditions.		
		he DSM Covid 19 sign in 20 at 11:25 AM revealed the		All license	ed and non-licensed nursing		
	Construction of the state of th	new or worsening cough.			eping, and laundry staff will b		
	Down did not nave a l	lew of worsening cough.			ed on the facility stall will be		
	On 6-29-2020 at 1:05	PM an observation of the		Infection			
	facility staff providing	the lunch meal revealed the					
		es Manager (DSM) had a		The Adm	inistrator hired an outside		
	surgical mask on. Th	e DSM started coughing in a		consultar	nt to improve the facility⊡s		
	-	ted through the kitchen.		infection facility.	control program within the		
		B PM an interview was					
		SM. During the interview			f Development Coordinator o		
		f the cough was new, the			will oversee infection preven		
		uring the interview the DSM		and cont	rol education for all new hires	S.	
	Second and the second construction of the second second research and the second s second second s	sign or symptom of COVID		The ener			
		sening cough. When asked			loyee COVID-19 sign-in she ructured. Any symptoms will		
		ppened, the DSM reported tor should have been			rectly to the Administrator or	be	
	notified and was not.			designee	5. CA		
		) PM a follow up interview			n to all team members regar	ding	
	was conducted with t interview the DSM co	he DSM. During the onfirmed the cough was new.			PE per CDC guidelines.		
					le surface education signs pla		
		facility policy titled "Zones			nts⊡ room or bathroom, for F	PΕ	
		rotective equipment refers to		reference	e guide		
		loves, goggles, facemasks		Compete	ancy fair conducted on 8/4/20	20	
	infection)" indicated t	ne wearer from spread of hat the policy was		for PPE	ency fair conducted on 8/4/20 practice	20	
		/20. The policy identified a					
		onal zone) for residents		Educatio	n to the entire facility team		
		n the hospital/outside			s as follows:		

Facility ID: 130201

If continuation sheet Page 5 of 7

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFIC ENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULT PLE CONSTRUCTION (X3) DATE SURVEY **IDENT FICATION NUMBER** AND PLAN OF CORRECTION COMPLETED. A. BUILDING 285104 **B WING** 06/29/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 602 SOUTH 18TH STREET PRESTIGE CARE CENTER OF PLATTSMOUTH PLATTSMOUTH, NE 68048 SUMMARY STATEMENT OF DEFIC ENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID D (EACH DEFIC ENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENT FY NG INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 880 Continued From page 5 F 880 facilities or homes but have no known exposure Sparkling Surfaces to COVID -19 are admitted to the Gray Zone. All https://youtu.be/t7OH8ORr5Ig staff who enter resident rooms in the Gray Zone Clean Hands are to wear the following PPE: gown, gloves, eye https://youtu.be/xmYMUly7qiE protection (face shield) and N95 masks a Closely Monitor Residents disposable respirator that is intended to filter https://youtu.be/1ZbT1Njv6xA particles out of the air you breathe). Keep COVID-19 Out! https://youtu.be/7srwrF9MGdw Observation on 6/29/20 at 12:20 PM revealed that Lessons - https://youtu.be/YYTATw9yav4 Resident 2 resided in the facility Gray Zone. COVID-19- sign in education, all personal have been notified to contact Observation on 6/29/2020 at 12:25PM revealed administrator or designee with any sign or Employee Q entered Resident 2's room in the systems prior to entering. Doors remain Gray Zone with the lunch tray wearing a surgical locked until further notice. mask instead of an N95 mask. 5. How the corrective action(s) will be Interview on 6/29/2020 at 1: 10 PM with monitored to ensure the practice will not Employee Q revealed that surgical masks were recur: the only masks available to staff. The Infection Preventionist or designee is Observation on 6/29/2020 at 1:45 PM revealed monitoring the 24 COVID-19 report to Employee P took a mug of water into Resident 2's ensure that any resident/guest/team room wearing only a surgical mask for PPE. members with signs and symptoms of COVID-19 is immediately placed on Interview on 6/29/2020 at 12:50 PM with transmission-based precautions or not Employee P revealed that all employees took a allowed into the facility. Monitoring will surgical mask at the beginning of their shift and continue daily for 3 months. no N95 masks were provided. The DON or designee will randomly monitor hand hygiene practices amongst staff 3 times a week for 1 month and then weekly for 3 months. The DON or designee will do daily observation rounds for PPE for 3 months, then weekly for 1 month. The Administrator implemented a QAPI PIP to gather and process information

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 130201

If continuation sheet Page 6 of 7

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	08/27/2020 APPROVED 0938-0391
STATEMENT O	OF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:		CONSTRUCTION	(X3) DATE	10	
		285104	B. WING			06/	29/2020
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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			4	Р	LATTSMOUTH, NE 68048		50 12
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL .SC IDENT FY NG INFORMATION)	D PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) Completion Date
F 880	Continued From page	96	F	880	from the audits/monitoring processes. Findings will be reported at the monthl QAA meeting for a minimum of 3 mont DON/Designee will present any negati findings for monthly review and recommendations to the QAPI commit	hs. ve	
FORM CMS 255	7(02-99) Previous Versions Obs	olete Event ID:9.1k	7744	5-	sility ID: 130201 If con	4	eet Dage 7 of 7

If continuation sheet Page 7 of 7





DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Covernor

## **IMPORTANT NOTICE – PLEASE READ CAREFULLY**

July 14, 2020

Chasity Coover, Administrator Prestige Care Center Of Plattsmouth 602 South 18th Street Plattsmouth, NE 68048

CMS Certification No. 285104

Subject: Survey Results Cycle Start Date: June 29, 2020

Dear Administrator,

## UNANNOUNCED COVID-19 SURVEY

The Secretary of the U.S. Department of Health and Human Services (DHHS) has the duty and responsibility to protect the health, safety, welfare and rights of Medicare/Medicaid beneficiaries. The Secretary has delegated authority to administer and provide oversight of the Medicare program to Centers for Medicare & Medicaid Services (CMS).

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-31-All*, CMS and the State Survey Agency are conducting unannounced onsite surveys at certain Medicare certified provider and supplier types.

### SURVEY RESULTS

On June 29, 2020, a survey was completed at Prestige Care Center Of Plattsmouth by the State Survey Agency to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the CMS 2567 and will be posted on the ePOC system.

## PLAN OF CORRECTION

A Plan of Correction (PoC) for the deficiencies must be submitted by July 24, 2020, to the State Survey Agency Contact. Failure to submit an acceptable PoC by July 24, 2020 may result in the imposition of additional remedies. The PoC must contain the following:

- 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- 3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of the quality assurance being implemented, the earliest correction date will be the date of the revisit; and
- 5. Include dates when corrective action will be completed. The corrective action completion dates must be written in the completion date column within acceptable time frames. If the PoC is unacceptable for any reason, you will be notified in writing by this office. If the PoC is acceptable, you will be notified via ePOC. Please note that the facility is ultimately accountable for compliance, and that responsibility is not alleviated in cases where notification regarding the acceptability of the facility's PoC is not made timely. The PoC will serve as the facility's allegation of compliance.

# **ENFORCEMENT REMEDIES**

Based on the Statement of Deficiencies (Form CMS-2567), the following remedies are imposed:

• Directed Plan of Correction:

In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction is imposed on the facility. In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. The effective date is not a deadline for completion of the DPOC. However, the State Agency will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice.

Training option(s) which are the most appropriate for the type of noncompliance cited. For

Sparkling Surfaces - https://youtu.be/t7OH8ORr5Ig Clean Hands - https://youtu.be/xmYMUly7qiE Closely Monitor Residents - https://youtu.be/1ZbT1Njv6xA Keep COVID-19 Out! - https://youtu.be/7srwrF9MGdw Lessons - https://youtu.be/YYTATw9yav4

Please send all documentation to the State Agency at the following:

examp

Connie Vogt, RN, BSN dhhs.healthcarefacilities@Nebraska.gov In the Subject Line please put: DPOC

For states participating in the ePOC program, the DPOC may be added as an attachment.

Please note, if documentation includes any resident personal identifiable information (PII) or personal health information (PHI) it must be sent encrypted.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies, within 10 days after receipt of the Form CMS 2567. Please see the attached instructions (DPOC attachment) for detailed guidance.

# • Imposition of Denial of Payment for New Admissions (DPNA):

Payment will be denied for all <u>NEW</u> Medicare and Medicaid admissions, August 28, 2020 in accordance with the statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal regulations at 42 CFR §488.417. Your Medicare Administrative Contractor will be notified of the date the denial of payment begins. DPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated.

# WITHDRAWAL OF APPROVAL FOR NURSE AIDE TRAINING PROGRAM

Please note that Federal law, as specified in the Social Security Act at \$1819(f)(2)(B) and \$1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs (NATCEP) and nurse aide competency evaluation programs (NACEP) offered by, or in, a facility which, within the previous two years, if one or more of the following exists:

- Operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse);
- Has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care;
- Has been assessed a total civil money penalty of not less than \$10,697;
- Has been subject to a denial of payment;
- Appointment of a temporary manager;
- Terminated from participation, and/or
- In the case of an emergency, has been closed and/or had its residents transferred to other facilities.

# **INFORMAL DISPUTE RESOLUTION (IDR)**

You have one opportunity to dispute the deficiencies cited on the survey date through (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Connie Vogt, RN, BSN Email: dhhs.healthcarefacilities@Nebraska.gov In the Subject Line of the email put: Request IDR

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

This request must be submitted within 10 days from the date of the enforcement letter. An incomplete Informal Dispute Resolution process will not delay the effective date of any enforcement action.

Informal Dispute Resolution is in no way to be construed as a formal evidentiary hearing. It is an informal internal process to review additional information submitted by the facility. You will be advised of our decision relative to the informal dispute.

# **APPEAL RIGHTS**

If you disagree with the determination to impose remedies made on the basis of noncompliance identified at the June 29, 2020 survey, you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board (DAB). The appeal rights are set forth at 42 C.F.R. § 498.5 and the procedures for requesting a hearing are set forth at §498.40, et seq. You must file your hearing request electronically by using the DAB's Electronic Filing System (DAB E-File) at <a href="https://dab.efile.hhs.gov/">https://dab.efile.hhs.gov/</a>, unless you obtain a waiver from the DAB (*see* DAB Civil Remedies Division Procedures, § 6(a)(i)(1)). Your appeal must be filed no later than 60 days from the date of receipt of this letter.

We request that you provide an electronic copy of the request for appeal to:

ROkcmSCB@cms.hhs.gov and to the CMS Regional Chief Counsel at: OGCKansasCityGeneralInbox@hhs.gov

If you elect to dispute deficiencies through the Informal Dispute Resolution (IDR) process, this will not extend the 60 day period to file your appeal before the Departmental Appeals Board. Filing an appeal will not stop the imposition of any enforcement remedy.

If you experience problems with, or have questions about DAB e-File, please contact e-File System Support at <u>OSDABImmediateOffice@hhs.gov</u>. If you have questions about using the DAB e-file System, please visit: <u>https://dab.efile.hhs.gov/appeals/to\_crd\_instructions?locale=en</u>.

# **QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES**

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at <u>QIO</u> <u>Program Website</u>. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at <u>Locate Your QIO</u>.

## **CONTACT INFORMATION**

If you have any questions please contact this office.

Sincerely,

Connie Ellegt KNIBSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555

CV/kd

Enclosures: CMS 2567

Copies via e-mail to: CMS - RO DHHS - State Medicaid Agency DHHS - Nursing Support





July 2, 2020

Alicia Elson, Administrator Quality Living, Inc 6404 North 70th Plaza Omaha, NE 68104

### CMS CERTIFICATION NUMBER: 28A060

Dear Ms. Elson:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 17, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555





June 24, 2020

Mikel Ardley, Administrator Regency Square Care Center 3501 Dakota Avenue South Sioux City, NE 68776

CMS CERTIFICATION NUMBER: 285076

Dear Ms. Ardley:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 11, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555





July 16, 2020

Donald Weidermann, Administrator Regional West Garden County Nursing Home 1100 West 2nd Oshkosh, NE 69154

CMS CERTIFICATION NUMBER: 28E180

Dear Mr. Weidermann:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 15, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555





June 26, 2020

Erin Dye, Administrator Ridgecrest Rehabilitation Center 3110 Scott Circle Omaha, NE 68112

CMS CERTIFICATION NUMBER: 285239

Dear Ms. Dye:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 9, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555





July 7, 2020

Ruth (peg) Becker, Administrator Ridgewood Rehabilitation & Care Center 624 Pinewood Avenue Seward, NE 68434

CMS CERTIFICATION NUMBER: 285279

Dear Ms. Becker:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 29, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555



### **MIDWEST DIVISION OF SURVEY AND CERTIFICATION**

May 8, 2020

Aharon Kibel, Administrator River City Nursing and Rehabilitation 7410 Mercy Road Omaha, NE 68124

CMS Certification No: 285058

Dear Mr. Kibel:

SUBJECT: SURVEY RESULTS Cycle Start Date: April 28, 2020

# SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

# SURVEY RESULTS

On April 28, 2020, the Centers for Medicare & Medicaid Services (CMS) completed a COVID-19 Focused Survey at River City Nursing and Rehabilitation to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the enclosed form CMS 2567.

# PLAN OF CORRECTION

You must submit an acceptable plan of correction (POC) for the enclosed deficiencies that were cited during the April 28, 2020 survey. River City Nursing and Rehabilitation may choose to delay submission of a POC until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a POC. An acceptable POC will serve as your allegation of compliance. Upon receipt of an acceptable POC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an

acceptable POC can lead to termination of your Medicare and Medicaid participation.

To be acceptable, a provider's POC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice;
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; and
- The date that each deficiency will be corrected.

The POC must be signed and dated by an official facility representative. Please send your POC by fax or email to:

Eddie Grimes and Amanda Spicer Email: Eddie.Grimes@cms.hhs.gov Amanda.Spicer@cms.hhs.gov

# INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the April 28, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Marsophia Powers Email: Marsophia.Powers@cms.hhs.gov

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

River City Nursing and Rehabilitation may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

# QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at QIO Program Website. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at Locate Your QIO.

## CONTACT INFORMATION

If you have any questions please contact Kevin Wright, Principal Program Representative at (816) 426-2011.

Sincerely,

Kevin Wright Long Term Care Branch Survey & Operations Group Center for Clinical Standards & Quality CMS Kansas City

Enclosure: CMS 2567

cc: NE DHHS Powers/Grimes

					FORM APPROVED	
A CONTRACT OF A CONTRACT.	And a standard strength from an Automation and Automation	MEDICAID SERVICES			OMB NO. 0938-0391	
	OF DEFIC ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		285058	B. WING		04/28/2020	
NAME OF P	ROVIDER OR SUPPLIER		ST	IREET ADDRESS, CITY, STATE, ZIP CODE	2	
RIVER CIT	TY NURSING AND REHA	BILITATION	250	110 MERCY ROAD MAHA, NE 68124		
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F 000	INITIAL COMMENTS		F 000			
	was conducted by the Medicaid Services (C facility was found not and Centers for Disea	d Infection Control Survey e Centers for Medicare & MS) on April 28, 2020. The in compliance with CMS ase Control and Prevention practices to prepare for				
	Facility census: 79					
	Sample size: 6					
F 880 SS=F	Infection Prevention & CFR(s): 483.80(a)(1)(		F 880			
	infection prevention a designed to provide a comfortable environm	blish and maintain an nd control program a safe, sanitary and nent and to help prevent the nsmission of communicable				
	program. The facility must esta	brevention and control blish an infection prevention (IPCP) that must include, at ving elements:				
	reporting, investigatin and communicable di staff, volunteers, visitu providing services un arrangement based u	pon the facility assessment to §483.70(e) and following				
LABORATORY	D RECTOR'S OR PROV DER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE	(X6) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 08/27/2020

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07/06/2020

		MEDICAID SERVICES				10.0938-03		
	OF DEFIC ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:		CONSTRUCTION		re survey Mpleted		
		285058	B. WING		0	04/28/2020		
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP COD	E			
	Y NURSING AND REHA	BILITATION	7.0	410 MERCY ROAD MAHA, NE 68124				
(X4) ID PREFIX TAG	(EACH DEFIC ENC	TATEMENT OF DEFIC ENCIES BY MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE		
F 880	Continued From pag	e 1	F 880					
	§483.80(a)(2) Written	n standards, policies, and						
	procedures for the pr	rogram, which must include,						
	but are not limited to							
	(I) A system of surve possible communica	illance designed to identify						
	•	y can spread to other						
	persons in the facility							
		m possible incidents of						
	una presenta de la constitución de	se or infections should be						
	reported;	namianian based and subject						
		nsmission-based precautions vent spread of infections;						
		olation should be used for a						
	resident; including bu							
		ation of the isolation,						
		infectious agent or organism						
	involved, and	at the isolation should be the						
		ible for the resident under the						
	circumstances.							
	(v) The circumstance	es under which the facility						
		ees with a communicable						
		kin lesions from direct						
	contact with resident	s or their food, if direct						
		e procedures to be followed						
		irect resident contact.						
	§483.80(a)(4) A svst	em for recording incidents						
	identified under the f	acility's IPCP and the						
	corrective actions tal	ken by the facility.						
	§483.80(e) Linens.							
	Personnel must hand	dle, store, process, and						
	Personal and a subscription of the second second second second	s to prevent the spread of						
	infection.							
	§483.80(f) Annual re	view						

Facility ID: 280201

If continuation sheet Page 2 of 7

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391	
	OF DEFIC ENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		285058	B. WING		04/	28/2020		
NAME OF P	PROVIDER OR SUPPLIER		2.03	ST	REET ADDRESS, CITY, STATE, ZIP CODE			
RIVER CI	TY NURSING AND REHAI	BILITATION			110 MERCY ROAD MAHA, NE 68124			
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F 880	The facility will condul IPCP and update their This REQUIREMENT by: Based on interview a failed to maintain an econtrol program that is trended infections inco- potential to be affecte Specifically, the facilit -Accurately track infer- when a Resident (R1) facility documented the -Accurately documented the -Accurately documented infections for R3 and -Indicate the site of in- had documented infer- -Accurately document infections on the Infer- R2 who developed infer- 2020. -Ensure that ongoing completed, when the any trending of March- not yet started trendin- until 4/28/20. -Maintain an ongoing illnesses of employee or other people rende	Act an annual review of its ir program, as necessary. It is not met as evidenced and record review, the facility effective ongoing infection identified, tracked, and cluding residents that had the ed by COVID-19. Ity failed to: Inctions in February 2020, () developed and the hat R1 had a final field to the onset dates of R4 in March, 2020. Infections for R5 and R6, who ictions in March 2020. In onset dates of the citon Control Log for R1 and fections in the month of April trending of infections was facility failed to complete th 2020 infections, and had ing of infections for April 2020 Insystem to monitor the es, contractors, volunteers, ering services to the facility. iotential to affect all 79	F8	880				

DEPART	MENT OF HEALTH AN	ND HUMAN SERVICES				ORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				3 NO. 0938-0391
	DF DEFIC ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT F A. BUILDING	PLE CONSTRUCTION		DATE SURVEY COMPLETED
		285058	B. WING			04/28/2020
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
<b>RIVER CIT</b>	TY NURSING AND REHA	BILITATION		7410 MERCY ROAD OMAHA, NE 68124		
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F 880	Continued From page	9 3	F 88	80		
	Findings include:					
	month of February 20 facility logged 14 infect 14 infections, two were diagnostic test comple- indicate if the other 12 testing completed, or The facility failed to in- infections originated in community. The facility or symptoms of infect infections. All 14 infect antibiotics, however, to on the Infection Contra antibiotic was approp- organisms or infection failed to document if a resolved, or were ong document the individu	ity failed to document signs tion for any of the 14 ctions were treated with the facility failed to indicate rol Log if the ordered oriate to treat the infectious us process. The facility				
	documented that R1 of on 2/14 note in R1's chart, dat that R1 readmitted to hospitalization for The Infection indicate that R1 experi- month. 2. Review of the Infect 2020 revealed that the	4/20. Review of a nursing ated 2/28/20, documented the facility following Control Log failed to erienced during the ction Control Log for March				

If continuation sheet Page 4 of 7

CENTERS FOR MEDICARE & MEDICAR SERVICES         OMB NO. 038-031           STATURNOT OF DECIDENCE         011 PROVIDENCIARE & MEDICARD SERVICES         021 MULT PLE CONSTRUCTION         04/28/2020           NME OF PROVIDER OR SUPPLIER         3TREET ADDRESS, CITY, STREE, 2P CODE         74 MM BREY RADD         04/28/2020           NME OF PROVIDER OR SUPPLIER         SUMMAY STATURENT OF DIFTE ENERS         0 MERCY RADD         04/28/2020           YEER CITY NURSING AND REHABILITATION         SUMMAY STATURENT OF DIFTE ENERS         0 MARA N. E 6124         0 MARA N. E 6124           Paperix         SUMMAY STATURENT OF DIFTE ENERS         0 MERCY RADD         0 MERCY RADD         0 MERCY RADD           YEER CITY NURSING AND REHABILITATION         PERCENT MURSING AND REHABILITATION         PERCENT         10 MERCY RADD         0 MERCY RADD           YEER CITY NURSING AND REHABILITATION         SUMMAY STATURENT OF DIFTE ENERS         0         0 MERCY RADD         0 MERCY RADD           YEER CITY NURSING AND REHABILITATION         SUMMAY STATURENT OF DIFTE ENERS         0 MERCY RADD         0 MERCY RADD         0 MERCY RADD           YEER CITY NURSING AND REHABILITATION         SUMMAY STATURENT OF DIFTE ENERS         0 MERCY RADD	DEPARTMENT OF HEALTH AND HUMAN SERVICES							APPROVED
AND PLAN OF CORRECTION     DENT FIGATION NUMBER:     A BUILDING     COMPLETED       285058     B: WING     04/28/2020       STREET ADDRESS, CITY, STATE, ZIP CODE:       7410 MERCY ROAD       RVER CITY NURSING AND REHABILITATION       7410 MERCY ROAD       VIEW CITY NURSING AND REHABILITATION       7410 MERCY ROAD       VIEW CITY NURSING AND REHABILITATION       7410 MERCY ROAD       VIEW CITY NURSING AND REHABILITATION       VIEW CITY NURSING AND REHABILITATION       7410 MERCY ROAD       VIEW CITY NURSING AND REHABILITATION       VIEW CITY NURSING AND REHABILITATIO	CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0938-0391
NMME OF PROVIDER OR SUPPLIER     STREET ADDRESS, GTV, STATE, 2P CODE       RIVER CITY NURSING AND REHABILITATION     STREET ADDRESS, GTV, STATE, 2P CODE       MANA NE BESTA     STREET ADDRESS, GTV, STATE, 2P CODE       MORE OF PROVIDER OR REST DO THE OF DECISION     PROVIDERS DR AND CORRECTION       MORE OF PROVIDER OF DEVIDENCE DOCTS     PROVE DEVIDENCE PROVIDER OF DEVIDENCE DOCTS       MORE OF PROVIDER OF DEVIDENCE DOCTS     PROVIDERS DR AND CORRECTION       PROVIDER OR AND REHABILITATION     PROVIDENCE DATE AND CORRECTION       PROVIDER OR AND CORRECTION     PROVIDENCE DATE AND CORRECTION       PROVIDER OR AND REHABILITATION     PROVIDENCE DATE AND CORRECTION       PROVIDER OF AND REHABILITATION     PROVIDENCE DATE AND CORRECTION       PROVIDER OF AND REHABILITATION DEVIDENCE DA	CONSIGNATION OF STATES OF STATES							
7419 MERCY ROAD DMAHA, NE 98124       7419 MERCY ROAD DMAHA, NE 98124       CALL DERICE NOT DEFICE NOT DEFICE NOTES (EACH DERICE NOT WISE DE PERCEDED BY FULL) TAC     7419 MERCY ROAD DMAHA, NE 98124       F 880       Continued From page 4 diagnostic testing, and failed to indicate if any infectious organisms were identified. The facility failed to indicate if any of the infections resolved, or were ongoing. The facility failed to document the individual resident locations for the residents documented on the Infections. The facility failed to indicate if any of the infections. The Infection Control Log for March 2020 documented that R5 and R6 required antibiotics to treat facility-acquired infections. The Infection Control Log for March 2020 documented that R5 and R6 required antibiotics to treat active active of R3's progress notes, data 37/20, the days prior. The Infection Control Log for March 2020 documented that R5 exhibited an increased temperature and decreased oxygen saturation level. R3 was admitted to the hospital intensive Care Unit (ICU) for treatment. The Infection Control Log for March 2020 documented that R3 and R9's prior. The Infection Control Log for March 2020 documented that R3 active of R4's progress notes, dated 31/720, Accumented that R4 began antibiotics for m or 31/720, R5 required antibiotics for m or 31/720, R5 required			285058	B. WING			04/28/2020	
RIVER CITY NURSING AND REHABILITATION         OMAHA, NE 88124           (X4) ID PRETIX TAC         ISUMMARY STATEMENT OF DEFICENCIES (PACH ORE REVAINS) TE MENDERDE BY FULL REGULATORY OR LSC DENT FY NO INFORMATION)         D PRETIX TAC         PROVIDER'S PLAN OF CORRECTION (CACCORRECTIVE ACTION SHOULD BE CREASE HERE REVAINS) TE MENDERDE BY FULL REGULATORY OR LSC DENT FY NO INFORMATION)         0(95) (CACCORRECTIVE ACTION SHOULD BE CREASE HERE REVAINS) TE MENDERDE BY FULL REGULATORY OR LSC DENT FY NO INFORMATION)         0(95) (CACCORRECTIVE ACTION SHOULD BE CREASE HERE REVAINS TE MENDERDE BY FULL REGULATORY OR LSC DENT FY NO INFORMATION)         0(95) (CACCORRECTIVE ACTION SHOULD BE CREASE HERE REVAINS TE MENDERDE BY FULL REGULATORY OR LSC DENT FY NO INFORMATION)         0(95) (CACCORRECTIVE ACTION SHOULD BE CREASE HERE REVAINS TE MENDERDE BY FULL REGULATORY OR LSC DENT FY NO INFORMATION)         0(95) (CACCORRECTIVE ACTION SHOULD BE CREASE HERE REVAINS THE MENDER REVEAL TO THE ACTION SHOULD BE CREASE HERE REVAINS THE MENDER REVEAL TO THE ACTION SHOULD BE CREASE HERE REVAINS THE MENDER REVEAL TO THE ACTION SHOULD BE CREASE HERE REVAINS THE ACTION SHOULD BE REVEAL TO THE ACTION SHOULD B	NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		200 A
Prefix TAG         (EACH DEFICENCY ALST BE PRÉCEDED BY FULL REGULATORY OR LSC BERT FY NO INFORMATION)         PRÉYX TAG         (EACH CORREPENCE)         CONSTRUENCE (CROSS-REFERENCE) DO THE APPROPRIATE         COMPETING DEFICIENCY)           F 880         Continued From page 4 diagnostic testing, and failed to indicate if any indicatous organisms were identified. The facility failed to document any signs or symptoms of infections from any of the 23 infections. The facility failed to indicate if any of the infections resolved, or were orgoing. The facility failed to document the individual resident locations for the residents documented on the Infection. The facility failed to document any other identifiable information regarding R5 and R6 required antibiotics to treat facility-acquired infections. The infection Control Log for March 2020 documented that R3 and R6 required antibiotics to treat facility-acquired infections. The infection Control Log for March 2020 documented that R3 exhibited an increased antibiotics to treat measure of R3's and R6's infections. The infection Control Log for March 2020 documented that R3 exhibited an increased temperature and decreased 0xygen saturation level. R3 was admitted to the hospital Intensive Care Unit (ICU) for treatment. The infection Control Log for March 2020 documented that R3 exhibited an increased temperature and decreased 0xygen saturation level. R3 was admitted to the hospital Intensive Care Unit (ICU) for treatment. The infection Control Log for March 2020 documented that R4 sprogress notes, dated 3/17/20, documented that R4 began antibiotics to treat mention and the contracted in the community. Preview of R4's progress notes, dated 3/17/20, documented that R4 began antibiotics for the rending of infections for the month of March 2020. 3. Review of the Infection Control Log for April 2020 documented that the facility figged eight	<b>RIVER CIT</b>	Y NURSING AND REHA	BILITATION					2
diagnostic testing, and failed to indicate if any infectious organisms were identified. The facility failed to document any signs or symptoms of infection for any of the 23 infections. The facility failed to indicate if any of the infections resolved, or were ongoing. The facility failed to document the individual resident locations for the residents documented that R5 and R6 required antibiotics to treat facility-acquired infections. The facility failed to induce infections. The facility failed to document any other identifiable information regarding R5 and R6's infections. The Infection Control Log for March 2020 documented that R0 and R6's infections. The Infection Control Log for March 2020 documented that R3 whibited an increased temperature and decreased oxygen saturation level. R3 was admitted to the hospital Intensive Care Unit (ICU) for treatment. The Infection Control Log for March 2020 documented that R3 exhibited an increased temperature and occured oxygen saturation level. R3 was admitted to the hospital Intensive Care Unit (ICU) for treatment. The Infection Control Log for March 2020 documented that R3 exhibited an increased temperature and occured to 3/2/3/20. R4 required antibiotics to treat the which she contracted in the community. Review of R4's progress notes, dated 3/17/20, occurented that R4 began antibiotics for in 0.3/27/20, six days prior. The facility failed to provide any information related to the trending of infections for the month of March 2020. 3. Review of the Infection Control Log for April 2020 documented that the facility logged eight	PREFIX	(EACH DEFIC ENC)	Y MUST BE PRECEDED BY FULL	PREFID	2421.5	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
infections for the month. The facility failed to indicate if any infections received any diagnostic	F 880	diagnostic testing, and infectious organisms failed to document and infection for any of the failed to indicate if any or were ongoing. The the individual resident documented on the In The Infection Control documented that R5 at to treat facility-acquire failed to document and information regarding The Infection Control documented that on 3 antibiotics to treat progress notes, dated documented that R3 at temperature and decr level. R3 was admitte Care Unit (ICU) for the The Infection Control documented that on 3 antibiotics to treat the community. Reviet dated 3/17/20, docum antibiotics for The facility failed to pr related to the trending of March 2020. 3. Review of the Infect 2020 documented that	d failed to indicate if any were identified. The facility by signs or symptoms of e 23 infections. The facility y of the infections resolved, facility failed to document t locations for the residents infection Control Log. Log for March 2020 and R6 required antibiotics ed infections. The facility by other identifiable R5 and R6's infections. Log for March 2020 3/17/20, R3 required Review of R3's d 3/7/20, ten days prior, exhibited an increased reased oxygen saturation ed to the hospital Intensive eatment. Log for March 2020 3/23/20, R4 required which she contracted in ew of R4's progress notes, nented that R4 began on 3/17/20, six days prior. rovide any information g of infections for the month	F	380			

NATE OF BRIDE AND A		ID HUMAN SERVICES				FORM	APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES							0.0938-0391
	OF DEFIC ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		285058	B. WING		04/	28/2020	
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RIVER CIT	Y NURSING AND REHA	RII ITATION		74	410 MERCY ROAD		
				0	MAHA, NE 68124		
(X4) ID PREFIX TAG	(EACH DEFIC ENC)	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	testing. The facility fai infections resolved, or failed to document ind for the residents docu Control Log. The Infection Control documented that on 4 required antibiotic tree progress notes, dated documented that R1 of The Infection Control documented that R1 of The Infection Control documented that on 4 to the emergency roo appointment. Review dated 4/7/20, docume an increased tempera on isolation precautio progress note, dated went to the hospital w Infection Control Log hospitalization for isolated following an i 4. The facility tracked to COVID-19 for the r failed to provide any a the months of Februa 5. On 4/28/20 at 3:450 (DON) indicated that f infection trending for that the facility failed to	A series of an additional 4/9/20, documented that R2 experienced ature of 100.4F, and was put of R2's progress notes, ented that R2 experienced ature of 100.4F, and was put ons. Review of an additional 4/9/20, documented that R2 vith additional competent experiature.	F	880			
	(DON) indicated that infection trending for that the facility failed to infections for the mon	the facility failed to complete the month of March, and to initiate trending of					

Facility ID: 280201

If continuation sheet Page 6 of 7

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 08/27/2020 APPROVED 0: 0938-0391	
STATEMENT	OF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE A. BUILDING	CONSTRUCTION	8	(X3) DATE	1	
		285058	B. WING		<u></u>	04/28/2020		
NAME OF P	ROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		25	
RIVER CITY NURSING AND REHABILITATION			25	410 MERCY ROAD MAHA, NE 68124				
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL SC IDENT FY NG INFORMATION)	D PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 880	ongoing process. 6. On 4/28/20 at 4:15 the facility failed to do applicable information not limited to signs an resolution dates of inf testing was completed ongoing trending of in 2020, and that the fac infection trending in th that tracking of employ what was related only the month of April 202 7. The facility policy, of "Infection Prevention documented: "3. Surveillance: A system of surveillar identifying, resorting, infections and commu-	f infections was to be an pm, the DON indicated that boument all required in for infections, including but ad symptoms of infection, fections, and if diagnostic d. The DON indicated that iffections would begin in May cility failed to timely complete the past. The DON indicated yee illnesses was limited to to COVID-19, and began in 20. dated 10/2018, titled and Control Program,"	F 880					

DEPART	MENT OF HEALTH AN	D HUMAN SERVICES				M APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				O. 0938-0391	
	OF DEFIC ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:		E CONSTRUCTION		e survey Pleted	
		285058	B. WING		04/28/2020		
NAME OF PI	ROVIDER OR SUPPLIER		6	STREET ADDRESS, CITY, STATE, ZIP CODE			
<b>RIVER CIT</b>	Y NURSING AND REHA	BILITATION		7410 MERCY ROAD OMAHA, NE 68124			
00010		ATEMENT OF DEFIC ENCIES	D	PROVIDER'S PLAN OF CORRECT		00	
(X4) ID PREFIX TAG	(EACH DEFIC ENC	Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
E 000	Initial Comments		E 00	D			
	Survey was conducte Medicare & Medicaid 2020. The facility was	d Emergency Preparedness ed by the Centers for Services (CMS) on April 28, s found to be in compliance related to E-0024 (b)(6).					
LABORATORY	D RECTOR'S OR PROV DER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		(X6) DATE 07/06/2020	

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.





July 16, 2020

Stacey Knox, Administrator Rock County Hospital Long Term Care 100 East South Street Bassett, NE 68714-5510

CMS CERTIFICATION NUMBER: 285304

Dear Ms. Knox:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 8, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555



### MIDWEST DIVISION OF SURVEY AND CERTIFICATION

May 7, 2020

Chris Ulven, Administrator Rose Blumkin Jewish Home 323 South 132nd Street Omaha, NE 68154

CMS Certification No: 285059

Dear Mr. Ulven:

# SUBJECT: SURVEY RESULTS Cycle Start Date: April 28, 2020

## SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-20-All*, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/gso-20-20-allpdf.pdf-0.

### SURVEY RESULTS

On April 28, 2020, the Centers for Medicare & Medicaid Services (CMS) completed a COVID-19 Focused Survey at Rose Blumkin Jewish Home to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was in substantial compliance with participation requirements and no deficiencies were cited. The findings from this survey are documented on the enclosed form CMS 2567.

No additional action is required on the facility's part.

## **QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES**

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at <u>QIO Program Website</u>. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at <u>Locate Your QIO</u>.

# **CONTACT INFORMATION**

If you have any questions please contact Kevin Wright, Principal Program Representative at (816) 426-2011.

Sincerely,

Kevin Wright Long Term Care Branch Survey & Operations Group Center for Clinical Standards & Quality CMS Kansas City

cc: NE DHHS Powers/Grimes





July 23, 2020

Sarah Watson, Administrator Rose Lane Home Rr 2 Box 46, 1005 North 8th Street Loup City, NE 68853-0046

### CMS CERTIFICATION NUMBER: 285228

Dear Ms. Watson:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 15, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555





July 16, 2020

Stephanie Clifton, Administrator Sandhills Care Center 143 N Fullerton Street Ainsworth, NE 69210-1515

### CMS CERTIFICATION NUMBER: 285298

Dear Ms. Clifton:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 7, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555





August 6, 2020

Stephanie Clifton, Administrator Sandhills Care Center 143 N Fullerton Street Ainsworth, NE 69210-1515

CMS CERTIFICATION NUMBER: 285298

Dear Ms. Clifton:

This is to acknowledge the results of the Infection Control survey conducted at your facility on August 5, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555





July 7, 2020

Janice Edwards, Administrator Sarah Ann Hester Memorial Home P O Box 646, 407 Dakota Street Benkelman, NE 69021

### CMS CERTIFICATION NUMBER: 285241

Dear Ms. Edwards:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 29, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555



### MIDWEST DIVISION OF SURVEY AND CERTIFICATION

July 10, 2020

Samuel Prokopec, Administrator Saunders Medical Center 1760 County Rd J Wahoo, NE 68066-0185

CMS Certification No: 285296

Dear Mr. Prokopec:

# SUBJECT: SURVEY RESULTS Cycle Start Date: June 16, 2020

## SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-20-All*, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

### SURVEY RESULTS

On June 16, 2020, the Centers for Medicare & Medicaid Services (CMS) completed a COVID-19 Focused Survey at Saunders Medical Center to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was in substantial compliance with participation requirements and no deficiencies were cited. The findings from this survey are documented on the enclosed form CMS 2567.

No additional action is required on the facility's part.

## **QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES**

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at <u>QIO Program Website</u>: <u>https://qioprogram.org/covid-19</u>. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance

related to infection control. QIOs per state can be found at <u>Locate Your QIO</u>: <u>https://qioprogram.org/locate-your-qio</u>.

# **CONTACT INFORMATION**

If you have any questions please contact Lisa Hauptman, Principal Program Representative at (816) 426-2011.

Sincerely,

Lisa Hauptman

Lisa Hauptman Long Term Care Branch Survey & Operations Group Center for Clinical Standards & Quality CMS Kansas City

cc: NE DHHS Power/Grimes





July 29, 2020

Judy Frerichs, Administrator Sidney Regional Medical Center-Extended Care 549 Keller Drive Sidney, NE 69162-1775

CMS CERTIFICATION NUMBER: 285290

Dear Ms. Frerichs:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 28, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555





July 13, 2020

Ronald Stavely, Administrator Skyview Care And Rehab At Bridgeport 505 O Street Bridgeport, NE 69336-4045

CMS CERTIFICATION NUMBER: 285224

Dear Mr. Stavely:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 9, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555



#### MIDWEST DIVISION OF SURVEY AND CERTIFICATION

June 30, 2020

Brooke Belina, Administrator South Haven Living Center 1400 Mark Drive Wahoo, NE 68066

CMS Certification No: 285231

Subject: Survey Results Cycle Start Date: June 18, 2020

Dear Ms. Belina,

COVID-19 FOCUSED INFECTION CONTROL SURVEY

The Secretary of the U.S. Department of Health and Human Services (DHHS) has the duty and responsibility to protect the health, safety, welfare and rights of Medicare/Medicaid beneficiaries. The Secretary has delegated authority to administer and provide oversight of the Medicare program to Centers for Medicare & Medicaid Services (CMS).

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-31-All, CMS and the State Survey Agency are conducting unannounced onsite surveys at certain Medicare certified provider and supplier types.

SURVEY RESULTS

On June 18, 2020, a survey was completed at South Haven Living Center by CMS to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the enclosed form CMS 2567.

# PLAN OF CORRECTION

A Plan of Correction (PoC) for the deficiencies must be submitted within ten (10) calendar days of your receipt of this notice. Use the space provided to the right of each item of deficiency to type your PoC and the expected date of completion. A PoC must be entered for each item clearly identifying HOW, WHAT, WHEN, AND WHERE it was or will be corrected. The plan should also include provisions instituted to prevent reoccurrence. The PoC must contain the following:

• Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

• Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

• Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;

• Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of the quality assurance being implemented, the earliest correction date will be the date of the revisit; and

• Include dates when corrective action will be completed. The corrective action completion dates must be written in the completion date column within acceptable time frames. If the PoC is unacceptable for any reason, you will be notified in writing by this office. If the PoC is acceptable, you will be notified via telephone, e-mail, etc. Please note that the facility is ultimately accountable for compliance, and that responsibility is not alleviated in cases where notification regarding the acceptability of the facility's PoC is not made timely. The PoC will serve as the facility's allegation of compliance.

You must send this office the original, signed and dated Statement of Deficiencies (SoD) with the PoC to:

Vonda Young, Nurse Consultant

Vonda.Young@cms.hhs.gov

ENFORCEMENT REMEDIES

Based on the Statement of Deficiencies (Form CMS-2567), the following remedies are imposed:

Civil Money Penalty (CMP)

In determining the amount of the Federal Civil Money Penalty (CMP) that we are imposing, we have considered your facility's history, including any repeated deficiencies; and the factors specified in the Federal requirement at 42 CFR § 488.404. Additionally, CMS issued new CMP policies for infection control deficiencies in QSOG Memorandum QSO 20-31-ALL, effective June 1, 2020. We are imposing the following CMP in accordance with these policies:

• A per-instance Federal Civil Money Penalty in the amount of \$5,000.00 for the deficiency described at the Federal citation, F0880 -- S/S: E -- 483.80(a)(1)(2)(4)(e)(f) - Infection Prevention & Control.

The total amount of the CMP is \$5,000.00.

# Directed Plan of Correction:

In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction (DPOC) is imposed on the facility. In accordance with 42 CFR § 488.402(f), this remedy is effective July 16, 2020. The DPOC may be completed before or after that date. The effective date is not a deadline for completion of the DPOC. However, CMS will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice.

The DPOC requires that your plan of correction include the following:

• A plan for all facility staff to view the two Centers for Disease Control (CDC) training videos located at the following: https://youtu.be/YYTATw9yav4 and https://youtu.be/7srwrF9MGdw. Training may be supervised by the Director of Nursing,

Infection Preventionist, or Medical Director with an attestation statement of completion by all staff.

• A Root Cause Analysis (RCA) of the deficient practices cited, conducted with assistance from the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee and Governing Body. The RCA should be incorporated into the intervention plan. Information regarding RCAs can be found at:

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies, within 10 days after receipt of the Form CMS 2567. Please send all documentation to CMS at the following:

Vonda Young, Nurse Consultant

Email: Vonda.Young@cms.hhs.gov

Please note, if documentation includes any resident personal identifiable information (PII) or personal health information (PHI) it must be sent encrypted.

Imposition of Denial of Payment for New Admissions (DPNA):

Payment will be denied for all NEW Medicare and Medicaid admissions, beginning August 15, 2020, in accordance with the statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal regulations at 42 CFR §488.417. Your Medicare Administrative Contractor will be notified of the date the denial of payment begins. DPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated. FINANCIAL HARDSHIP

If you believe your facility's financial condition lacks the ability to support the amount of the CMP, you can request a financial hardship review. For CMS to consider whether payment of the CMP would create a financial hardship and allow your request for installment payments, the following documents should be submitted to this office (kevin.wright@cms.hhs.gov) within fifteen (15) days from the receipt of this notice:

• Written, dated request specifying the reason financial hardship is alleged.

• Brief summary listing the supporting documents being submitted (if all documents cannot be included please provide rationale as to why).

• Organizational chart with an explanation/description concerning the related entities. If there is a Parent Company, provide names and addresses (please indicate in your written request if you have a Parent company).

• The following financial statements for the Provider and the Parent Company (of note, we need consolidated financials for the Parent Company and complete financials for the subsidiary (not by facility)):

Current Balance sheet (segregated by CURRENT assets and liabilities);

• Current Income statement or Statement of Operations or Profit and Loss Statement (has to include NET INCOME);

• Current Statement of Cash Flows (to include the total change in cash flow);

• Most recent, full-year audited financial statements prepared by an independent accounting firm (including footnotes). If audited financial statements are not available, most recent tax returns may be substituted;

• Most recent full-year audited financial statements of the home office and/or related entities (including footnotes). If audited financial statements are not available, most recent tax returns may be substituted;

• Schedule showing amounts due to/from related companies, or individuals, included in the balance sheets. The schedule should list the names of related organizations, or persons, and indicate where the amounts appear on the balance sheet (e.g., Accounts Receivable, Notes Receivable, etc.);

• Copy of tax returns for the preceding two years;

• Disclosure of expenses and amounts paid/accrued to the home office and/or related entities;

• Documentation of any/all financing arrangements including mortgages, long term debt, and lines of credit;

• If the nursing home requests an extended payment schedule of more than twelve (12) months duration, the provider must submit a letter from a financial institution denying the provider's loan request for the amount of the CMP (requests for extended payment schedules are reviewed based on financial need).

Knowingly and willfully sending false or fraudulent information, or concealing materials of fact, can lead to penalties under 18 U.S.C. §§ 1001, 1035 and 1516.

INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with §488.431, when a civil money penalty (CMP) is imposed and is subject to being collected and placed in an escrow account, you have one opportunity to question cited deficiencies through an Independent Informal Dispute Resolution (IIDR) process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of substandard quality of care (SQC) or IJ. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing the deficiencies, including the scope and severity assessments of deficiencies which have been found to constitute SQC or IJ) to: LCDR Marsophia R. Powers, Long Term Care Branch Manager

Email: marsophia.powers@cms.hhs.gov

This request must be sent within 10 calendar days of receipt of this notice. An incomplete Independent IDR process will not delay the effective date of any enforcement action. WITHDRAWAL OF APPROVAL FOR NURSE AIDE TRAINING PROGRAM Please note that Federal law, as specified in the Social Security Act at §1819(f)(2)(B) and §1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs (NATCEP) and nurse aide competency evaluation programs (NACEP) offered by, or in, a facility in which, within the previous two years, one or more of the following exists:

• Operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse);

• Has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care;

- Has been assessed a total civil money penalty of not less than \$10,697;
- Has been subject to a denial of payment;
- Appointment of a temporary manager;
- Terminated from participation, and/or

• In the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Your facility will receive further information regarding this from the State Agency.

# APPEAL RIGHTS

The following remedies are being imposed:

- CMP `
- Directed Plan of Correction
- DPNA

If you disagree with this action imposed on your facility, you or your legal representative are

required to file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/. To file a new appeal using DAB E-File, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user\_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

Clicking the File New Appeal link on the Manage Existing Appeals screen, then clicking Civil Remedies Division on the File New Appeal screen. Entering and uploading the requested information and documents on the "File New Appeal- Civil Remedies Division" form. At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. The DAB will set the location for the hearing. Counsel may represent you at a hearing at your own expense.

All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions for using DAB E-File in cases before the DAB's Civil Remedies Division can be found by clicking the button marked E-Filing Instructions after logging-in to DAB E-File.

For questions regarding the E-Filing system, please contact E-File System Support at OSDABImmediateOffice@hhs.gov.

Please note that all hearing requests must be filed electronically unless you have no access to the internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. Such a request should be made to:

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, D.C. 20201

A request for a hearing must be filed no later than 60 days from the date of receipt of this notice.

A copy of the hearing request shall be submitted electronically to: kevin.wright@cms.hhs.gov

# WAIVER

If you would like to waive your right to a hearing, you must do so in writing to this office (kevin.wright@cms.hhs.gov) within 60 calendar days of the date of the notice of imposition. If you waive your right to a hearing in accordance with the requirements specified at 42 CFR

488.436, the amount of the CMP will be reduced by 35 percent. After you submit a timely written waiver of your right to a hearing, CMS will send you a letter with instructions on how to remit the adjusted amount of the CMP.

If you believe you have achieved substantial compliance, you should contact the CMS RO. In addition, if substantial compliance has not been achieved within six (6) months after the last date of the survey identifying noncompliance, June 4, 2020, we will terminate your Medicare provider agreement effective December 18, 2020.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at QIO Program Website. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at Locate Your QIO. CONTACT INFORMATION

Thank you for the time and courtesy extended to our surveyors during the survey. If you have any questions regarding the survey, please contact Vonda Young, Nurse Consultant. For questions

regarding enforcement, Kevin Wright, Health Insurance Specialist. Both can be reached in our Kansas City Regional Office at (816) 426-2011.

Sincerely,

CDR Marsophia R. Powers Long Term Care Branch Manager Survey & Operations Group Center for Clinical Standards & Quality

CMS Kansas City

Enclosures CMS 2567

Copies via e-mail to: NE DHHS Powers/Grimes/Young WPS OGC





DEPT. OF HEALTH AND HUMAN SERVICES

## **IMPORTANT NOTICE – PLEASE READ CAREFULLY**

July 1, 2020

David Bergmann, Administrator Southlake Village Rehabilitation & Care Center 9401 Andermatt Drive Lincoln, NE 68526

CMS Certification No. 285219

Subject: Survey Results Cycle Start Date: June 11, 2020

Dear Administrator,

#### UNANNOUNCED COVID-19 SURVEY

The Secretary of the U.S. Department of Health and Human Services (DHHS) has the duty and responsibility to protect the health, safety, welfare and rights of Medicare/Medicaid beneficiaries. The Secretary has delegated authority to administer and provide oversight of the Medicare program to Centers for Medicare & Medicaid Services (CMS).

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-31-All*, CMS and the State Survey Agency are conducting unannounced onsite surveys at certain Medicare certified provider and supplier types.

#### SURVEY RESULTS

On June 11, 2020, a survey was completed at Southlake Village Rehabilitation & Care Center by the State Survey Agency to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the CMS 2567 and will be posted on the ePOC system.

### PLAN OF CORRECTION

A Plan of Correction (PoC) for the deficiencies must be submitted by July 11, 2020, to the State Survey Agency Contact. Failure to submit an acceptable PoC by July 11, 2020 may result in the imposition of additional remedies. The PoC must contain the following:

- 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- 3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of the quality assurance being implemented, the earliest correction date will be the date of the revisit; and
- 5. Include dates when corrective action will be completed. The corrective action completion dates must be written in the completion date column within acceptable time frames. If the PoC is unacceptable for any reason, you will be notified in writing by this office. If the PoC is acceptable, you will be notified via ePOC. Please note that the facility is ultimately accountable for compliance, and that responsibility is not alleviated in cases where notification regarding the acceptability of the facility's PoC is not made timely. The PoC will serve as the facility's allegation of compliance.

## **ENFORCEMENT REMEDIES**

Based on the Statement of Deficiencies (Form CMS-2567), the following remedies are imposed:

• Directed Plan of Correction:

In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction is imposed on the facility. In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. The effective date is not a deadline for completion of the DPOC. However, the State Agency will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice.

Training option(s) which are the most appropriate for the type of noncompliance cited. For

Sparkling Surfaces - https://youtu.be/t7OH8ORr5Ig Clean Hands - https://youtu.be/xmYMUly7qiE Closely Monitor Residents - https://youtu.be/1ZbT1Njv6xA Keep COVID-19 Out! - https://youtu.be/7srwrF9MGdw Lessons - https://youtu.be/YYTATw9yav4

Please send all documentation to the State Agency at the following:

examp

Connie Vogt, RN, BSN Email: dhhs.healthcarefacilities@Nebraska.gov In the Subject Line please put: DPOC

For states participating in the ePOC program, the DPOC may be added as an attachment.

Please note, if documentation includes any resident personal identifiable information (PII) or personal health information (PHI) it must be sent encrypted.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies, within 10 days after receipt of the Form CMS 2567. Please see the attached instructions (DPOC attachment) for detailed guidance.

# • Imposition of Denial of Payment for New Admissions (DPNA):

Payment will be denied for all <u>NEW</u> Medicare and Medicaid admissions, beginning August 15, 20 of the date the denial of payment begins. DPNA will continue until the day before your facility ac

## **INFORMAL DISPUTE RESOLUTION (IDR)**

You have one opportunity to dispute the deficiencies cited on the survey date through (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Connie Vogt, RN, BSN Email: dhhs.healthcarefacilities@Nebraska.gov In the Subject Line please type: Request IDR

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by

counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

This request must be submitted within 10 days from the date of the enforcement letter. An incomplete Informal Dispute Resolution process will not delay the effective date of any enforcement action.

Informal Dispute Resolution is in no way to be construed as a formal evidentiary hearing. It is an informal internal process to review additional information submitted by the facility. You will be advised of our decision relative to the informal dispute.

# APPEAL RIGHTS

If you disagree with the determination to impose remedies made on the basis of noncompliance identified at the June 11, 2020 survey, you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board (DAB). The appeal rights are set forth at 42 C.F.R. § 498.5 and the procedures for requesting a hearing are set forth at §498.40, et seq. You must file your hearing request electronically by using the DAB's Electronic Filing System (DAB E-File) at <a href="https://dab.efile.hhs.gov/">https://dab.efile.hhs.gov/</a>, unless you obtain a waiver from the DAB (*see* DAB Civil Remedies Division Procedures, § 6(a)(i)(1)). Your appeal must be filed no later than 60 days from the date of receipt of this letter.

We request that you provide an electronic copy of the request for appeal to: and to the CMS Regional Chief Counsel at:

OGCK ansas CityGeneralInbox@hhs.gov

If you elect to dispute deficiencies through the Informal Dispute Resolution (IDR) process, this will not extend the 60 day period to file your appeal before the Departmental Appeals Board. Filing an appeal will not stop the imposition of any enforcement remedy.

If you experience problems with, or have questions about DAB e-File, please contact e-File System Support at <u>OSDABImmediateOffice@hhs.gov</u>. If you have questions about using the DAB e-file System, please visit: <u>https://dab.efile.hhs.gov/appeals/to\_crd\_instructions?locale=en</u>.

# **QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES**

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at <u>QIO</u> <u>Program Website</u>. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at <u>Locate Your QIO</u>.

# **CONTACT INFORMATION**

If you have any questions please contact this office.

ROkcm

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555

CV/kd

Enclosures: CMS 2567

Copies via e-mail to: CMS-RO DHHS - State Medicaid Agency DHHS - Nursing Support





June 24, 2020

Melody Gagner, Administrator St Jane De Chantal 2200 South 52nd Street Lincoln, NE 68506-2134

CMS CERTIFICATION NUMBER: 285004

Dear Ms. Gagner:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 9, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555





July 22, 2020

Candace Gibson, Administrator St Joseph's Hillside Villa 540 E Washington Street West Point, NE 68788

#### CMS CERTIFICATION NUMBER: 285303

Dear Ms. Gibson:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 8, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555



#### MIDWEST DIVISION OF SURVEY AND CERTIFICATION

July 9, 2020

Rita Raffety, Administrator St. Joseph Rehabilitation & Care Center 401 North 18<sup>th</sup> Street Norfolk, NE 68701

CMS Certification No: 285160

Dear Administrator:

## SUBJECT: SURVEY RESULTS Cycle Start Date: June 25, 2020

### SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-20-All*, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

#### SURVEY RESULTS

On June 25, 2020, the Centers for Medicare & Medicaid Services (CMS) completed a COVID-19 Focused Survey at St. Joseph Rehabilitation & Care Center to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was in substantial compliance with participation requirements and no deficiencies were cited. The findings from this survey are documented on the enclosed form CMS 2567.

No additional action is required on the facility's part.

### **QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES**

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at <u>QIO Program Website</u>: <u>https://qioprogram.org/covid-19</u>. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance

related to infection control. QIOs per state can be found at <u>Locate Your QIO</u>: <u>https://qioprogram.org/locate-your-qio</u>.

# **CONTACT INFORMATION**

If you have any questions please contact Treesie Farmer, Principal Program Representative at (816) 426-2011.

Sincerely,

Treesie Farmer Long Term Care Branch Survey & Operations Group Center for Clinical Standards & Quality CMS Kansas City

cc: NE DHHS Powers/Grimes



#### **MIDWEST DIVISION OF SURVEY AND CERTIFICATION**

May 8, 2020

Hector Leguillow, Administrator St. Joseph Villa Nursing Center 2305 South 10th Street Omaha, NE 68108-1154

CMS Certification No: 285078

Dear Mr. Leguillow:

## SUBJECT: SURVEY RESULTS Cycle Start Date: April 30, 2020

#### SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-20-All*, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/gso-20-20-allpdf.pdf-0.

#### SURVEY RESULTS

On April 30, 2020, the Centers for Medicare & Medicaid Services (CMS) completed a COVID-19 Focused Survey at St. Joseph Villa Nursing Center to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was in substantial compliance with participation requirements and no deficiencies were cited. The findings from this survey are documented on the enclosed form CMS 2567.

No additional action is required on the facility's part.

### **QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES**

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at <u>QIO Program Website</u>. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at <u>Locate Your QIO</u>.

## **CONTACT INFORMATION**

If you have any questions please contact Kevin Wright, Principal Program Representative at (816) 426-2011.

Sincerely,

Kevin Wright Long Term Care Branch Survey & Operations Group Center for Clinical Standards & Quality CMS Kansas City

cc: NE DHHS Powers/Grimes





July 7, 2020

Hector Leguillow, Administrator St. Joseph Villa Nursing Center 2305 South 10th Street Omaha, NE 68108-1154

#### CMS CERTIFICATION NUMBER: 285078

Dear Mr. Leguillow:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 24, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555





July 31, 2020

Hector Leguillow, Administrator St. Joseph Villa Nursing Center 2305 South 10th Street Omaha, NE 68108-1154

CMS CERTIFICATION NUMBER: 285078

Dear Mr. Leguillow:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 29, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555





June 24, 2020

Trisha Steager, Administrator St. Joseph's Villa, Inc. 927 Seventh Street David City, NE 68632

CMS CERTIFICATION NUMBER: 285249

Dear Ms. Steager:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 11, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555

CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROV							
					OMB NO. 0938-0391		
		(X2) MULT PLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		285102	B. WING		07/01/2020		
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
STANTON	HEALTH CENTER		P	O BOX 407, 301 17TH STREET			
STANTON	INCALIN CENTER		S	TANTON, NE 68779	2		
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E 000	Initial Comments		E 000				
	This facility is in com Preparedness tag at l	pliance with the Emergency E0024.					
LABORATORY	D RECTOR'S OR PROV DER/S	SUPPLIER REPRESENTATIVE'S SIGNATU	RE	TITLE	(X6) DATE		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 08/27/2020

# DEDARTMENT OF HEALTH AND HUMAN SERVICES





DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Covernor

### **IMPORTANT NOTICE – PLEASE READ CAREFULLY**

July 15, 2020

April Johnston, Administrator Stanton Health Center P O Box 407, 301 17th Street Stanton, NE 68779-0407

CMS Certification No. 285102

Subject: Survey Results Cycle Start Date: July 1, 2020

Dear Administrator,

### UNANNOUNCED COVID-19 SURVEY

The Secretary of the U.S. Department of Health and Human Services (DHHS) has the duty and responsibility to protect the health, safety, welfare and rights of Medicare/Medicaid beneficiaries. The Secretary has delegated authority to administer and provide oversight of the Medicare program to Centers for Medicare & Medicaid Services (CMS).

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-31-All*, CMS and the State Survey Agency are conducting unannounced onsite surveys at certain Medicare certified provider and supplier types.

#### SURVEY RESULTS

On July 1, 2020, a survey was completed at Stanton Health Center by the State Survey Agency to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the CMS 2567 and will be posted on the ePOC system.

### PLAN OF CORRECTION

A Plan of Correction (PoC) for the deficiencies must be submitted by July 25, 2020, to the State Survey Agency Contact. Failure to submit an acceptable PoC by July 25, 2020 may result in the imposition of additional remedies.

The PoC must contain the following:

- 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- 3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of the quality assurance being implemented, the earliest correction date will be the date of the revisit; and
- 5. Include dates when corrective action will be completed. The corrective action completion dates must be written in the completion date column within acceptable time frames. If the PoC is unacceptable for any reason, you will be notified in writing by this office. If the PoC is acceptable, you will be notified via ePOC. Please note that the facility is ultimately accountable for compliance, and that responsibility is not alleviated in cases where notification regarding the acceptability of the facility's PoC is not made timely. The PoC will serve as the facility's allegation of compliance.

## **ENFORCEMENT REMEDIES**

Based on the Statement of Deficiencies (Form CMS-2567), the following remedies are imposed:

• Directed Plan of Correction:

In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction is imposed on the facility. In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. The effective date is not a deadline for completion of the DPOC. However, the State Agency will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice.

Training option(s) which are the most appropriate for the type of noncompliance cited. For

Sparkling Surfaces - https://youtu.be/t7OH8ORr5Ig Clean Hands - https://youtu.be/xmYMUly7qiE Closely Monitor Residents - https://youtu.be/1ZbT1Njv6xA Keep COVID-19 Out! - https://youtu.be/7srwrF9MGdw Lessons - https://youtu.be/YYTATw9yav4

Please send all documentation to the State Agency at the following:

examp

Connie Vogt, RN, BSN dhhs.healthcarefacilities@Nebraska.gov In the Subject Line please put: DPOC

For states participating in the ePOC program, the DPOC may be added as an attachment.

Please note, if documentation includes any resident personal identifiable information (PII) or personal health information (PHI) it must be sent encrypted.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies, within 10 days after receipt of the Form CMS 2567. Please see the attached instructions (DPOC attachment) for detailed guidance.

# • Imposition of Denial of Payment for New Admissions (DPNA):

Payment will be denied for all <u>NEW</u> Medicare and Medicaid admissions, August 29, 2020 in accordance with the statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal regulations at 42 CFR §488.417. Your Medicare Administrative Contractor will be notified of the date the denial of payment begins. DPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated.

# WITHDRAWAL OF APPROVAL FOR NURSE AIDE TRAINING PROGRAM

Please note that Federal law, as specified in the Social Security Act at \$1819(f)(2)(B) and \$1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs (NATCEP) and nurse aide competency evaluation programs (NACEP) offered by, or in, a facility which, within the previous two years, if one or more of the following exists:

- Operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse);
- Has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care;
- Has been assessed a total civil money penalty of not less than \$10,697;
- Has been subject to a denial of payment;
- Appointment of a temporary manager;
- Terminated from participation, and/or
- In the case of an emergency, has been closed and/or had its residents transferred to other facilities.

# **INFORMAL DISPUTE RESOLUTION (IDR)**

You have one opportunity to dispute the deficiencies cited on the survey date through (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Connie Vogt, RN, BSN Email: dhhs.healthcarefacilities@Nebraska.gov In the Subject Line of the email put: Request IDR

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

This request must be submitted within 10 days from the date of the enforcement letter. An incomplete Informal Dispute Resolution process will not delay the effective date of any enforcement action.

Informal Dispute Resolution is in no way to be construed as a formal evidentiary hearing. It is an informal internal process to review additional information submitted by the facility. You will be advised of our decision relative to the informal dispute.

## **APPEAL RIGHTS**

If you disagree with the determination to impose remedies made on the basis of noncompliance identified at the July 1, 2020 survey, you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board (DAB). The appeal rights are set forth at 42 C.F.R. § 498.5 and the procedures for requesting a hearing are set forth at §498.40, et seq. You must file your hearing request electronically by using the DAB's Electronic Filing System (DAB E-File) at <a href="https://dab.efile.hhs.gov/">https://dab.efile.hhs.gov/</a>, unless you obtain a waiver from the DAB (*see* DAB Civil Remedies Division Procedures, § 6(a)(i)(1)). Your appeal must be filed no later than 60 days from the date of receipt of this letter.

We request that you provide an electronic copy of the request for appeal to:

ROkcmSCB@cms.hhs.gov and to the CMS Regional Chief Counsel at: OGCKansasCityGeneralInbox@hhs.gov

If you elect to dispute deficiencies through the Informal Dispute Resolution (IDR) process, this will not extend the 60 day period to file your appeal before the Departmental Appeals Board. Filing an appeal will not stop the imposition of any enforcement remedy.

If you experience problems with, or have questions about DAB e-File, please contact e-File System Support at <u>OSDABImmediateOffice@hhs.gov</u>. If you have questions about using the DAB e-file System, please visit: <u>https://dab.efile.hhs.gov/appeals/to\_crd\_instructions?locale=en</u>.

# **QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES**

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at <u>QIO</u> <u>Program Website</u>. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at <u>Locate Your QIO</u>.

## **CONTACT INFORMATION**

If you have any questions please contact this office.

Sincerely,

Connie Ellegt KNIBSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555

CV/kd

Enclosures: CMS 2567

Copies via e-mail to: CMS - RO DHHS - State Medicaid Agency DHHS - Nursing Support

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	O. 0938-0391
STATEMENT OF DEFIC ENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENT FICATION NUMBER:         285102				X2) MULT PLE CONSTRUCTION A. BUILDING		e survey Pleted
		B. WING	2	07/01/2020		
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STANTON	HEALTH CENTER		10	P O BOX 407, 301 17TH STREET STANTON, NE 68779		
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F 000	INITIAL COMMENTS	r	F 000			
F 880	Governing Licensure Nursing Facilities, and Facilities" have been as they apply to defic Infection Prevention &	Chapter 12 "Regulations of Skilled Nursing Facilities, d Intermediate Care included in the survey report ient practices identified. & Control	F 880			
SS=F	infection prevention a designed to provide a comfortable environm	ntrol blish and maintain an and control program a safe, sanitary and nent and to help prevent the asmission of communicable				
	program. The facility must esta	prevention and control blish an infection prevention (IPCP) that must include, at ving elements:				
	reporting, investigatin and communicable di staff, volunteers, visit providing services un arrangement based u	pon the facility assessment to §483.70(e) and following				
	procedures for the probut are not limited to:	llance designed to identify				

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 08/27/2020

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.

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 08/27/2020 APPROVED 0: 0938-0391
STATEMENT OF DEFIC ENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENT FICATION NUMBER:		(X2) MULT PLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		285102	B. WING			07/	01/2020
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F 880	infections before they persons in the facility; (ii) When and to whor communicable diseas reported; (iii) Standard and tran to be followed to prev (iv)When and how iso resident; including but (A) The type and dura depending upon the in involved, and (B) A requirement tha least restrictive possit circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit th (vi)The hand hygiene by staff involved in dir §483.80(a)(4) A syste identified under the fa corrective actions take §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rev The facility will condu IPCP and update thei	y can spread to other m possible incidents of se or infections should be msmission-based precautions yent spread of infections; blation should be used for a at not limited to: ation of the isolation, infectious agent or organism at the isolation should be the ble for the resident under the s under which the facility ees with a communicable kin lesions from direct s or their food, if direct he disease; and p procedures to be followed rect resident contact. em for recording incidents acility's IPCP and the ten by the facility. Ile, store, process, and s to prevent the spread of view. Ict an annual review of its ir program, as necessary. T is not met as evidenced	F 880				

Facility ID: 840101

If continuation sheet Page 2 of 6

Landon Amberlandia		D HUMAN SERVICES			FORM	APPROVED	
			()(2) 1411 7	DIE		Contractor of the Internet of	0.0938-0391
STATEMENT OF DEFIC ENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENT FICATION NUMBER:			(X2) MULT PLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	285102		B. WING			07/01/2020	
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STANTON	HEALTH CENTER				O BOX 407, 301 17TH STREET TANTON, NE 68779		
	SUMMARY ST		D		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 880	Continued From page	e 2	F8	880			
	Based on observatior	ns, interview, and record					
	review; the facility fail	led to implement infection					
		o prevent the spread of dents on the Memory Care					
		rea used to protect and					
		residents needs and to					
		sociated with dementia) did 6 feet distance between					
		r masks (the facility reported					
		the MCU); 2) staff failed to					
	perform correct use a personal protective e	and procedures for use of quipment (PPE) for					
	residents in isolation;						
		handwashing and gloving.					
	was 56.	6 and the facility census					
	Findings are:	edicare and Medicaid					
		orandum dated March 13,					
	2020 provided guidar						
		cel communal dining and all					
		as internal and external 2) Remind residents to					
		cing and perform frequent					
	hand hygiene.						
		ease Control and Prevention					
		ns for Memory Care Units in					
	2020 stated that nurs	lities", updated May 12, ing homes providing					
		1) Try to keep environment					
	and routines as consi	istent as possible while still					
	Contrast Statistics and a second statistical statistics and a	ing with frequent hand ncing, and use of cloth face					
		i), and 2) limit the number					
	of residents or space	residents at least 6 feet					
	apart as much as feasible when in a common						

Facility ID: 840101

If continuation sheet Page 3 of 6

PRINTED: 08/27/2020

CENTER		ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE A. BUILDING _	E CONSTRUCTION	PRINTED: 08/27/2020 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
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F 880	carefully redirect resid and are in close proxi C. On 6/30/20 at 9:35 MCU (memory care u wearing masks and 3 at a table all within 2 other residents were i in the commons area masks. On 6/30/20 at 12:00 F observed sitting in the and staff were serving social distancing note present in the room w 3 residents at one tab table all sitting within An interview on 6/30// Medication Aide (MA) residents were not be encouraged to social have communal dinin D. On 6/30/20 at 10: used face mask and p isolation caddy locate on top of the clean ga caddy. The Director of the NA-G to retrieve to isolation caddy and in your pocket" which N Resident 3's room. E. On 6/30/20 at 11:4 noted to be in the hall	and staff spend time, and dents who are ambulatory imity to other residents. AM surveyor entered the unit), noted 2 staff members residents unmasked sitting feet of each other. Two noted sitting in easy chairs and were not wearing PM all MCU residents were e dining room of the MCU g the residents lunch. No ed. Three tables were with 5 residents at one table, ole, and 4 residents at one 2 feet or another resident. 20 at 9:40 AM with A confirmed that MCU ing monitored for or distance and continued to g. 15 AM NA-G removed a blaced it in the clean ed on Resident 3's door, and arbage bags located in the of Nursing (DON) prompted he face mask from the astructed NA-G to "put it in	F 880			

Facility ID: 840101

If continuation sheet Page 4 of 6

	S FOR MEDICARE &					0938-039	
STATEMENT OF DEFIC ENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENT FICATION NUMBER:         285102		IDENT FIGATION NUMBER		JLT PLE CONSTRUCTION DING		SURVEY	
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STANTON HEALTH CENTER			P O BOX 407, 301 17TH STREET STANTON, NE 68779				
(X4) ID Prefix Tag	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 880	some cleaning suppli room, upon leaving th removed and dispose put on without washin Housekeeper-E proc resident room for clear F. On 6/30/20 at 11:4	es and entered a resident ne room the gloves were ed of, new clean gloves were ng or sanitizing hands and eeded to enter the next aning. 5 AM NA-F was observed	F 880				
	(who was on isolation was handed to NA-F NA-F entered the roo from a zip lock bag, a NA-F grabbed the dir the resident room, bu bag back into the bin the receiving laundry then grabbed a clean isolation caddy on the	vay of Resident 1's room and put on a gown that by NA-G from the hallway. and put on the face shield and put on the face shield. ty laundry from the bin within at then set the dirty laundry when NA-G reported that bin was "overflowing". NA-F alaundry bag from the e resident's door without					
	the dirty laundry from laundry bag in the bir approximately 3 minu to assist, removed th back into a zip lock b gown and gloves and and trash receptacles	anitizing hands. NA-F lifted the bin and placed a new h. NA-F waited ttes and when no one came e face shield and placed it ag. NA-F then removed the I place them in the laundry s, picked up the soiled th the baggie (containing the					
	dirty face shield) rubb laundry bag. NA-F le washing or sanitizing laundry bag with the against it, to a storag laundry receptacle wa assistance for approx arrived so NA-F set to	bing up against the dirty off the resident room without hands. NA-F carried the baggie continuing to rub e area to dispose of it. The as full. After waiting for kimately 3 minutes, no one he bag down, returned to the into a bathing area currently					

Facility ID: 840101

If continuation sheet Page 5 of 6

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 08/27/2020 MAPPROVED D. 0938-0391
STATEMENT OF DEFIC ENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:		(X2) MULT PLE CONSTRUCTION A. BUILDING		(X3) DATE	(X3) DATE SURVEY COMPLETED	
		285102	B. WING		07	/01/2020
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		25
STANTON	HEALTH CENTER		10420	P O BOX 407, 301 17TH STREET STANTON, NE 68779		
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 880	box containing 6 other face shields in them. and left the room. G. An interview with t PM confirmed: 1) Har performed before and masks and face shiel clean surfaces or in s face shields need to b	r baggies with masks and NA-F then washed hands he DON on 6/30/20 at 12:45	F 880			

Facility ID: 840101

If continuation sheet Page 6 of 6

DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services Kansas City Regional Office 601 East 12th Street, Room 355 Kansas City, Missouri 64106



#### MIDWEST DIVISION OF SURVEY AND CERTIFICATION

July 9, 2020

Abby Lehr, Administrator Sumner Place 1750 South 20th Street Lincoln, NE 68502

CMS Certification No: 285002

Dear Ms. Lehr:

## SUBJECT: SURVEY RESULTS Cycle Start Date: June 24, 2020

### SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-20-All*, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/gso-20-20-allpdf.pdf-0.

#### SURVEY RESULTS

On June 24, 2020, the Centers for Medicare & Medicaid Services (CMS) completed a COVID-19 Focused Survey at Sumner Place to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was in substantial compliance with participation requirements and no deficiencies were cited. The findings from this survey are documented on the enclosed form CMS 2567.

No additional action is required on the facility's part.

### **QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES**

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at <u>QIO Program Website</u>. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at <u>Locate Your QIO</u>.

# CONTACT INFORMATION

If you have any questions please contact Treesie Farmer, Principal Program Representative at (816) 426-2011.

Sincerely,

Treesie Farmer Long Term Care Branch Survey & Operations Group Center for Clinical Standards & Quality CMS Kansas City

cc: NE DHHS Powers/Grimes



#### MIDWEST DIVISION OF SURVEY AND CERTIFICATION

May 28, 2020

Seth Stauffer, Administrator Sunrise Country Manor PO Box A, 610 224th Street Milford, NE 68405

CMS Certification No: 285232

Dear Mr. Stauffer:

SUBJECT: SURVEY RESULTS Cycle Start Date: January 21, 2020

## SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

## SURVEY RESULTS

On May 19, 2020, the Centers for Medicare & Medicaid Services (CMS) completed a COVID-19 Focused Survey at Sunrise Country Manor to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the enclosed form CMS 2567.

## PLAN OF CORRECTION

You must submit an acceptable plan of correction (POC) for the enclosed deficiencies that were cited during the May 19, 2020 survey. Sunrise Country Manor may choose to delay submission of a POC until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a POC. An acceptable POC will serve as your allegation of compliance. Upon receipt of an acceptable POC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable POC can lead to termination of your Medicare and Medicaid participation.

To be acceptable, a provider's POC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice;

• What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;

• How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; and

• The date that each deficiency will be corrected.

The POC must be signed and dated by an official facility representative. Please send your POC by fax or email to:

Eddie Grimes

Email: Eddie.Grimes@cms.hhs.gov

## INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the April 28, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Lisa Hauptman Email: Lisa.Hauptman@cms.hhs.gov

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

Sunrise Country Manor may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at QIO Program Website. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at Locate Your QIO.

### CONTACT INFORMATION

If you have any questions please contact Kevin Wright, Principal Program Representative at (816) 426-2011.

Sincerely,

Kevin Wright Long Term Care Branch Survey & Operations Group Center for Clinical Standards & Quality CMS Kansas City

Enclosure: CMS 2567

cc: NE DHHS Hauptman/Grimes

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		285232	B. WING		05/19/2020
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
SUNRISE	COUNTRY MANOR			PO BOX A, 610 224TH STREET	
				MILFORD, NE 68405	
(X4) ID PREFIX		ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL	D	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	· · · · ·
TAG		LSC IDENT FY NG INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	
				DEFICIENCY)	
F 000	INITIAL COMMENTS	r	F 000		
		d Infection Control survey			
		althcare Management			
		half of the Centers for			
	Medicare & Medicaid				
	and the second	0. The facility was found not ompliance with 42 CFR			
		trol regulations and has not			
	implemented the CMS	S and Centers for Disease			
		on (CDC) recommended			
	practices to prepare f	or COVID-19.			
	Survey Census: 67				
	Sample Size: 5				
	Supplemental: 0				
F 880			F 880		
SS=F	CFR(s): 483.80(a)(1)	(2)(4)(e)(f)			
	§483.80 Infection Cor	ntrol			
		blish and maintain an			
	infection prevention a				
	designed to provide a	a sate, sanitary and nent and to help prevent the			
		ismission of communicable			
	diseases and infection				
	\$483.80(a) Infection	prevention and control			
	program.				
	The facility must esta	blish an infection prevention			
		(IPCP) that must include, at			
	a minimum, the follow	ving elements:			
	§483.80(a)(1) A syste	em for preventing, identifying,			
		ig, and controlling infections			
		seases for all residents,			
	statt, volunteers, visit	ors, and other individuals			
ABORATORY	D RECTOR'S OR PROV DER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	F	TITLE	(X6) DATE

06/08/2020

PRINTED: 08/27/2020

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.

Landon Indetterring		D HUMAN SERVICES				FORM	: 08/27/2020 APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	-			OMB NO	. 0938-0391
CONTRACTOR OF STREET, S	DF DEFIC ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE A. BUILDING _	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		285232	B. WING			05/	19/2020
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE		
SUNRISE	COUNTRY MANOR		104.20	O BOX A, 610 224TH STR MILFORD, NE 68405	REET		
(X4) ID PREFIX TAG	(EACH DEFIC ENC)	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL SC IDENT FY NG INFORMATION)	D PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	conducted according accepted national sta §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicabi infections before they persons in the facility; (ii) When and to whor communicable disease reported; (iii) Standard and tran- to be followed to prev (iv)When and how iso resident; including bu (A) The type and dura- depending upon the in involved, and (B) A requirement that least restrictive possil circumstances. (v) The circumstances must prohibit employed disease or infected sk contact will transmit th (vi)The hand hygiene by staff involved in dir	der a contractual pon the facility assessment to §483.70(e) and following indards; standards, policies, and ogram, which must include, lance designed to identify le diseases or can spread to other in possible incidents of the or infections should be ismission-based precautions ent spread of infections; lation should be used for a t not limited to: at not limited to: at not limited to: at the isolation should be the oble for the resident under the s under which the facility ees with a communicable in lesions from direct to or their food, if direct he disease; and procedures to be followed rect resident contact.	F 880				

Facility ID: 800102

If continuation sheet Page 2 of 5

1 de la contractiona da a		ID HUMAN SERVICES				FORM	0: 08/27/2020 APPROVED 0. 0938-0391
STATEMENT O	OF DEFIC ENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE A. BUILDING	CONSTRUCTION	6	(X3) DATE	
		285232	B. WING			05/	19/2020
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
SUNRISE	COUNTRY MANOR		+C+208	O BOX A, 610 224TH STR MILFORD, NE 68405	EET		
(X4) ID PREFIX TAG	(EACH DEFIC ENC)	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	(EACH CORRECCEOSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	Personnel must handl transport linens so as infection. §483.80(f) Annual rev The facility will conduct IPCP and update their This REQUIREMENT by: Based on observation review, the facility failly complied with infection procedures and staff se rule out any possible of signs and/or symptom residents. This screen to expose any of the of facility and/or staff me communicable diseas Findings include: Observation on 5/18/2 Hospice Registered N entrance door code, evisitor screening form area and entered Root temperature. In an interview on 5/1. Director of Nursing (D contractors taking the	Ile, store, process, and a to prevent the spread of view. Inter an annual review of its in program, as necessary. T is not met as evidenced on, interview, and record led to ensure visitors on control screening screenings were reviewed to communicable disease ns prior to working with the ning failure had the potential 67 people residing in the embers working to possible ses. 2020 at 1:25 PM showed Nurse (RN) enter the locked enter the facility, stop at the oning table and fill out the h. Hospice RN then left the tom 102 without taking a 18/2020 at 1:30 PM, Hospice down her "temperature from 18/2020 at 1:35 PM, the	F 880				

Facility ID: 800102

If continuation sheet Page 3 of 5

		ND HUMAN SERVICES				FORM	0: 08/27/2020 APPROVED 0. 0938-0391
STATEMENT C	DF DEFIC ENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE A. BUILDING	CONSTRUCTION	8	(X3) DATE	
		285232	B. WING			05/	19/2020
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
SUNRISE	COUNTRY MANOR		104200	O BOX A, 610 224TH STF IILFORD, NE 68405	REET		
(X4) ID PREFIX TAG	(EACH DEFIC ENC)	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page	ə 3	F 880				
		creening table on 5/18/2020 a food delivery person enter					
		door security code and enter					
		very person stood at the waited until someone came					
	-	p/pay for the food, then					
	exited the building.						
	In an interview on 5/1 Infection Preventionis	19/2020 at 12:16 PM, the st RN (IP) stated the					
	employee screening l	logs are reviewed by her					
		before I leave." At 12:20					
	PM, the IP clarified he 7:00-7:30 AM to 4:00- week.	er normal nours were I-4:15 PM five days per					
		policy "Coronavirus Disease Entrance Screening," dated					
		URE: Entrance to the facility					
		ssential facility staff and					
		ceptions may be made for to the facility will remain					
	locked. A keypad at th	he main entrance will be					
		l workers. The keypad code					
	24 C C C C C C C C C C C C C C C C C C C	ast monthly or with any ance. All individuals entering					
	the facility are require	ed to pass through a					
	screening station prio station will be compris	or to entry. The screening					
	-Hand sanitizing statio	-					
	-Temperature check						
		naire regarding COVID-19					
	exposure and sympto -Facemask distributio						
		e temperature is above 100 or that answer YES to any of					

Facility ID: 800102

If continuation sheet Page 4 of 5

		ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 08/27/2020 MAPPROVED D. 0938-0391
STATEMENT (	OF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE A. BUILDING	E CONSTRUCTION	(X3) DATE	
		285232	B. WING		05/	19/2020
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		20,
SUNRISE	COUNTRY MANOR		1040	PO BOX A, 610 224TH STREET MILFORD, NE 68405		
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL .SC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 880	questions are instruct charge nurse, infection further instruction. The monitored by the infe- arrival and departure throughout the day. (1) at the same frequence Review of the three-ri- self-screening logs da 5/18/2020, and 5/19/2 the IP in the lower rig In an interview on 5/1 regarding the employ IP confirmed there was weekend Charge Nur- stated, "The Charge Nur- stated," The Charge Nur- stated, "The Charge Nur- stated, "The Charge Nur- stated," The Charge Nur- stated, "The Charge Nur- stated," The Charge Nur- stated, "The Charge Nur- stated," The Charge Nur- stated, "No, I don't ma- name], [Administrator	or symptom screening red to go outside and contact on preventionist, or DON for e screening station will be ction preventionist upon as well as randomly Weekends will be monitored y by the charge nurse)." Ing binder with the employee ated 5/17/2020 (a Sunday), 2020 showed the initials of ht corner of the page.	F 880			

If continuation sheet Page 5 of 5

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO	D. 0938-0391
	DF DEFIC ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT I A. BUILDIN	PLE CONSTRUCTION G		E SURVEY PLETED
		285232	B. WING	22	05	/19/2020
NAME OF PR	ROVIDER OR SUPPLIER		2,03	STREET ADDRESS, CITY, STATE, ZIP CODE		
SUNRISE	COUNTRY MANOR			PO BOX A, 610 224TH STREET		
20			100	MILFORD, NE 68405		18
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		EO	00		
	Survey was conducte Management Solution Centers for Medicare on 5/18/2020 - 5/19/2	d Emergency Preparedness ad by Healthcare hs, LLC on behalf of the & Medicaid Services (CMS) 2020. The facility was found //th 42 CFR 483.73 related				
LABORATORY	D RECTOR'S OR PROV DER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
						06/08/2020

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.

PRINTED: 08/27/2020

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO	0.0938-0391
	DF DEFIC ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		285277	B. WING		07	/06/2020
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SUTTON (	COMMUNITY HOME, INC		0			
			2.0	SUTTON, NE 68979		2
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 000			
	Governing Licensure Nursing Facilities, and	Chapter 12- "Regulations of Skilled Nursing Facilities, d Intermediate Care included in survey report as				
F 880 SS=F	Infection Prevention & CFR(s): 483.80(a)(1)		F 880			7/23/20
	infection prevention a designed to provide a comfortable environm	blish and maintain an ind control program a safe, sanitary and nent and to help prevent the nsmission of communicable				
	program. The facility must esta	prevention and control blish an infection prevention (IPCP) that must include, at ving elements:				
	reporting, investigatin and communicable di staff, volunteers, visit providing services un arrangement based u	pon the facility assessment to §483.70(e) and following				
	procedures for the probut are not limited to:	llance designed to identify				
LABORATORY	D RECTOR'S OR PROV DER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
Electroni	cally Signed					07/23/2020

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.

PRINTED: 08/27/2020

		ID HUMAN SERVICES			FORM	APPROVED
		MEDICAID SERVICES				. 0938-0391
	OF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE A. BUILDING	CONSTRUCTION	(X3) DATE COMPL	
		285277	B. WING		07/0	06/2020
NAME OF PR	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		85
SUTTON C	OMMUNITY HOME, INC			106 NORTH SAUNDERS SUTTON, NE 68979		
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Continued From page infections before they persons in the facility (ii) When and to whor communicable diseas reported; (iii) Standard and trar to be followed to prev (iv)When and how iso resident; including bu (A) The type and dura depending upon the i involved, and (B) A requirement that least restrictive possil circumstances. (v) The circumstance must prohibit employed disease or infected sk contact with residents contact will transmit th (vi)The hand hygiene by staff involved in din §483.80(a)(4) A syste identified under the fa corrective actions tak §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rev The facility will condu- IPCP and update thei This REQUIREMENT by:	e 1 r can spread to other m possible incidents of se or infections should be asmission-based precautions rent spread of infections; blation should be used for a t not limited to: ation of the isolation, infectious agent or organism at the isolation should be the ble for the resident under the s under which the facility ees with a communicable (in lesions from direct as or their food, if direct the disease; and procedures to be followed rect resident contact. em for recording incidents acility's IPCP and the en by the facility. le, store, process, and to prevent the spread of	F 880	Residents did not experience any		
				negative outcomes as none of the		

Facility ID: 180301

If continuation sheet Page 2 of 4

PRINTED: 08/27/2020

				E CONSTRUCTION	OMB NO. 0938-03
	DF DEFIC ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		285277	B. WING	-	07/06/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
SUTTON	COMMUNITY HOME, INC	2		1106 NORTH SAUNDERS SUTTON, NE 68979	
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIC
F 880	Continued From page	e 2	F 88	)	
	2003 M 54 199	ns, interviews and record		residents have had any signs or	
	an and the second s	ailed to implement infection		symptoms throughout the building.	
		Centers for Medicare and		Screening of all employees is condu	cted
		CMS) guidelines to prevent		before the employee's shift begins b	-
		mination including the		nursing staff to assure residents are	
		( a mild to severe respiratory		protected against any symptomatic	
		by a coronavirus) the facility ening results for facility		employee. Self screening will not be allowed. It	fanv
		ensure the screening sheets		symptoms are shown, the employee	
	contained full staff ide			be sent home immediately and Infec	
		t names and titles, failure to		Control nurse or charge nurse will fo	
		ymptoms indicated on		up with employee later in the day an	
		failure to prevent self		still symptomatic will be sent to eithe	
		y failure had the potential to the building. The facility		Clinic or Test Nebraska for a Covid t be completed.	est to
	identified a cerisus of	125.		Sutton Community Home will ensure	that
				no residents come in contact with an	
	Findings are:			symptomatic employee by all employ	
				being screened before their shift by	
	A. A record review of			member of the nursing staff. Screen	
		n sheet (SSE, a screening		will take place at the west entrance	
		ptoms and exposure) dated		to employee clocking in for their shif	
		ee A revealed no temperature or to allowing Employee A to		symptom responses of concern will brought immediately to the charge n	
		of the SSE for Employee A		on duty by the nurse doing the scree	
		o evidence of a follow up		Self screening is not allowed. Any st	
	evaluation prior			that have any "out of the ordinary"	
	to allowing Employee	A to work.		symptoms will be immediately sent h	
				and will be followed up by the Infecti	
		the SSE dated 07/02/20 for		Control nurse or charge nurse within	that
		an "x" documented in the		day of being sent home and if still	
		ovid-19 exposure and a of the SSE for Employee B		symptomatic will be sent to either the Clinic or Test Nebraska for a Covid t	
		o evidence of a follow up		be completed. Employee will not ref	
		owing Employee B to work.		work until Covid test results are in an	
		en mener en en en de la calabater - En en de France en l'autor de la deservation de la calabater en antipatrici		negative. If Employee tests positive	,
		the SSE dated 07/01/20 for		employee will not be allowed to return	
	Employee C revealer	the SSE had been left	1	work until the employee tests negati	

Facility ID: 180301

If continuation sheet Page 3 of 4

		ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 08/27/2020 MAPPROVED D. 0938-0391
STATEMENT	OF DEFIC ENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE A. BUILDING	CONSTRUCTION	(X3) DATE	
		285277	B. WING		07/	06/2020
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		2.
SUTTON	COMMUNITY HOME, INC.	2 2		106 NORTH SAUNDERS SUTTON, NE 68979		
(X4) ID PREFIX TAG	(EACH DEFIC ENC)	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	blank regarding Covid review of the SSE for was no evidence of a allowing Employee C D. A record review of Employee D revealed blank regarding Covid review of the SSE for was no evidence of a allowing Employee D E. A record review of Employee E revealed having a headache. F Employee E revealed follow up evaluation p to work. F. A record review of Director of Nursing (D had completed their of G. On 07/06/20 at 12: conducted with the fai interview, a review of Employees A, B, C, D facility D.O.N. confirm follow up evaluations symptoms and was no H. On 07/06/20 at 12: conducted with the fai facility D.O.N During the SSE for the D.O.N.	d-19 symptoms. Further Employee C revealed there follow up evaluation prior to to work. the SSE dated 07/01/20 for the SSE had been left d-19 symptoms. Further Employee D revealed there follow up evaluation prior to to work. the SSE dated 07/01/20 for Employee E had indicated Further review of the SSE for there was no evidence of a prior to allowing Employee E the SSE dated for the D.O.N.) indicated the D.O.N. own screen. :00 P.M. an interview was icility D.O.N During the the SSE sheets for D, and E was completed. The ned there should have been regarding employee iot. :00 P.M. an interview was icility Administrator and the g the interview, a review of N. dated 6/26/20 was ty D.O.N. confirmed that self	F 880	twice with tests being at 24 hrs or me hours apart or per CDC guidelines for return to work. All Staff have viewed the 5 CMS DP4 videos. Charge Nurse will review sheets each to assure no symptomatic employee or have been working. DON or desig will audit the staff screening sheets to assure all questions are being answe and documented appropriately as per guidelines. A copy of the audit sheet attached. DON or designee will bring audit sheets to QAPI monthly for 3 months.	or DE h day s are gnee o ered r t is	

Facility ID: 180301

If continuation sheet Page 4 of 4





DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Covernor

#### **IMPORTANT NOTICE – PLEASE READ CAREFULLY**

July 14, 2020

Janet Lytton, Administrator Sutton Community Home, Inc. 1106 North Saunders Sutton, NE 68979-0543

CMS Certification No. 285277

Subject: Survey Results Cycle Start Date: July 6, 2020

Dear Administrator,

#### UNANNOUNCED COVID-19 SURVEY

The Secretary of the U.S. Department of Health and Human Services (DHHS) has the duty and responsibility to protect the health, safety, welfare and rights of Medicare/Medicaid beneficiaries. The Secretary has delegated authority to administer and provide oversight of the Medicare program to Centers for Medicare & Medicaid Services (CMS).

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-31-All*, CMS and the State Survey Agency are conducting unannounced onsite surveys at certain Medicare certified provider and supplier types.

#### SURVEY RESULTS

On July 6, 2020, a survey was completed at Sutton Community Home, Inc. by the State Survey Agency to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the CMS 2567 and will be posted on the ePOC system.

#### PLAN OF CORRECTION

A Plan of Correction (PoC) for the deficiencies must be submitted by July 24, 2020, to the State Survey Agency Contact. Failure to submit an acceptable PoC by July 24, 2020 may result in the imposition of additional remedies. The PoC must contain the following:

- 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- 3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of the quality assurance being implemented, the earliest correction date will be the date of the revisit; and
- 5. Include dates when corrective action will be completed. The corrective action completion dates must be written in the completion date column within acceptable time frames. If the PoC is unacceptable for any reason, you will be notified in writing by this office. If the PoC is acceptable, you will be notified via ePOC. Please note that the facility is ultimately accountable for compliance, and that responsibility is not alleviated in cases where notification regarding the acceptability of the facility's PoC is not made timely. The PoC will serve as the facility's allegation of compliance.

### **ENFORCEMENT REMEDIES**

Based on the Statement of Deficiencies (Form CMS-2567), the following remedies are imposed:

• Directed Plan of Correction:

In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction is imposed on the facility. In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. The effective date is not a deadline for completion of the DPOC. However, the State Agency will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice.

Training option(s) which are the most appropriate for the type of noncompliance cited. For

Sparkling Surfaces - https://youtu.be/t7OH8ORr5Ig Clean Hands - https://youtu.be/xmYMUly7qiE Closely Monitor Residents - https://youtu.be/1ZbT1Njv6xA Keep COVID-19 Out! - https://youtu.be/7srwrF9MGdw Lessons - https://youtu.be/YYTATw9yav4

Please send all documentation to the State Agency at the following:

examp

Connie Vogt, RN, BSN dhhs.healthcarefacilities@Nebraska.gov In the Subject Line please put: DPOC

For states participating in the ePOC program, the DPOC may be added as an attachment.

Please note, if documentation includes any resident personal identifiable information (PII) or personal health information (PHI) it must be sent encrypted.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies, within 10 days after receipt of the Form CMS 2567. Please see the attached instructions (DPOC attachment) for detailed guidance.

## • Imposition of Denial of Payment for New Admissions (DPNA):

Payment will be denied for all <u>NEW</u> Medicare and Medicaid admissions, August 13, 2020 in accordance with the statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal regulations at 42 CFR §488.417. Your Medicare Administrative Contractor will be notified of the date the denial of payment begins. DPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated.

## WITHDRAWAL OF APPROVAL FOR NURSE AIDE TRAINING PROGRAM

Please note that Federal law, as specified in the Social Security Act at \$1819(f)(2)(B) and \$1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs (NATCEP) and nurse aide competency evaluation programs (NACEP) offered by, or in, a facility which, within the previous two years, if one or more of the following exists:

- Operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse);
- Has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care;
- Has been assessed a total civil money penalty of not less than \$10,697;
- Has been subject to a denial of payment;
- Appointment of a temporary manager;
- Terminated from participation, and/or
- In the case of an emergency, has been closed and/or had its residents transferred to other facilities.

# INFORMAL DISPUTE RESOLUTION (IDR)

You have one opportunity to dispute the deficiencies cited on the survey date through (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the

specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Connie Vogt, RN, BSN Email: dhhs.healthcarefacilities@Nebraska.gov In the Subject Line of the email put: Request IDR

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

This request must be submitted within 10 days from the date of the enforcement letter. An incomplete Informal Dispute Resolution process will not delay the effective date of any enforcement action.

Informal Dispute Resolution is in no way to be construed as a formal evidentiary hearing. It is an informal internal process to review additional information submitted by the facility. You will be advised of our decision relative to the informal dispute.

### **APPEAL RIGHTS**

If you disagree with the determination to impose remedies made on the basis of noncompliance identified at the July 6, 2020 survey, you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board (DAB). The appeal rights are set forth at 42 C.F.R. § 498.5 and the procedures for requesting a hearing are set forth at §498.40, et seq. You must file your hearing request electronically by using the DAB's Electronic Filing System (DAB E-File) at <a href="https://dab.efile.hhs.gov/">https://dab.efile.hhs.gov/</a>, unless you obtain a waiver from the DAB (*see* DAB Civil Remedies Division Procedures, § 6(a)(i)(1)). Your appeal must be filed no later than 60 days from the date of receipt of this letter.

We request that you provide an electronic copy of the request for appeal to:

ROkcmSCB@cms.hhs.gov

and to the CMS Regional Chief Counsel at:

OGCK ansas CityGeneralInbox@hhs.gov

If you elect to dispute deficiencies through the Informal Dispute Resolution (IDR) process, this will not extend the 60 day period to file your appeal before the Departmental Appeals Board. Filing an appeal will not stop the imposition of any enforcement remedy.

If you experience problems with, or have questions about DAB e-File, please contact e-File System Support at <u>OSDABImmediateOffice@hhs.gov</u>. If you have questions about using the DAB e-file System, please visit: <u>https://dab.efile.hhs.gov/appeals/to\_crd\_instructions?locale=en</u>.

### **QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES**

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at <u>QIO</u> <u>Program Website</u>. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at <u>Locate Your QIO</u>.

### **CONTACT INFORMATION**

If you have any questions please contact this office.

Sincerely,

Connie Ellegt KNIBSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555

CV/kd

Enclosures: CMS 2567

Copies via e-mail to: CMS - RO DHHS - State Medicaid Agency DHHS - Nursing Support





DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Covernor

#### **IMPORTANT NOTICE – PLEASE READ CAREFULLY**

July 14, 2020

Kelsie Ryan, Administrator Tabitha At The Landing 6120 South 34th Street Lincoln, NE 68516-4748

CMS Certification No. 285288

Subject: Survey Results Cycle Start Date: June 30, 2020

Dear Administrator,

#### UNANNOUNCED COVID-19 SURVEY

The Secretary of the U.S. Department of Health and Human Services (DHHS) has the duty and responsibility to protect the health, safety, welfare and rights of Medicare/Medicaid beneficiaries. The Secretary has delegated authority to administer and provide oversight of the Medicare program to Centers for Medicare & Medicaid Services (CMS).

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-31-All*, CMS and the State Survey Agency are conducting unannounced onsite surveys at certain Medicare certified provider and supplier types.

#### SURVEY RESULTS

On June 30, 2020, a survey was completed at Tabitha At The Landing by the State Survey Agency to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the CMS 2567 and will be posted on the ePOC system.

#### PLAN OF CORRECTION

A Plan of Correction (PoC) for the deficiencies must be submitted **by July 24, 2020**, to the State Survey Agency Contact. **Failure to submit an acceptable PoC by July 24, 2020 may result** 

### in the imposition of additional remedies.

The PoC must contain the following:

- 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- 3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of the quality assurance being implemented, the earliest correction date will be the date of the revisit; and
- 5. Include dates when corrective action will be completed. The corrective action completion dates must be written in the completion date column within acceptable time frames. If the PoC is unacceptable for any reason, you will be notified in writing by this office. If the PoC is acceptable, you will be notified via ePOC. Please note that the facility is ultimately accountable for compliance, and that responsibility is not alleviated in cases where notification regarding the acceptability of the facility's PoC is not made timely. The PoC will serve as the facility's allegation of compliance.

### **ENFORCEMENT REMEDIES**

Based on the Statement of Deficiencies (Form CMS-2567), the following remedies are imposed:

• Directed Plan of Correction:

In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction is imposed on the facility. In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. The effective date is not a deadline for completion of the DPOC. However, the State Agency will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice.

Training option(s) which are the most appropriate for the type of noncompliance cited. For

Sparkling Surfaces - https://youtu.be/t7OH8ORr5Ig Clean Hands - https://youtu.be/xmYMUly7qiE Closely Monitor Residents - https://youtu.be/1ZbT1Njv6xA Keep COVID-19 Out! - https://youtu.be/7srwrF9MGdw Lessons - https://youtu.be/YYTATw9yav4 examp

Please send all documentation to the State Agency at the following:

Connie Vogt, RN, BSN Email: dhhs.healthcarefacilities@Nebraska.gov In the Subject Line please put: DPOC

For states participating in the ePOC program, the DPOC may be added as an attachment.

Please note, if documentation includes any resident personal identifiable information (PII) or personal health information (PHI) it must be sent encrypted.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies, within 10 days after receipt of the Form CMS 2567. Please see the attached instructions (DPOC attachment) for detailed guidance.

### **INFORMAL DISPUTE RESOLUTION (IDR)**

#### **Background:**

Regulations at 42 CFR 488.331 require that CMS and the States, as appropriate, offer skilled nursing facilities, nursing facilities, and dually participating facilities an informal opportunity to dispute cited deficiencies upon the facility's receipt of the official Form CMS-2567. The following is a suggested example of IDR language that can be used.

You have one opportunity to dispute the deficiencies cited on the survey date through (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Connie Vogt, RN, BSN at dhhs.healthcarefacilities@Nebraska.gov

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

This request must be submitted within 10 days from the date of the enforcement letter. An incomplete Informal Dispute Resolution process will not delay the effective date of any enforcement action.

Informal Dispute Resolution is in no way to be construed as a formal evidentiary hearing. It is an informal internal process to review additional information submitted by the facility. You will be advised of our decision relative to the informal dispute.

### APPEAL RIGHTS

### **Background:**

When non-compliance is associated with an infection control deficiency, enforcement remedies include a Directed Plan of Correction, Discretionary Denial of Payment for New Admissions, and Civil Money Penalties. When enforcement remedies are imposed by the State Survey Agency, appeal rights' language must be included in the notice to the facility. The following is a suggested example of appeal language that can be used.

If you disagree with the determination to impose remedies made on the basis of noncompliance identified at the June 30, 2020 survey, you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board (DAB). The appeal rights are set forth at 42 C.F.R. § 498.5 and the procedures for requesting a hearing are set forth at §498.40, et seq. You must file your hearing request electronically by using the DAB's Electronic Filing System (DAB E-File) at <a href="https://dab.efile.hhs.gov/">https://dab.efile.hhs.gov/</a>, unless you obtain a waiver from the DAB (*see* DAB Civil Remedies Division Procedures, § 6(a)(i)(1)). Your appeal must be filed no later than 60 days from the date of receipt of this letter.

We request that you provide an electronic copy of the request for appeal to ROkcmSCB@cms.hhs.gov and to the CMS Regional Chief Counsel OGCKansasCityGeneralInbox@hhs.gov.

If you elect to dispute deficiencies through the Informal Dispute Resolution (IDR) process, this will not extend the 60 day period to file your appeal before the Departmental Appeals Board. Filing an appeal will not stop the imposition of any enforcement remedy.

If you experience problems with, or have questions about DAB e-File, please contact e-File System Support at <u>OSDABImmediateOffice@hhs.gov</u>. If you have questions about using the DAB e-file System, please visit: <u>https://dab.efile.hhs.gov/appeals/to\_crd\_instructions?locale=en</u>.

## **QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES**

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at <u>QIO</u> <u>Program Website</u>. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at <u>Locate Your QIO</u>.

### **CONTACT INFORMATION**

If you have any questions please contact this office.

Sincerely,

Connie Ellegt KNIBSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555

CV/kd

Enclosures: CMS 2567

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO	0.0938-0391
	DF DEFIC ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:		ECONSTRUCTION		E SURVEY PLETED
		285288	B. WING		06	/30/2020
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
TABITHA	AT THE LANDING		1.00	S120 SOUTH 34TH STREET		
an order a constant				INCOLN, NE 68516		1
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL .SC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 000			
	Governing Licensure Nursing Facilities, and	Chapter 12- "Regulations of Skilled Nursing Facilities, d Intermediate Care included in survey report as				
F 880 SS=E	Infection Prevention & CFR(s): 483.80(a)(1)		F 880			8/4/20
	infection prevention a designed to provide a comfortable environm	blish and maintain an nd control program I safe, sanitary and nent and to help prevent the nsmission of communicable				
	program. The facility must esta	prevention and control blish an infection prevention (IPCP) that must include, at ving elements:				
	reporting, investigatin and communicable di staff, volunteers, visit providing services un arrangement based u	pon the facility assessment to §483.70(e) and following				
	procedures for the probut are not limited to:	lance designed to identify				
LABORATORY	D RECTOR'S OR PROV DER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
Electroni	cally Signed					07/23/2020

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.

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 08/18/2020 APPROVED 0: 0938-0391
STATEMENT C	DEFICENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE A. BUILDING	CONSTRUCTION	8	(X3) DATE	
		285288	B. WING		<u></u>	06/:	30/2020
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		80
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F 880	communicable disease reported; (iii) Standard and tran to be followed to prev (iv)When and how iso resident; including bu (A) The type and durat depending upon the in involved, and (B) A requirement that least restrictive possific circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact with residents contact will transmit th (vi)The hand hygiene by staff involved in dir §483.80(a)(4) A syster identified under the fat corrective actions take §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rev The facility will condu IPCP and update thei This REQUIREMENT by: Licensure Reference	r can spread to other m possible incidents of se or infections should be asmission-based precautions rent spread of infections; blation should be used for a t not limited to: ation of the isolation, infectious agent or organism at the isolation should be the ble for the resident under the s under which the facility ees with a communicable kin lesions from direct as or their food, if direct the disease; and procedures to be followed rect resident contact. em for recording incidents acility's IPCP and the en by the facility. Ite, store, process, and to prevent the spread of view. ct an annual review of its ir program, as necessary. is not met as evidenced	F 880		aff in the facility will		
	12-006.17B			have completed ec	lucation on zoning		

Facility ID: NH0014

If continuation sheet Page 2 of 5

		MEDICAID SERVICES			OMB NO. 0938-03 (X3) DATE SURVEY
AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:			(X2) MULT PLE CONSTRUCTION A. BUILDING		
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F 880	Continued From page	e 2	F 880		
	<ul> <li>F 880 Continued From page 2</li> <li>Based on interviews, CDC guidance, and record review, the facility failed to ensure an Observation zone resident did not ambulate into a green zone area of resident care potentially cross contaminating residents in the Covid Free or green zone area. This had the potential to effect the 14 residents in the Harbor house. The facility census was 43.</li> <li>CDC guidance updated June 25, 2020 titled "Preparing for COVID-19 in Nursing Homes" directs Long Term Facilities to create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown. The directions includes the following;</li> <li>Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP should</li> </ul>			<ul> <li>definitions, processes to be followed when providing care to any resident residents designated zone and the Closely Monitoring Residents video vassigned by the Director of Nursing of designee.</li> <li>All staff were educated on when a resident resides in Transitional Zone (resident⊡s private room) resident will to remain in the room for all act of a resident needs to leave the facilities a medical appointment, resident will to have a facemask on while moving their room (Transitional Zone) to exit facility. Staff will ensure that no other residents are present in the hallway immediate area while the resident is transported to the nearest exit. Tele appointments will be set up when available.</li> </ul>	in the was or fill tivity. ty for need from the er or being
	protection (i.e., goggl shield that covers the gloves, and gown wh residents. Residents observation area to th afebrile and without so their admission. Testic can be considered to resident is not infected Record review of Re record revealed the r facility on factors. Staff attempted to an	tor is not available), eye les or a disposable face a front and sides of the face), en caring for these can be transferred out of the he main facility if they remain symptoms for 14 days after ing at the end of this period increase certainty that the		The charge nurse will complete roun during their shift to observe the Transitional Zone resident and ensur compliance of remaining in rooms, th nurse will document the results of the findings on the provided auditing too Director of Nursing or Designee will monitor the documentation in the electronic health record and the audi performed by the nurse. The Directo Designee will report findings to the C subcommittee team weekly, including trends &/or findings. Adjustments wi directed as deemed necessary by th QAPI subcommittee team. The QAP team will review quarterly and will recommend continuation or	re eir I. it or or DAPI g ill be e

Facility ID: NH0014

If continuation sheet Page 3 of 5

DEPART	MENT OF HEALTH AN	ND HUMAN SERVICES				08/18/202 APPROVE
		MEDICAID SERVICES	Test to a			0938-039
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1 000			F OOL	NAMES AND ADDRESS AND ADDRESS		
	refused.	9/2020 but the resident		discontinuation of the study.		
		sisted to ambulate out of the				
		arantine" room to the				
	PM.	0/2020 at 10:07 AM and 9				
	The resident was assisted to ambulate out of the					
	"Observation" or "Quarantine" room to the					
	"Green" zone on 6/21/2020 at 1:30 PM and 9:19					
	PM.					
	The resident was assisted to ambulate out of the					
		arantine" room to the				
	"Green" zone on 6/22 PM.	2/2020 at 9:57 AM and 9:08				
	The resident was assisted to ambulate out of the					
		arantine" room to the				
	"Green" zone on 6/23 PM.	3/2020 at 9:55 AM and 2:43				
		sisted to ambulate out of the				
		arantine" room to the				
	a Paral and a second second second second	4/2020 at 9:50 AM and 6:19				
	PM.	sisted to ambulate out of the				
		arantine" room to the				
		5/2020 at 9:38 AM and 9:59				
		sisted to ambulate out of the				
		arantine" room to the				
	Contraction Statements and State	6/2020 at 10:15 AM and 9:11				
	PM. The resident was assisted to ambulate out of the					
		arantine" room to the				
	"Green" zone on 6/27	7/2020 at 9:47 AM and 2:58				
	PM.					
		sisted to ambulate out of the				
		arantine" room to the				
	Contraction and the second second second second	8/2020 at 10:34 AM and 7:52				
	PM.					
	The resident was ass	sisted to ambulate out of the	-			

Facility ID: NH0014

If continuation sheet Page 4 of 5

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F 880	"Observation" or "Qua "Green" zone on 6/29 PM. The resident was ass "Observation" or "Qua "Green" zone on 6/30 Interview with NA 1 or revealed the staff men 1 to ambulate in the re assisted Resident 1 or resident is in isolation the room. Hospice has the resident could not When anxious Reside family on the phone or room. Interview with Directo 1:50 PM confirmed Re "Observation/Quarant at various times of the facility. All other reside	arantine" room to the b/2020 at 10:31 AM and 6:13 disted to ambulate out of the arantine" room to the b/2020 at 10:10 AM. In 6/30/2020 at 3:50 PM mber had assisted Resident room. NA 1 had not but of the room as the in and should not be out of ad performed bed baths as t go to the whirlpool tub. ent 1 enjoyed talking with or working on a puzzle in the performed in the the tine" area multiple times and is day to go on walks in the dents in the Harbor house is in the "Green" or Covid	F 880				

Facility ID: NH0014

If continuation sheet Page 5 of 5





DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Covernor

#### **IMPORTANT NOTICE – PLEASE READ CAREFULLY**

July 15, 2020

Sherri Due, Administrator Tabitha Nursing Center At Crete 1800 East 13th Street Crete, NE 68333

CMS Certification No. 285283

Subject: Survey Results Cycle Start Date: July 9, 2020

Dear Administrator,

#### UNANNOUNCED COVID-19 SURVEY

The Secretary of the U.S. Department of Health and Human Services (DHHS) has the duty and responsibility to protect the health, safety, welfare and rights of Medicare/Medicaid beneficiaries. The Secretary has delegated authority to administer and provide oversight of the Medicare program to Centers for Medicare & Medicaid Services (CMS).

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-31-All*, CMS and the State Survey Agency are conducting unannounced onsite surveys at certain Medicare certified provider and supplier types.

#### SURVEY RESULTS

On July 9, 2020, a survey was completed at Tabitha Nursing Center At Crete by the State Survey Agency to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the CMS 2567 and will be posted on the ePOC system.

#### PLAN OF CORRECTION

A Plan of Correction (PoC) for the deficiencies must be submitted by July 25, 2020, to the State Survey Agency Contact. Failure to submit an acceptable PoC by July 25, 2020 may result in the imposition of additional remedies.

The PoC must contain the following:

- 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- 3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of the quality assurance being implemented, the earliest correction date will be the date of the revisit; and
- 5. Include dates when corrective action will be completed. The corrective action completion dates must be written in the completion date column within acceptable time frames. If the PoC is unacceptable for any reason, you will be notified in writing by this office. If the PoC is acceptable, you will be notified via ePOC. Please note that the facility is ultimately accountable for compliance, and that responsibility is not alleviated in cases where notification regarding the acceptability of the facility's PoC is not made timely. The PoC will serve as the facility's allegation of compliance.

### **ENFORCEMENT REMEDIES**

Based on the Statement of Deficiencies (Form CMS-2567), the following remedies are imposed:

• Directed Plan of Correction:

In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction is imposed on the facility. In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. The effective date is not a deadline for completion of the DPOC. However, the State Agency will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice.

Training option(s) which are the most appropriate for the type of noncompliance cited. For

Sparkling Surfaces - https://youtu.be/t7OH8ORr5Ig Clean Hands - https://youtu.be/xmYMUly7qiE Closely Monitor Residents - https://youtu.be/1ZbT1Njv6xA Keep COVID-19 Out! - https://youtu.be/7srwrF9MGdw Lessons - https://youtu.be/YYTATw9yav4

Please send all documentation to the State Agency at the following:

examp

Connie Vogt, RN, BSN dhhs.healthcarefacilities@Nebraska.gov In the Subject Line please put: DPOC

For states participating in the ePOC program, the DPOC may be added as an attachment.

Please note, if documentation includes any resident personal identifiable information (PII) or personal health information (PHI) it must be sent encrypted.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies, within 10 days after receipt of the Form CMS 2567. Please see the attached instructions (DPOC attachment) for detailed guidance.

## • Imposition of Denial of Payment for New Admissions (DPNA):

Payment will be denied for all <u>NEW</u> Medicare and Medicaid admissions, August 29, 2020 in accordance with the statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal regulations at 42 CFR §488.417. Your Medicare Administrative Contractor will be notified of the date the denial of payment begins. DPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated.

## WITHDRAWAL OF APPROVAL FOR NURSE AIDE TRAINING PROGRAM

Please note that Federal law, as specified in the Social Security Act at \$1819(f)(2)(B) and \$1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs (NATCEP) and nurse aide competency evaluation programs (NACEP) offered by, or in, a facility which, within the previous two years, if one or more of the following exists:

- Operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse);
- Has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care;
- Has been assessed a total civil money penalty of not less than \$10,697;
- Has been subject to a denial of payment;
- Appointment of a temporary manager;
- Terminated from participation, and/or
- In the case of an emergency, has been closed and/or had its residents transferred to other facilities.

# **INFORMAL DISPUTE RESOLUTION (IDR)**

You have one opportunity to dispute the deficiencies cited on the survey date through (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those

deficiencies, and (4) supporting documentation by fax or email to:

Connie Vogt, RN, BSN Email: dhhs.healthcarefacilities@Nebraska.gov In the Subject Line of the email put: Request IDR

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

This request must be submitted within 10 days from the date of the enforcement letter. An incomplete Informal Dispute Resolution process will not delay the effective date of any enforcement action.

Informal Dispute Resolution is in no way to be construed as a formal evidentiary hearing. It is an informal internal process to review additional information submitted by the facility. You will be advised of our decision relative to the informal dispute.

### **APPEAL RIGHTS**

If you disagree with the determination to impose remedies made on the basis of noncompliance identified at the July 9, 2020 survey, you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board (DAB). The appeal rights are set forth at 42 C.F.R. § 498.5 and the procedures for requesting a hearing are set forth at §498.40, et seq. You must file your hearing request electronically by using the DAB's Electronic Filing System (DAB E-File) at <a href="https://dab.efile.hhs.gov/">https://dab.efile.hhs.gov/</a>, unless you obtain a waiver from the DAB (*see* DAB Civil Remedies Division Procedures, § 6(a)(i)(1)). Your appeal must be filed no later than 60 days from the date of receipt of this letter.

We request that you provide an electronic copy of the request for appeal to: ROkcmSCB@cms.hhs.gov and to the CMS Regional Chief Counsel at: OGCKansasCityGeneralInbox@hhs.gov If you elect to dispute deficiencies through the Informal Dispute Resolution (IDR) process, this will not extend the 60 day period to file your appeal before the Departmental Appeals Board. Filing an appeal will not stop the imposition of any enforcement remedy.

If you experience problems with, or have questions about DAB e-File, please contact e-File System Support at <u>OSDABImmediateOffice@hhs.gov</u>. If you have questions about using the DAB e-file System, please visit: <u>https://dab.efile.hhs.gov/appeals/to\_crd\_instructions?locale=en</u>.

### **QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES**

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at <u>QIO</u> <u>Program Website</u>. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at <u>Locate Your QIO</u>.

#### **CONTACT INFORMATION**

If you have any questions please contact this office.

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555

CV/kd

Enclosures: CMS 2567

Copies via e-mail to: CMS - RO DHHS - State Medicaid Agency DHHS - Nursing Support

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	infection prevention a designed to provide a comfortable environm development and tran diseases and infection	nd control program safe, sanitary and ent and to help prevent the smission of communicable					
	program. The facility must estal	blish an infection prevention IPCP) that must include, at					
	reporting, investigatin and communicable di staff, volunteers, visite providing services un arrangement based u	pon the facility assessment to §483.70(e) and following					
	procedures for the pro- but are not limited to: (i) A system of surveil possible communicab						
LABORATORY	D RECTOR'S OR PROV DER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE
Electroni	cally Signed						07/16/2020

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Licensure Reference Number 175 NAC       -How will corrective action be         12-006.17A       accomplished for those residents found to	F 880	infections before they persons in the facility; (ii) When and to whor communicable diseas reported; (iii) Standard and tran to be followed to prev (iv)When and how iso resident; including bu (A) The type and dura depending upon the in involved, and (B) A requirement tha least restrictive possific circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit th (vi)The hand hygiene by staff involved in dir §483.80(a)(4) A syste identified under the fa corrective actions tak §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rev The facility will condu IPCP and update thei This REQUIREMENT by: Licensure Reference	y can spread to other ; m possible incidents of se or infections should be msmission-based precautions yent spread of infections; blation should be used for a it not limited to: ation of the isolation, infectious agent or organism at the isolation should be the ble for the resident under the s under which the facility ees with a communicable kin lesions from direct s or their food, if direct he disease; and procedures to be followed rect resident contact. em for recording incidents acility's IPCP and the ten by the facility. Ile, store, process, and s to prevent the spread of view. Ict an annual review of its ir program, as necessary. T is not met as evidenced	F 88	-How will corrective action be		

Event ID: VWTF11

Facility ID: 760102

If continuation sheet Page 2 of 5

		ID HUMAN SERVICES MEDICAID SERVICES			FORM A OMB NO. 0	PPROVE 938-039
AND DEAN OF CODDECTION IDENT FICATION NUMBED		(X2) MULT F A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SU COMPLET		
		285283	B. WING		07/09/	2020
NAME OF P	ROVIDER OR SUPPLIER	•	5. Q	STREET ADDRESS, CITY, STATE, ZIP CODE		
		D		1800 EAST 13TH STREET		
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F 880	Continued From page	2	F 88	20		
	100 M 10 M 10 M	ns, interviews and record	1 00			
	reviews, the facility fa	iled to implement infection Centers for Medicare and		have been affected by the deficien practice:	L .	
		MS) guidelines to prevent		Staff identified in this report, received	/ed	
	the potential spread of	of COVID by failing to ensure		training to ensure the proper proce	dures	
		195 masks to provide care		for wearing N95 masks and PPE for	or new	
		within the prior 2 weeks.		admits for 14 days.		
	The census was 35 a	ind sample size was 6.				
	A Record review of a	lirection from the Centers for		The staff will wear a N95 mask, ey protection, gloves and gown when		
		l "Preparing for Covid-19 in		for any new admission for 14 days		
		d June 25, 2020 revealed		date of admission.		
		es should create a plan for				
	_	sions and readmissions		-How will the facility identify other		
	whose Covid-19 statu	us is unknown. Health care		residents having the potential to be	e	
	-	ar an N95 or higher-level		affected by the same deficient prac	ctice:	
		, eye protection (i.e., goggles			1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.	
		shield that covers the front		Training and education for all staff		
		), gloves, and gown when		proper Infection Control procedure	s with	
	caring for these resid	ents.		wearing of N95 masks for new admissions and continue with the p	oroper	
	Review of a documer	nt titled "Tabitha Health Care		PPE practices that are already in p		
	Services Personal Pr	otective Equipment (PPE)				
		2020 revealed the following.		What measures will be put into pla		
		ion had 10,565 N95 masks		what systemic changes will be made		
		een/Yellow/and Gray zones.		ensure that the deficient practice d	loes not	
		ion had 1800 N95 masks in		recur:		
	of the form was the for	se. Bulleted at the bottom		At least three unannounced observ	vations	
		tional Zones are very close		will be conducted on proper use of		
		Chain will order 3000 N95		masks in the residences monthly.		
		osable gowns to reach full		Variance on amount of observation	ns will	
		lso directed that N95 masks		depend on number of residents in		
		red, yellow and gray zone		transitional zone.		
	activity."			102123 5122122 52 A2220 3027 AVA		
	<b>D</b>			-How will the facility monitor perfor		
		document provided by the		to make sure the solutions are sus	tained:	
	require 200 N95 mas	oncluded the facility would		At least three unannounced observ	vations	
	require 200 Mao mas	No per week.	4	At least three unannounced observ	auons	

Facility ID: 760102

If continuation sheet Page 3 of 5

DEPARTMENT OF HEALTH AN				PRINTED: 08/18/2020 FORM APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFIC ENCIES         (X1) PROVIDER/SUPPLIER/CLIA           AND PLAN OF CORRECTION         IDENT FICATION NUMBER:		(X2) MULT PLE CONSTRUCTION A. BUILDING		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
285283			2 	07/09/2020
NAME OF PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE,	
TABITHA NURSING CENTER AT C	DETE		1800 EAST 13TH STREET	
IABITHA NORSING CENTER AT C			CRETE, NE 68333	
PREFIX (EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	( (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) EACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE CIENCY)
of Crete to Corporate masks were made or 6/25. Requests of Pf there were no request this time. The total of Tabitha Corporate bas provided was a total equivalent of a half w need of N95 masks. Observation of theray transitional/gray room AM on 7/8/2020 reve been wearing a surgi available N95 mask t who had admitted with Observation of facility Equipment storage of Administrator and Dir revealed the facility h unused N95 or KN95 box. Interview with LPN B revealed the resident of and isolation in a transitio available but were no unless the resident w There was plenty of F surgical mask, gown, in a transitional room	requests made from Tabitha e revealed requests of 20 h 5/8, 5/14, 6/11, 6/18 and PE were made on 5/21 but ats of N95 masks made at fall N95 requests made to used upon information of 100 N95 masks or the veek of the facility's reported by staff member A exiting h # 11 of house #2 at 10:27 aled the staff member had cal mask rather than an to provide care to Resident 2 thin the prior 2 weeks. y Personal Protective n 7/8/2020 at 11:00 AM with rector of Nursing (DON) had approximately 8 boxes of masks with 20 masks per on 7/8/2020 at 9:00 AM f #2 was newly admitted as remained in 2 weeks of on room. N95 masks were of used in transitional rooms yould have tested positive. PPE. Staff were to wear a goggles, and gloves when	F8	<ul> <li>will be conducted on pr masks in the residence</li> <li>Any identified areas of addressed immediately</li> <li>The Director of Nursing designee) will be respondent review, the results of the and direct corrective additional submitted to the facilitient improvement Team quatering and/or corrective Adjustments will be dirent necessary by the Perfort Improvement committee Performance Improven recommend continuation discontinuation of the statistical submitted is a statistical statistical statistical additional statistical statistical statistical additional statistical statistical statistical additional statistical statistical additional statistical statistical additional statistical statistical additional statistical statistical statistical additional statistical statistical statistical additional statistical statistical statistical additional statistical statistical statistical statistical additional statistical statistical statistical statistical additional statistical statistical statistical statistical additional statistical stati</li></ul>	es monthly. concern will be /. g (or his/her possible for the ne observations, ction as needed. t findings will be es Performance arterly, including e action. ected as deemed prmance be. The nent Committee will on or

If continuation sheet Page 4 of 5

CENTER STATEMENT ( AND PLAN OF		D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER: 285283	A. BUILDING B. WINGS	TREET ADDRESS, CITY, ST	_	FORM OMB NC (X3) DATE COMP	): 08/18/2020 1 APPROVED 0. 0938-0391 SURVEY LETED 09/2020
TABITHA	NURSING CENTER AT C	RETE	26	800 EAST 13TH STREET RETE, NE 68333			
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F 880	the use of surgical mains interview with the Infe on 7/8/2020 at 10:40 wanted to use CDC g masks for new admissible been able to secure at for transitional zones. know the current num at the facility. Supplie Corporate by the DOP Preventionist. B. Observation on 7/8 that NA D and NA E v masks and goggles at and washed hands at gowns, gloves and we Upon exiting Residen NA E removed gown them into trash contai inside of room. NA D sanitizer and then rent then exited room and put on new surgical mains of the second second second second second second second second second second second second second second second second second second second se	itional zones only required	F 880				

If continuation sheet Page 5 of 5





July 22, 2020

Jade Harrah, Administrator The Ambassador Lincoln 4405 Normal Blvd Lincoln, NE 68506

CMS CERTIFICATION NUMBER: 285066

Dear Ms. Harrah:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 13, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555





August 11, 2020

Jade Harrah, Administrator The Ambassador Lincoln 4405 Normal Blvd Lincoln, NE 68506

#### CMS CERTIFICATION NUMBER: 285066

Dear Ms. Harrah:

This is to acknowledge the results of the Infection Control survey conducted at your facility on August 10, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555





July 7, 2020

Jessica Crunk, Administrator The Ambassador Nebraska City 1800 14th Avenue Nebraska City, NE 68410-0547

CMS CERTIFICATION NUMBER: 285126

Dear Ms. Crunk:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 30, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555



# IMPORTANT NOTICE – PLEASE READ CAREFULLY

June 19, 2020

Jake Bleach, Administrator The Ambassador Omaha 1540 North 72nd Street Omaha, NE 68114-1999

Number: 285127

**CMS** Certification

Subject: Survey Results Cycle Start Date: June 2, 2020

Dear Mr. Bleach,

# COVID-19 FOCUSED INFECTION CONTROL SURVEY

The Secretary of the U.S. Department of Health and Human Services (DHHS) has the duty and responsibility to protect the health, safety, welfare and rights of Medicare/Medicaid beneficiaries. The Secretary has delegated authority to administer and provide oversight of the Medicare program to Centers for Medicare & Medicaid Services (CMS).

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-31-All, CMS and the State Survey Agency are conducting unannounced onsite surveys at certain Medicare certified provider and supplier types.

SURVEY RESULTS

On June 2, 2020, a survey was completed at The Ambassador Omaha by CMS to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the enclosed form CMS 2567.

# PLAN OF CORRECTION

A Plan of Correction (PoC) for the deficiencies must be submitted within ten (10) calendar days of your receipt of this notice. Use the space provided to the right of each item of deficiency to type your PoC and the expected date of completion. A PoC must be entered for each item clearly identifying HOW, WHAT, WHEN, AND WHERE it was or will be corrected. The plan should also include provisions instituted to prevent reoccurrence. The PoC must contain the following:

• Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

• Address how the facility will identify other residents having the potential to be affected

by the same deficient practice;

• Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;

• Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of the quality assurance being implemented, the earliest correction date will be the date of the revisit; and

• Include dates when corrective action will be completed. The corrective action completion dates must be written in the completion date column within acceptable time frames. If the PoC is unacceptable for any reason, you will be notified in writing by this office. If the PoC is acceptable, you will be notified via telephone, e-mail, etc. Please note that the facility is ultimately accountable for compliance, and that responsibility is not alleviated in cases where notification regarding the acceptability of the facility's PoC is not made timely. The PoC will serve as the facility's allegation of compliance.

You must send this office the original, signed and dated Statement of Deficiencies (SoD) with the PoC to:

Amanda Spicer, Nurse Consultant

Amanda.Spicer@cms.hhs.gov

# ENFORCEMENT REMEDIES

Based on the Statement of Deficiencies (Form CMS-2567), the following remedies are imposed:

# Directed Plan of Correction:

In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction (DPOC) is imposed on the facility. In accordance with 42 CFR § 488.402(f), this remedy is effective July 4, 2020. The DPOC may be completed before or after that date. The effective date is not a deadline for completion of the DPOC. However, CMS will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice.

The DPOC requires that your plan of correction include the following:

• A plan for all facility staff to view the two Centers for Disease Control (CDC) training videos located at the following: https://youtu.be/YYTATw9yav4 and https://youtu.be/7srwrF9MGdw. Training may be supervised by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion by all staff.

• The Infection Preventionist and Director of Nursing, in conjunction with the Medical Director, and senior leadership/Governing Body concurrence, shall complete the following:

o Develop and implement procedures to utilize an at-the-door symptom check for all visitors, vendors and others before entering the facility.

o Develop and implement procedures for screening all staff at the beginning of their shift for fever and respiratory symptoms. This will include actively measuring and recording staff temperatures and assessment of shortness of breath, new or changed cough, and sore throat. Screening logs will be maintained and signed by the staff member who conducts the screening.

• A Root Cause Analysis (RCA) of the deficient practices cited, conducted with assistance from the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee and Governing Body. The RCA should be incorporated into the intervention plan. Information regarding RCAs can be found at:

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/Guidan ceforRCA.pdf

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies, within 10 days after receipt of the Form CMS 2567. Please send all documentation to CMS at the following:

Amanda Spicer, Nurse Consultant

Email: Amanda.Spicer@cms.hhs.gov

Please note, if documentation includes any resident personal identifiable information (PII) or personal health information (PHI) it must be sent encrypted.

Imposition of Denial of Payment for New Admissions (DPNA):

Payment will be denied for all NEW Medicare and Medicaid admissions, beginning August 3, 2020, in accordance with the statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal regulations at 42 CFR §488.417. Your Medicare Administrative Contractor will be notified of the date the denial of payment begins. DPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated. INFORMAL DISPUTE RESOLUTION (IDR)

You have one opportunity to dispute the deficiencies cited on the survey date through (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Lisa Hauptman, Acting Long Term Care Branch Manager Email: Lisa.Hauptman@cms.hhs.gov

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for

informal dispute resolution.

This request must be submitted within 10 days from the date of the enforcement letter. An incomplete Informal Dispute Resolution process will not delay the effective date of any enforcement action.

Informal Dispute Resolution is in no way to be construed as a formal evidentiary hearing. It is an informal internal process to review additional information submitted by the facility. You will be advised of our decision relative to the informal dispute.

# WITHDRAWAL OF APPROVAL FOR NURSE AIDE TRAINING PROGRAM

Please note that Federal law, as specified in the Social Security Act at \$1819(f)(2)(B) and \$1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs (NATCEP) and nurse aide competency evaluation programs (NACEP) offered by, or in, a facility in which, within the previous two years, one or more of the following exists: Operated under a \$1819(b)(4)(C)(ii)(II) or \$1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse);

Has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care;

Has been assessed a total civil money penalty of not less than \$10,697;

Has been subject to a denial of payment;

Appointment of a temporary manager;

Terminated from participation, and/or

In the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Your facility will receive further information regarding this from the State Agency.

# APPEAL RIGHTS

The following remedies are being imposed:

- Directed Plan of Correction
- DPNA

If you disagree with this action imposed on your facility, you or your legal representative are required to file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/. To file a new appeal using DAB E-File, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user\_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

Clicking the File New Appeal link on the Manage Existing Appeals screen, then clicking Civil Remedies Division on the File New Appeal screen. Entering and uploading the requested information and documents on the "File New Appeal- Civil Remedies Division" form. At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. The DAB will set the location for the hearing. Counsel may represent you at a hearing at your own expense.

All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions for using DAB E-File in cases before the DAB's Civil Remedies Division can be found by clicking the button marked E-Filing Instructions after logging-in to DAB E-File.

For questions regarding the E-Filing system, please contact E-File System Support at OSDABImmediateOffice@hhs.gov.

Please note that all hearing requests must be filed electronically unless you have no access to the internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. Such a request should be made to:

Department of Health and Human Services

Departmental Appeals Board, MS 6132

Civil Remedies Division

330 Independence Avenue, SW

Cohen Building, Room G-644

Washington, D.C. 20201

A request for a hearing must be filed no later than 60 days from the date of receipt of this notice.

A copy of the hearing request shall be submitted electronically to:

kevin.wright@cms.hhs.gov

If you believe you have achieved substantial compliance, you should contact the CMS RO. In addition, if substantial compliance has not been achieved within six (6) months after the last date of the survey identifying noncompliance, June 2, 2020, we will terminate your Medicare provider agreement effective December 2, 2020.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at QIO Program Website. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at Locate Your QIO. CONTACT INFORMATION

Thank you for the time and courtesy extended to our surveyors during the survey. If you have any

questions regarding the survey, please contact Amanda Spicer, Nurse Consultant. For questions regarding enforcement, Kevin Wright, Health Insurance Specialist. Both can be reached in our Kansas City Regional Office at (816) 426-2011. Sincerely,

Lisa Hauptman

Acting Long Term Care Branch Manager Survey & Operations Group Center for Clinical Standards & Quality

CMS Kansas City

Enclosures CMS 2567

Copies via e-mail to: NE DHHS Hauptman/Grimes WPS OGC

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				0938-0391
	OF DEFIC ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE A. BUILDING	CONSTRUCTION	(X3) DATE S COMPL	ETED
		285263	B. WING		C	9/2020
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	0.5/2	5/2020
WERTEIEI	LD QUALITY CARE OF A		PC	D BOX 166, 1313 1ST STREET		
WESTFIEL	LD QUALITT CARE OF A	IORORA	A	URORA, NE 68818		2
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 000			
	Governing Licensure Nursing Facilities, an	Chapter 12- "Regulations of Skilled Nursing Facilities, d Intermediate Care included in survey report as				
F 880		<ul> <li>A second constraint of the second seco</li></ul>	F 880		7	7/20/20
SS=D	CFR(s): 483.80(a)(1)	(2)(4)(e)(f)				
	infection prevention a designed to provide a comfortable environm	blish and maintain an and control program a safe, sanitary and nent and to help prevent the nsmission of communicable				
	program. The facility must esta	brevention and control blish an infection prevention (IPCP) that must include, at ving elements:				
	reporting, investigatir and communicable d staff, volunteers, visit providing services un arrangement based u	pon the facility assessment to §483.70(e) and following				
	procedures for the pr but are not limited to:	llance designed to identify				
		SUPPLIER REPRESENTATIVE'S SIGNATURI	E	TITLE		X6) DATE
Electroni	cally Signed				C	07/14/2020

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.

NATE OF DESCRIPTION OF		ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES				OMB NO. 0938-0391	
	OF DEFIC ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	and the second second		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. DOILDI	<b>NO</b>	10	0	
		285263	B. WING			e transfer	29/2020
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		10
WESTFIEL	D QUALITY CARE OF A	URORA		P	0 BOX 166, 1313 1ST STREET		
				A	URORA, NE 68818		
(X4) ID PREFIX		ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL	D PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	F	(X5) COMPLETION
TAG		SC IDENT FY NG INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
	67				DEFICIENCY)		
E 000	Orationed From a co						
F 880	Continued From page		F8	880			
	infections before they persons in the facility;						
		, m possible incidents of					
		e or infections should be					
	reported;						
		nsmission-based precautions vent spread of infections;					
	[Mark 2009 108] [2009 108]	plation should be used for a					
	resident; including bu						
	(A) The type and dura						
	depending upon the in involved, and	nfectious agent or organism					
		t the isolation should be the					
		ble for the resident under the					
	circumstances.						
		s under which the facility					
		ees with a communicable kin lesions from direct					
		or their food, if direct					
	contact will transmit th						
		procedures to be followed					
	by staff involved in dir	rect resident contact.					
	§483.80(a)(4) A syste	em for recording incidents					
	identified under the fa	cility's IPCP and the					
	corrective actions tak	en by the facility.					
	§483.80(e) Linens.						
		le, store, process, and					
		to prevent the spread of					
	infection.						
	§483.80(f) Annual rev	/iew					
		ct an annual review of its					
		r program, as necessary.					
	100 000 0000 000 000000 000000000	is not met as evidenced					
	by:	Number 175 NAC 12-006B			The facility denies that the alloged for		
		NUMBEL 175 NAC 12-006B			The facility denies that the alleged fac as set forth constitute a deficiency und		

Facility ID: 410102

If continuation sheet Page 2 of 5

Nerte String and the Value of		ID HUMAN SER∀ICES MEDICAID SER∀ICES			FO	ED: 08/18/2020 RM APPROVED NO. 0938-0391
STATEMENT C	OF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:		PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		285263	B. WING		0	C 5/29/2020
NAME OF PF	ROVIDER OR SUPPLIER		6. S	STREET ADDRESS, CITY, STATI	E, ZIP CODE	8.
WESTEIEI	D QUALITY CARE OF A	URORA		PO BOX 166, 1313 1ST STREE	ET	
				AURORA, NE 68818		
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	K (EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 880	review the facility faile infection control pract Medicare and Medica prevent potential cross the spread of COVID virus primarily spread through respiratory di serious illness and even personnel that were re entry and did not have Equipment) masks in practice. This had the resident 2 sampled (F census was 44. Findings are: AN observation on 5/ LP (Lab Personnel) E nurse's desk after ent F stood next to the se observed that neither mask during entry. L that required complet nurses station and en resident. Record review of Lab 5 revealed; the lab wa Record review of Scre	h, interview, and record ed; to follow implemented tices and CMS (Centers for aid Services) guidelines to as contamination including 19 (a highly contagious I from person to person roplets, which can lead to ven death) related to lab not screened upon facility e PPE (Personnel Protective place per the facility e potential to affect 1 Resident 5). The facility 29/20 at 1.50 PM revealed; E and LP F had come to the tering the building. LP E and creening station. It was LP E nor LP F had a face P-E gained information lab ion. LP E and F left the netered the hallway for poratory Results for Resident as drawn at 1:58 PM. eening for LP (Lab /29/20 revealed; LP E had 0 PM. LP E had traveled	F	<ul> <li>the interpretations of law. The preparation of correction should r an admission nor an a facility of the truth of the conclusions set forth deficiencies. The plan prepared for this defice solely because it is read of state and federal late the forgoing statement that regards to this cite.</li> <li>The Laboratory Person had been screened for symptoms and known morning at Memorial performing lab rounds: Care of Aurora. There rare chance of any person any residents of Wess Aurora existed, which screening. All other reappropriate screening date, as of the receip deficiency 7-8-20, the</li> </ul>	federal and state of the following plan not be interpreted as agreement by the the facts alleged, or in the statement of n of correction ciency was executed equired by provision aw. Without waiving nt, the facility states tation: onnel, in question, or COVID19 n exposure that vary Hospital prior to s at Westfield Quality efore, an extremely otential exposure to tfield Quality Care of n is the intent of all ecords indicated that g had taken place. To t of this alleged ere are no new tests of COVID19 at re of Aurora and and staff have been The screening proven effective.	
	afebrile. LP E had co			observations made b were made following	the time that the	
	Record review of Sch	eening for LP F dated	-	laboratorians were so	Jeeneu.	

Event ID: ZMXR11

Facility ID: 410102

If continuation sheet Page 3 of 5

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				PRINTED: 08/18/2020 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	• •	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285263	B. WING		C 05/29/2020
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
WESTFIELD QUALITY CARE O	DF AURORA		PO BOX 166, 1313 1ST STREET AURORA, NE 68818	
PREFIX (EACH DEFIC	Y STATEMENT OF DEFIC ENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
<ul> <li>2:00 PM. LP F has symptoms, and we with Covid 19.</li> <li>Record review of 4 revealed; the last An observation or and LP-F in the fm masks that were reasks that there was unaware that out the paperwork. The LPN reported Hospice and one reasks that had Hospice and one reasks that had Hospice and one reasks that had Hospice and hat hat hat hat hat hat hat hat hat hat</li></ul>	LP F had been screened at d not traveled, had no as afebrile. LP F had contact Laboratory Result for Resident b had been drawn at 2:22 PM. 15/29/20 at 2:02 PM of LP-E ont of the nurse's station without required in the resident areas. (29/20 at 2:02 PM with LP E P-E and LP-F had not screened b on a resident. They were e was a screening station and was located. (29/20 at 2:03 PM with LPN al Nurse) G revealed; LPN G the lab personnel needed to fill c on entry and be screened. I there was a book for the for therapy, but was unaware if	F 880	<ul> <li>A laboratory personnel binder was prepared at the time of the incident v laboratorians are to sign-in upon arritic the facility.</li> <li>Signs were posted at both entrances the facility indicating that ANYONE entering the facility must be screened.</li> <li>Masks and hand sanitizer are available both entrances to the facility.</li> <li>Nursing staff and laboratory staff have been educated on the need for and the process of screening the laboratory staff or 7-15-20.</li> <li>Audits are being performed on the screening tools and follow-up by nursishould any outlier symptoms exist or reported travel present as a concern These results are reporting to QA monthly.</li> </ul>	val to to d. ble at re he staff in

If continuation sheet Page 4 of 5

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391
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		285263	B. WING		25	0.000	29/2020
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
WESTFIEI	D QUALITY CARE OF A	URORA			OX 166, 1313 1ST STREET ORA, NE 68818		2
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	DON confirmed that the screened prior to leave DON reported that the should have been screened searching for that doo DON reported that the Lab personnel. An interview on 5/29/2 personnel and the no came was aware of the and screen. RN H in the screening process remember to complete personnel. Additional information An interview on 6/2/2 Administrator revealed locate any past documents	20 at 3:07 PM with Interim the lab personnel had ving the facility. The interim e previous lab personnel reening and the staff were cumentation. The Interim ere was not a binder for the 20 at 4:15 PM with RN I confirmed; lab personnel 0 were not the normal lab rmal lab personnel that he process and would stop reported they were aware of s and they had not	F8	80			

Facility ID: 410102

If continuation sheet Page 5 of 5

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				0.0938-0391
	OF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
		285127	B. WING		06	/02/2020
NAME OF PR	ROVIDER OR SUPPLIER		2-03	STREET ADDRESS, CITY, STATE, ZIP CODE		23
				1540 NORTH 72ND STREET		
THE AMB/	ASSADOR OMAHA			OMAHA, NE 68114		
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL SC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 000		d Infection Control Survey	FOC	00		
	Medicaid Services (C facility was found to n CFR §483.80 infectio					
	Total residents: 80					
F 880 SS=F	Infection Prevention & CFR(s): 483.80(a)(1)		F 88	30		
	infection prevention a designed to provide a comfortable environm	blish and maintain an nd control program a safe, sanitary and nent and to help prevent the nsmission of communicable				
	program. The facility must esta	brevention and control blish an infection prevention (IPCP) that must include, at ving elements:				
	reporting, investigatin and communicable di staff, volunteers, visit providing services un arrangement based u	pon the facility assessment to §483.70(e) and following				
LABORATORY	D RECTOR'S OR PROV DER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

07/13/2020

PRINTED: 08/18/2020

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.

		ID HUMAN SERVICES				FORM	): 08/18/2020 I APPROVED
CENTER	RS FOR MEDICARE &	MEDICAID SERVICES			)	OMB NO	0938-0391
	OF DEFIC ENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE A. BUILDING _	E CONSTRUCTION		(X3) DATE COMPL	SURVEY LETED
		285127	B. WING			06/0	02/2020
NAME OF P	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE AMB.	ASSADOR OMAHA			1540 NORTH 72ND STREE OMAHA, NE 68114	Ĩ		
(X4) ID PREFIX TAG	(EACH DEFIC ENC)	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	§483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicabi infections before they persons in the facility; (ii) When and to whom communicable diseas reported; (iii) Standard and tran to be followed to prev (iv)When and how iso resident; including but (A) The type and durat depending upon the in involved, and (B) A requirement that least restrictive possit circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit th (vi)The hand hygiene by staff involved in dir §483.80(a)(4) A syste identified under the fa corrective actions take §483.80(e) Linens. Personnel must hand	a standards, policies, and ogram, which must include, llance designed to identify ole diseases or y can spread to other ; m possible incidents of se or infections should be nomission-based precautions yent spread of infections; olation should be used for a at not limited to: ation of the isolation, infectious agent or organism at the isolation should be the ble for the resident under the s under which the facility ees with a communicable kin lesions from direct is or their food, if direct he disease; and procedures to be followed rect resident contact. em for recording incidents acility's IPCP and the ien by the facility. lle, store, process, and is to prevent the spread of	F 880				

Facility ID: 280202

If continuation sheet Page 2 of 6

CENTERS FOR MEDICARE & MEDICAND SERVICES         OND 000000000000000000000000000000000000	1 de la contra del trava a		ID HUMAN SER∀ICES				FORM	): 08/18/2020 / APPROVED
AND PLAN OF CORRECTION     DENT FICATION NUMBER:     A BUILDING     COMMETER       285127     B: WING     06002/2020       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STARE, 2P CODE     00002/2020       THE AMBASSADOR OMAHA     STREET ADDRESS, CITY, STARE, 2P CODE     00002/2020       Vietrix     SUMMARY STREMANT OF DEPICE INCERS     0000711 2700 STREET     000000000000000000000000000000000000	AN ADDRESS AND ADDRESS AND ADDRESS	No Constant Restaurce of the Article Restaurce and the		In the second				
INME OF PROVIDER OF SUPPLIER     STREET ADDRESS, CITY, STATE, 2P CODE 1540 MORTH 72ND STREET       THE AMBASSADOR OMAHA     STREET ADDRESS, CITY, STATE, 2P CODE 1540 MORTH 72ND STREET       PHETRY TAG     ISUMMARY STREEMENT OF DEPIC ENCES (EACH DEPIC NOW MUST ER PRECEDED BY FULL REGULATIONY OR LISC DEPIT I'N IS INFORMATION)     P       F 880     Continued From page 2 The facility will conduct an annual review of its IPCP and update their program, as necessary. This RECULIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to throughly screen visitors, when the Federal surveyor entered the facility and was not screened by staff. Additionally, the facility failed to throughly screen visitors, when the Federal surveyor entered the facility, and was not screened by staff. Additionally, the facility failed to screen fatf, when the facility failed to screen fatf, when the facility failed to screen fatf, when the facility failed to screen fatf, and RN2 sat at the 3R, or pediatric floor, nursing station. RN1 and RN2 each had their masks beneats, but failed to very fine masks appropriately, RN1 and RN2 each had their mask beneats their noces.     - On 6/2/20 at 11:03pm, the Pediatric Supervisor indicated that facemasks user their noses.       On 6/2/20 at 12:03pm, the Pediatric Supervisor indicated that she was not aware of any issues with staff wering facemasks had slipped beneath their noces.     - On 6/2/20 at 12:17pm, RN1 and RN2 indicated their facemasks had slipped beneath their noces.						10		
THE AMBASSADOR OMAHA         1549 HORTH 72ND STREET OMAHA, NE 88114           PRETX TAG         SUMMARY STATEMENT OF DERIC ENCIES (EACH CORRECTIVE ATON SHOULD BE REGULTION OF OLISIC DENT FY NEINFORMATION)         D PETRX TAG         D PETRX TAG         D CACH ZOORS FEETRATION SHOULD BE CACH CORRECTIVE ATON SHOULD BE CACH ZOORS FEETRATION SHOULD BE CACH ZOOR SHOULD BE CACH ZOORS FEETRATION SHOULD BE CACH ZOOR SHOULD BE CACH ZOORS FEETRATION SHOULD BE CACH ZOOR SHOU			285127	B. WING			06/	02/2020
THE AMBASSADOR OMAIA         OMAMA, NE 68114           [04] ID PRETIX TAC         ISUMMARY STATEMENT OF DEFICE ENDES (EXCLUENCE AVAINST BE PRECEDED BY FULL REDUCTORY ON LISC DENT PY ING WFORMATION)         IP PRETIX PRECEDURE OF ACTION SHOULD BE (EXCLUENCE ACTION SHOULD BE DEPUENCY)         000 EPRECEDURE OF DEPUENCY)         000 EPRECEDURE OF DEPUENCY)           F 880         Continued From page 2 The facility will conduct an annual review of its IPCP and update their program, as necessary. This RECURRENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement CMS and CDC recommendations in order to prepare for COVID-19. The facility failed to screen staff, when the facility failed to ask CDC-recommended screening questions prior to staff caring for residents. The facility failed to screen staff, when the facility failed to ask CDC-recommended screening usetions prior to staff caring for residents. The facility failed to ask CDC-recommended screening usetions. Prior to residents. Findings included: - On 6/2/20 at 11:30am, Registered Nurse (RN1) and RN2 sat at the 3R, or pediatric floor, nursing station. RN1 and RN2 each had their mask beneath their noce, leaving the redeation surveyor, RN1 and RN2 pulled their facemasks over their noses.           On 6/2/20 at 11:30am, the Pediatric Supervisor indicated that facemasks uset be worn over the mouth and nose. The Pediatric Supervisor indicated that she was not aware of any issues with staff wearing facemasks in appropriately.         In 6/2/20 at 12:37pm, RN1 and RN2 pulled their facemasks had slipped beneath their noses.         In 6/2/20 at 12:37pm, RN1 and RN2	NAME OF PF	ROVIDER OR SUPPLIER		100				
Prefix TAG         (EACH CERCENCY MIST BE PRECEDED BY FULL REGULTORY OR USCIDENT FING INFORMATION)         Prefix TAG         (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE OT THE APPROPRIATE DEFICIENCY)         constraints           F 880         Continued From page 2 The facility will conduct an annual review of its IPCP and update their program, as necessary, This REQUIREMENT is not met as evidenced by;         F 880         F 880         F 880           CDC recommendations in order to prepare for COVID-19. The facility failed to implement CMS and CDC recommendations in order to prepare for COVID-19. The facility failed to screen staff, when the facility failed to screen staff, additionally, the facility failed to screen staff, when the facility failed to screen staff, orrectig used to spreave that staff correctly wore facemasks at all times while in the facility, and while within six feet of residents.         Findings included:         -           - On 6/2/20 at 11:30am, Registered Nurse (RN1) and RN2 sat at the 3R, or pediatric floor, nursing station, RN1 and RN2 each had their mask beneath their nose, leaving their noses supposed, Up on seing the Federal surveyor, RN1 and RN2 pulled their facemasks nurst be wom over the mouth and nose. The Pediatics Supervisor indicated that facemasks inappropriately.         On 6/2/20 at 12:30pm, the Pediatics Supervisor indicated that she was not avare of any issues with staff wearing facemasks had slipped beneath their noses.         On 6/2/20 at 12:30pm, RN1 and RN2         On 6/2/20 at 12:30pm, RN1 and RN2	THE AMB/	ASSADOR OMAHA		20		ET		
The facility will conduct an annual review of its IPCP and update their program, as necessary. This RECUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement CMS and CDC recommendations in order to prepare for COVID-19. The facility failed to thoroughly screen visitors, when the Federal surveyor entered the facility and was not screened by staff. Additionally, the facility failed to ask CDC-recommended screening questions prior to staff caring for residents. The facility failed to ask CDC-recommended screening questions prior to staff caring for residents. The facility failed to ask CDC-recommended screening questions prior to staff caring for residents. The facility failed to ask CDC-recommended screening questions prior to staff caring for residents. The facility failed to ask CDC-recommended screening questions prior to staff caring for residents. The facility failed to ask CDC-recommended screening questions prior to staff caring for residents. The facility failed to ask cPC-recommended screening questions prior to staff caring for residents. The facility failed to ensure that staff correctly wore facemasks at all times while in the facility. and while within six feet of residents. Findings included: - On 6/2/20 at 11:30am, Registered Nurse (RN1) and RN2 sat at the 3R, or pediatric floor, nursing station. RN1 and RN2 vore disposable surgical facemasks, but failed to wear the masks beneath their nose, leaving their noses exposed. Upon seeling the Federal surveyor, RN1 and RN2 pulled their facemasks over their noses. On 6/2/20 at 12:30m, the Pediatrics Supervisor indicated that facemasks in an appropriately. On 6/2/20 at 12:17pm, RN1 and RN2 indicated that their facemasks had slipped beneath their noses.	PREFIX	(EACH DEFIC ENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD B		COMPLETION
On 6/2/20 at 12:37pm, a housekeeper (H1)	F 880	The facility will condul IPCP and update their This REQUIREMENT by: Based on observation review, the facility fail CDC recommendation COVID-19. The facility visitors, when the Feo facility and was not so Additionally, the facility when the facility failed screening questions p residents. The facility correctly wore facema facility, and while with Findings included: - On 6/2/20 at 11:30a and RN2 sat at the 3F station. RN1 and RN2 facemasks, but failed appropriately. RN1 ar beneath their nose, le Upon seeing the Fede pulled their facemask On 6/2/20 at 12:03pm indicated that facema mouth and nose. The indicated that she was with staff wearing face On 6/2/20 at 12:17pm that their facemasks to noses.	at a nanual review of its is program, as necessary. is not met as evidenced n, interview, and record ed to implement CMS and ns in order to prepare for y failed to thoroughly screen deral surveyor entered the creened by staff. ty failed to screen staff, d to ask CDC-recommended orior to staff caring for failed to ensure that staff asks at all times while in the nin six feet of residents. am, Registered Nurse (RN1) R, or pediatric floor, nursing 2 wore disposable surgical to wear the masks nd RN2 each had their mask eaving their noses exposed. eral surveyor, RN1 and RN2 s over their noses. n, the Pediatrics Supervisor s not aware of any issues emasks inappropriately. n, RN1 and RN2 indicated had slipped beneath their	F 880				

Facility ID: 280202

If continuation sheet Page 3 of 6

CENTER STATEMENT (		ND HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE A. BUILDING _	E CONSTRUCTION	2	FORM OMB NO (X3) DATE	0: 08/18/2020 1 APPROVED 0. 0938-0391 SURVEY LETED
		285127	B. WING			06/	02/2020
NAME OF P	ROVIDER OR SUPPLIER		12	STREET ADDRESS, CITY, ST			85
THE AMB	ASSADOR OMAHA		2	1540 NORTH 72ND STREET DMAHA, NE 68114	T		
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F 880	cleaned R1's room wh common area. H1 wo facemask, however, H beneath her chin, leave exposed while she clear On 6/2/20 at 12:47pm too hot, so she pulled her chin. H1 indicated appropriate mask weat On 6/2/20 at 12:58pm R2 was present. H1 s looked in the direction played cartoons. H1's beneath her chin, leave exposed. H1 then exit dustpan, collected son R2's room. H1 failed t leaving the room and hallway. On 6/2/20 at 1:05pm, and talked with the re disposable surgical far mask was pulled dow exposed. Upon seeing pulled her facemask of On 6/2/20 at 1:22pm, mask had slipped dow fixed it yet. RN3 indicated worn over the mouth at On 6/2/20 at 2:30pm, (LPN1) indicated that over the mouth and mouther over the mouth and mouther	hile R1 watched TV in the bre a disposable surgical H1's mask was pulled wing her mouth and nose eaned the room. In, H1 indicated that she was d her mask down beneath d that this was not aring, and fixed her mask. In, H1 swept R2's room, while stood directly next to R2 and n of R2's television, which is facemask was again pulled wing her mouth and nose ited the room and retrieved a one floor debris, then exited to sanitize her hands after beginning to vacuum the science ited the room esident. RN3 wore a accemask, however, the <i>rn</i> , leaving R3's nose of the Federal surveyor, RN3 over her nose. RN3 indicated that her wn, and that she had not cated that masks must be and nose. Licensed Practical Nurse t facemasks must be worn nose at all times. LPN1 bast, she had observed staff	F 880				

Facility ID: 280202

If continuation sheet Page 4 of 6

CENTER STATEMENT ( AND PLAN OF NAME OF P	RS FOR MEDICARE & OF DEFIC ENCIES OF DEFIC ENCIES FORRECTION PROVIDER OR SUPPLIER BASSADOR OMAHA SUMMARY ST/ (EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)		(EACH CORREC	- Ate, ZIP code	FORM OMB NO (X3) DATE COMP 06/	2: 08/18/2020 1 APPROVED 0. 0938-0391 SURVEY LETED 02/2020 02/2020
F 880	happened occasional complete on-the-spot not correctly wear the - Review of CMS guid documented the follow "How should facilities Facilities should screet 1. International travel restricted countries. F restricted countries vi https://www.cdc.gov/c ncov/travelers/index.t 2. Signs or symptoms such as a fever, coug 3. Has had contact wi investigation for COV The guidance then sta "How should facilities care facility staff? The same screening p be performed for facil 3 above)." On 6/2/20 at 11:15am entered the facility. A The Federal surveyor purpose for the visit, a the Director of Nursin failed to screen the Fe Approximately five mi	Ily, and LPN1 would t education for staff who did eir masks. idance, dated 3/4/20, wing: a monitor or limit visitors? en visitors for the following: I within the last 14 days to For updated information on isit: coronavirus/2019- html s of a respiratory infection, gh, and sore throat. ith someone with or under /ID-19." tated: a monitor or restrict health performed for visitors should lity staff (numbers 1, 2, and n, the Federal surveyor a receptionist sat at the desk. r gave the reason and and the receptionist called ng (DON). The receptionist	F 88		DEFICIENCY		

Facility ID: 280202

If continuation sheet Page 5 of 6

Let son Architectures		ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 08/18/2020 APPROVED 0. 0938-0391
STATEMENT (	OF DEFIC ENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PL	E CONSTRUCTION	8	(X3) DATE	200 B.C
		285127	B. WING			06/	02/2020
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F 880	floor 3R. The DON fai surveyor. On 6/2/20 at 12:17pm facility screening proc their own temperature There were no screen On 6/2/20 at 12:28pm floors in the facility we either screened there which were directly by staff were to take their them. The DON indica screening questions s On 6/2/20 at 1:22pm, facility screening proc their temperatures an were asked if they hav COVID-19, but there we questions. Review of staff screen through the recent on had their temperature single question as to in symptoms of a respirat no other screening que	iled to screen the Federal h, RN2 indicated that the cess consisted of staff taking es and logging the result. hing questions to complete. h, the DON indicated that all ere locked, so staff were e or at the nursing stations, y the entry doors. Facility ir own temperatures and log ated that there were also staff were to complete. RN3 indicated that the cess consisted of staff taking ad logging the result. Staff ad signs or symptoms of were no further screening hing sheets, dated 3/15/20 hes, documented facility staff es taken, and answered a if they had signs or atory infection. There were uestions present. rovide any staff screening	F 880				

Facility ID: 280202

If continuation sheet Page 6 of 6





July 2, 2020

Brody Chandler, Administrator The Lighthouse At Lakeside Village 17600 Arbor Street Omaha, NE 68130

#### CMS CERTIFICATION NUMBER: 285280

Dear Mr. Chandler:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 18, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555



#### MIDWEST DIVISION OF SURVEY AND CERTIFICATION

June 30, 2020

Mikayla Wengler, Administrator Tiffany Square 3119 West Faidley Avenue Grand Island, NE 68803

CMS Certification No: 285087

Dear Ms. Wengler:

## SUBJECT: SURVEY RESULTS Cycle Start Date: June 22, 2020

### SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-20-All*, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/gso-20-20-allpdf.pdf-0.

### SURVEY RESULTS

On June 22, 2020, the Centers for Medicare & Medicaid Services (CMS) completed a COVID-19 Focused Survey at Tiffany Square to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was in substantial compliance with participation requirements and no deficiencies were cited. The findings from this survey are documented on the enclosed form CMS 2567.

No additional action is required on the facility's part.

## **QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES**

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at <u>QIO Program Website</u>. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at <u>Locate Your QIO</u>.

## **CONTACT INFORMATION**

If you have any questions please contact Kevin Wright, Principal Program Representative at (816) 426-2011.

Sincerely,

Kevin Wright Long Term Care Branch Survey & Operations Group Center for Clinical Standards & Quality CMS Kansas City

cc: NE DHHS Powers/Grimes





July 23, 2020

Jodi Dethlefs, Administrator Valley View Senior Village 220 South 26th Street Ord, NE 68862

#### CMS CERTIFICATION NUMBER: 285294

Dear Ms. Dethlefs:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 21, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555





July 23, 2020

Traci Haglund, Administrator Wakefield Health Care Center 306 Ash Street Wakefield, NE 68784

#### CMS CERTIFICATION NUMBER: 285209

Dear Ms. Haglund:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 16, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555





July 22, 2020

Lisa Kisinger, Administrator Wauneta Care And Therapy Center Po Box 520, 427 Legion Street Wauneta, NE 69045-0520

### CMS CERTIFICATION NUMBER: 285220

Dear Ms. Kisinger:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 13, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555



July 17, 2020

Cheri Wingert, Administrator Wayne Countryview Care and Rehabilitation 811 East 14th Street Wayne, NE 68787

CMS Certification Number: 285135

Dear Ms. Wingert:

## SUBJECT: SURVEY RESULTS Cycle Start Date: July 14, 2020

## SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-20-All*, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

## SURVEY RESULTS

On July 14, 2020, the Centers for Medicare & Medicaid Services (CMS) completed a COVID-19 Focused Survey at Wayne Countryview Care and Rehabilitation to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was in substantial compliance with participation requirements and no deficiencies were cited. The findings from this survey are documented on the enclosed form CMS 2567.

No additional action is required on the facility's part.

# **QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES**

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities

in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at <u>QIO Program Website</u>: <u>https://qioprogram.org/covid-19</u>. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at <u>Locate Your QIO</u>: <u>https://qioprogram.org/locate-your-qio</u>.

## **CONTACT INFORMATION**

If you have any questions please contact Kevin Wright, Principal Program Representative at (816) 426-2011.

Sincerely,

Kevin Wright Long Term Care Branch Survey & Operations Group Center for Clinical Standards & Quality CMS Kansas City

cc: NE DHHS Powers/Grimes





July 15, 2020

Allen Pannell, Administrator Western Nebraska Veterans Home 1102 West 42nd Street Scottsbluff, NE 69361

Dear Mr. Pannell:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 17, 2020 by representatives of this Department. Your facility was found in compliance with Skilled Nursing Facility, Nursing Facility and Intermediate Care Facilities.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555

CV/ls





Pete Ricketts, Covernor

July 8, 2020

Christopher Young, Administrator Westfield Quality Care Of Aurora Po Box 166, 1313 1st Street Aurora, NE 68818

Dear Mr. Young:

An unannounced visit was conducted to investigate a complaint at Westfield Quality Care Of Aurora on May 29, 2020, by representatives of the Department of Health and Human Services Division of Public Health. To complete this investigation, a representative sample of the residents who reside in the facility or had resided in the facility was selected. The investigative process included review of resident records; observation of the provision of care and services; and interviews with residents, family members and staff.

#### **ALLEGATION:**

The facility fails to implement infection control procedures to prevent the spread of infection.

#### FINDINGS:

The facility failed to implement infection control procedures to prevent the spread of infection per CMS directives related to COVID -19. To make this determination; record review of residents records and observations revealed, laboratory staff were not screened upon entering the facility or before resident contact. Interviews revealed laboratory staff were unaware of requirements in place to prevent infection transmission of COVID-19. Record reviews confirmed laboratory staff had not been screened prior to providing services to a resident. This facility failure is a violation of F880 Infection Control and Licensure Reference Number 175 NAC 12-006.17B.

These findings are related to regulations under the Licensure Unit's regulatory authority. Since each division has unique statutory and regulatory obligations and guidelines, it may be possible that your facility will receive additional findings from other divisions who have also participated in the investigation/assessment of these same or similar allegations.

Please contact this office if you have questions.

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986

(402) 471-3324, FAX: (402) 471-0555





## **IMPORTANT NOTICE – PLEASE READ CAREFULLY**

July 8, 2020

Christopher Young, Administrator Westfield Quality Care Of Aurora Po Box 166, 1313 1st Street Aurora, NE 68818

CMS Certification No. 285263

Subject: Survey Results Cycle Start Date: May 29, 2020

Dear Administrator,

### UNANNOUNCED COVID-19 SURVEY

The Secretary of the U.S. Department of Health and Human Services (DHHS) has the duty and responsibility to protect the health, safety, welfare and rights of Medicare/Medicaid beneficiaries. The Secretary has delegated authority to administer and provide oversight of the Medicare program to Centers for Medicare & Medicaid Services (CMS).

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-31-All*, CMS and the State Survey Agency are conducting unannounced onsite surveys at certain Medicare certified provider and supplier types.

### SURVEY RESULTS

On May 29, 2020, a survey was completed at Westfield Quality Care Of Aurora by the State Survey Agency to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the CMS 2567 and will be posted on the ePOC system.

## PLAN OF CORRECTION

A Plan of Correction (PoC) for the deficiencies must be submitted by July 18, 2020, to the State Survey Agency Contact. Failure to submit an acceptable PoC by July 18, 2020 may result in the imposition of additional remedies. The PoC must contain the following:

- 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- 3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of the quality assurance being implemented, the earliest correction date will be the date of the revisit; and
- 5. Include dates when corrective action will be completed. The corrective action completion dates must be written in the completion date column within acceptable time frames. If the PoC is unacceptable for any reason, you will be notified in writing by this office. If the PoC is acceptable, you will be notified via ePOC. Please note that the facility is ultimately accountable for compliance, and that responsibility is not alleviated in cases where notification regarding the acceptability of the facility's PoC is not made timely. The PoC will serve as the facility's allegation of compliance.

## **ENFORCEMENT REMEDIES**

Based on the Statement of Deficiencies (Form CMS-2567), the following remedies are imposed:

• Directed Plan of Correction:

In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction is imposed on the facility. In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. The effective date is not a deadline for completion of the DPOC. However, the State Agency will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice.

Training option(s) which are the most appropriate for the type of noncompliance cited. For

Sparkling Surfaces - https://youtu.be/t7OH8ORr5Ig Clean Hands - https://youtu.be/xmYMUly7qiE Closely Monitor Residents - https://youtu.be/1ZbT1Njv6xA Keep COVID-19 Out! - https://youtu.be/7srwrF9MGdw Lessons - https://youtu.be/YYTATw9yav4

Please send all documentation to the State Agency at the following:

examp

Connie Vogt, RN, BSN Email: dhhs.healthcarefacilities@Nebraska.gov In the Subject Line please put: DPOC

For states participating in the ePOC program, the DPOC may be added as an attachment.

Please note, if documentation includes any resident personal identifiable information (PII) or personal health information (PHI) it must be sent encrypted.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies, within 10 days after receipt of the Form CMS 2567. Please see the attached instructions (DPOC attachment) for detailed guidance.

## • Imposition of Denial of Payment for New Admissions (DPNA):

Payment will be denied for all <u>NEW</u> Medicare and Medicaid admissions, beginning August 8, 2020 of the date the denial of payment begins. DPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated.

## **INFORMAL DISPUTE RESOLUTION (IDR)**

You have one opportunity to dispute the deficiencies cited on the survey date through (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Connie Vogt, RN, BSN Email: dhhs.healthcarefacilities@Nebraska.gov In the Subject Line please type: Request IDR

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by

counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

This request must be submitted within 10 days from the date of the enforcement letter. An incomplete Informal Dispute Resolution process will not delay the effective date of any enforcement action.

Informal Dispute Resolution is in no way to be construed as a formal evidentiary hearing. It is an informal internal process to review additional information submitted by the facility. You will be advised of our decision relative to the informal dispute.

# APPEAL RIGHTS

If you disagree with the determination to impose remedies made on the basis of noncompliance identified at the May 29, 2020 survey, you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board (DAB). The appeal rights are set forth at 42 C.F.R. § 498.5 and the procedures for requesting a hearing are set forth at §498.40, et seq. You must file your hearing request electronically by using the DAB's Electronic Filing System (DAB E-File) at <a href="https://dab.efile.hhs.gov/">https://dab.efile.hhs.gov/</a>, unless you obtain a waiver from the DAB (*see* DAB Civil Remedies Division Procedures, § 6(a)(i)(1)). Your appeal must be filed no later than 60 days from the date of receipt of this letter.

We request that you provide an electronic copy of the request for appeal to: and to the CMS Regional Chief Counsel at:

OGCK ansas CityGeneralInbox@hhs.gov

If you elect to dispute deficiencies through the Informal Dispute Resolution (IDR) process, this will not extend the 60 day period to file your appeal before the Departmental Appeals Board. Filing an appeal will not stop the imposition of any enforcement remedy.

If you experience problems with, or have questions about DAB e-File, please contact e-File System Support at <u>OSDABImmediateOffice@hhs.gov</u>. If you have questions about using the DAB e-file System, please visit: <u>https://dab.efile.hhs.gov/appeals/to\_crd\_instructions?locale=en</u>.

# **QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES**

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at <u>QIO</u> <u>Program Website</u>. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at <u>Locate Your QIO</u>.

# **CONTACT INFORMATION**

If you have any questions please contact this office.

ROkcm

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555

CV/kd

Enclosures: CMS 2567

Copies via e-mail to: CMS-RO DHHS - State Medicaid Agency DHHS - Nursing Support

					FORM APPROVED
		MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFIC ENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENT FICATION NUMBER:		(X2) MULT PLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		285263	B. WING		05/29/2020
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	8.
WEATEIE		UDODA	P	O BOX 166, 1313 1ST STREET	
WESTFIE	LD QUALITY CARE OF A	URURA	A	URORA, NE 68818	
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F 880 SS=D	Infection Prevention & CFR(s): 483.80(a)(1)( §483.80 Infection Cor The facility must esta	(2)(4)(e)(f)	F 880		7/20/20
	infection prevention a designed to provide a comfortable environm	nd control program safe, sanitary and lent and to help prevent the ismission of communicable			
	program. The facility must esta	prevention and control blish an infection prevention IPCP) that must include, at ving elements:			
	reporting, investigatin and communicable di staff, volunteers, visiti providing services un arrangement based u	pon the facility assessment to §483.70(e) and following			
	procedures for the pro- but are not limited to: (i) A system of surveil possible communicabi infections before they persons in the facility; (ii) When and to whor communicable diseas reported; (iii) Standard and tran- to be followed to prev	can spread to other n possible incidents of e or infections should be smission-based precautions ent spread of infections; plation should be used for a			
		SUPPLIER REPRESENTATIVE'S SIGNATUR	)F	TITLE	(X6) DATE

**Electronically Signed** 

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.

DEDARTMENT OF USALTU AND UUMAAN OFD.

07/14/2020

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				0938-0391
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		285263	B. WING		- 05/29/20	
NAME OF P	ROVIDER OR SUPPLIER		54.03	STREET ADDRESS, CITY, STATE, ZIP CODE		21.
WESTFIELD QUALITY CARE OF AURORA				PO BOX 166, 1313 1ST STREET		
WESTFIELD QUALITY CARE OF AURORA				AURORA, NE 68818		
(X4) ID PREFIX TAG	(EACH DEFIC ENC)	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL SC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	involved, and (B) A requirement that least restrictive possilic circumstances. (v) The circumstances must prohibit employed disease or infected secontact with residents contact with residents contact will transmit the (vi)The hand hygiene by staff involved in dir §483.80(a)(4) A systemidentified under the fac corrective actions take §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rev The facility will condu IPCP and update theit This REQUIREMENT by: Licensure Reference Based on observation review the facility failed infection control pract Medicare and Medicat prevent potential cross the spread of COVID virus primarily spread through respiratory dr	ation of the isolation, infectious agent or organism it the isolation should be the ble for the resident under the is under which the facility ees with a communicable kin lesions from direct is or their food, if direct the disease; and procedures to be followed rect resident contact. It is in the facility is the facility is in the facility. It is the facility.	F8	The facility denies that the alleged fa as set forth constitute a deficiency un the interpretations of federal and state law. The preparation of the following p of correction should not be interpreted an admission nor an agreement by th facility of the truth of the facts alleged conclusions set forth in the statement deficiencies. The plan of correction prepared for this deficiency was exect solely because it is required by provisi	der blan I as e , or of	

Facility ID: 410102

If continuation sheet Page 2 of 5

		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROV OMB NO. 0938-03
STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:		(X2) MULT PL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		285263	B. WING		05/29/2020
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	
WESTFIELD QUALITY CARE OF AURORA		3	PO BOX 166, 1313 1ST STREET		
WESTFIEL	D QUALITY CARE OF A	URORA		AURORA, NE 68818	
(X4) ID Prefix Tag	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETIC
F 880	Continued From page	2	F 880		
	124600 2000		1 000	of state and federal law. Without wa	iving
		not screened upon facility e PPE (Personnel Protective		the forgoing statement, the facility s	
	Equipment) masks in			that regards to this citation:	INICO
	practice. This had th				
		Resident 5). The facility		The Laboratory Personnel, in questi	ion,
	census was 44.	, .		had been screened for COVID19	26
				symptoms and known exposure that	t vary
				morning at Memorial Hospital prior t	to
	Findings are:			performing lab rounds at Westfield (	
				Care of Aurora. Therefore, an extrem	
		29/20 at 1.50 PM revealed;		rare chance of any potential exposu	
		and LP F had come to the		any residents of Westfield Quality C	
		tering the building. LP E and		Aurora existed, which is the intent o	
		creening station. It was LP E nor LP F had a face		screening. All other records indicate appropriate screening had taken pla	
		P-E gained information lab		date, as of the receipt of this alleged	
		tion. LP E and F left the		deficiency 7-8-20, there are no new	
	nurses station and er			symptoms or positive tests of COVII	
	resident.	······,···		Westfield Quality Care of Aurora and	
				since ALL residents and staff have b	
	Record review of Lab	oratory Results for Resident		cleared of COVID19. The screening	0
	5 revealed; the lab wa	as drawn at 1:58 PM.		process in place has proven effectiv	/e.
	Record review of Scr			The Laboratory Personnel were scre	
	·	/29/20 revealed; LP E had		prior to the leaving the facility. They	
		0 PM. LP E had traveled		screened by Westfield Quality Care	
	from Omaha, had no			Aurora staff at 2:00PM. Many of the	
	afebrile. LP E had co	ontact with Covid 19.		observations made by the survey te	
	Record review of Cor	eening for LP F dated		were made following the time that the laboratorians were screened.	le
		F had been screened at			
	2:00 PM. LP F had no			A laboratory personnel binder was	
		afebrile. LP F had contact		prepared at the time of the incident	where
	with Covid 19.			laboratorians are to sign-in upon arr the facility.	
	Record review of Lab	oratory Result for Resident			
		ad been drawn at 2:22 PM.		Signs were posted at both entrance	s to
				the facility indicating that ANYONE	the name of
	An observation on 5/	29/20 at 2:02 PM of LP-E		entering the facility must be screene	he

Event ID: ZMXR11

Facility ID: 410102

If continuation sheet Page 3 of 5

		MEDICAID SERVICES	- Delay		OMB NO. 0938-03	
	ATEMENT OF DEFIC ENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENT FICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		285263	B. WING		05/29/2020	
NAME OF P	ROVIDER OR SUPPLIER		7.08	STREET ADDRESS, CITY, STATE, ZIP CODE		
WESTFIE	LD QUALITY CARE OF A	AURORA		PO BOX 166, 1313 1ST STREET AURORA, NE 68818		
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIO	
F 880	and LP-F in the front masks that were requ An interview on 5/29/ confirmed; both LP-E prior to drawing lab o unaware that there w where the station wa An interview on 5/29/ (Licensed Practical N was unaware that the out the paperwork on The LPN reported the Hospice and one for there was a book for An observation on 5/ Screening station rew that had Hospice and An interview on 5/29/ Interim DON (Directo personnel were to be building. An observation on 5/ hall revealed; the hal staff had the N95 ma An interview on 5/29/ DON confirmed that is screened prior to lear DON reported that the should have been sc searching for that dow	of the nurse's station without uired in the resident areas. (20 at 2:02 PM with LP E and LP-F had not screened on a resident. They were vas a screening station and s located. (20 at 2:03 PM with LPN lurse) G revealed; LPN G e lab personnel needed to fill o entry and be screened. ere was a book for the therapy, but was unaware if the lab. (29/20 at 2:04 PM of the vealed; there was a binder d a binder for Therapy. (20 at 2:05 PM with the or of Nurses) confirmed; lab e screened on entry to the (29/20 at 2:30 PM of the 300 I had resident doors closed,	F 88	<ul> <li>Masks and hand sanitizer are availed both entrances to the facility.</li> <li>Nursing staff and laboratory staff here educated on the need for an oprocess of screening the laboratory at the time of the incident. Addition education will be presented to staff 7-15-20.</li> <li>Audits are being performed on the screening tools and follow-up by near should any outlier symptoms exist reported travel present as a concert These results are reporting to QA monthly.</li> </ul>	ave d the y staff al f on ursing or	

If continuation sheet Page 4 of 5

CENTER STATEMENT		ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:		E CONSTRUCTION	FORM OMB NO (X3) DATE	D: 08/18/2020 M APPROVED D. 0938-0391 SURVEY PLETED
		285263	B. WING	<u></u>	05/	29/2020
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WESTFIE	LD QUALITY CARE OF A	URORA	1042	PO BOX 166, 1313 1ST STREET AURORA, NE 68818		
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	An interview on 5/29/ (Registered Nurse) H had come on 05/29/2 personnel and the no came was aware of th and screen. RN H r the screening process remember to complet personnel. Additional information An interview on 6/2/2 Administrator reveale locate any past docum	20 at 4:15 PM with RN confirmed; lab personnel 0 were not the normal lab rmal lab personnel that ne process and would stop eported they were aware of s and they had not te this with the lab	F 880			

If continuation sheet Page 5 of 5

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				0938-0391
AND DI AN OF CODDECTION		(X2) MULT PLE A. BUILDING	CONSTRUCTION	(X3) DATE S COMPL	ETED	
		285263	B. WING		— C — 05/29/2	
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	0.5/2	5/2020
WERTEIEI	LD QUALITY CARE OF A		PC	D BOX 166, 1313 1ST STREET		
WESTFIEL	LD QUALITT CARE OF A	IUKUKA	A	URORA, NE 68818		2
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 000			
	Governing Licensure Nursing Facilities, an	Chapter 12- "Regulations of Skilled Nursing Facilities, d Intermediate Care included in survey report as				
F 880		<ul> <li>A second constraint of the second seco</li></ul>	F 880		7	7/20/20
SS=D	CFR(s): 483.80(a)(1)	(2)(4)(e)(f)				
	infection prevention a designed to provide a comfortable environm	blish and maintain an and control program a safe, sanitary and nent and to help prevent the nsmission of communicable				
	program. The facility must esta	brevention and control blish an infection prevention (IPCP) that must include, at ving elements:				
	reporting, investigatir and communicable d staff, volunteers, visit providing services un arrangement based u	pon the facility assessment to §483.70(e) and following				
	procedures for the pr but are not limited to:	llance designed to identify				
		SUPPLIER REPRESENTATIVE'S SIGNATURI	E	TITLE		X6) DATE
Electroni	cally Signed				C	07/14/2020

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.

NATE OF BROKES SAVE &		ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES				OMB NO. 0938-0391	
STATEMENT OF DEFIC ENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENT FICATION NUMBER:		and the second second		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. DOILDI	<b>NO</b>	10	0	
		285263	B. WING			e transfer	29/2020
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		10
WESTFIEL	D QUALITY CARE OF A	URORA		P	0 BOX 166, 1313 1ST STREET		
				A	URORA, NE 68818		2
(X4) ID PREFIX			D PREFIX	PROVIDER'S PLAN OF CORRECTION			(X5) COMPLETION
TAG			TAG		CROSS-REFERENCED TO THE APPROPRIA	E APPROPRIATE DATE	
	67				DEFICIENCY)		
E 000	Orationed From a co						
F 880	Continued From page		F8	880			
	infections before they persons in the facility;						
		, m possible incidents of					
		e or infections should be					
	reported;						
		nsmission-based precautions vent spread of infections;					
	[Mark 2009 108] [2009 108]	plation should be used for a					
	resident; including bu						
	(A) The type and dura						
	depending upon the in involved, and	nfectious agent or organism					
		t the isolation should be the					
		ble for the resident under the					
	circumstances.						
		s under which the facility					
		ees with a communicable kin lesions from direct					
		or their food, if direct					
	contact will transmit th						
		procedures to be followed					
	by staff involved in dir	rect resident contact.					
	§483.80(a)(4) A syste	em for recording incidents					
	identified under the fa	cility's IPCP and the					
	corrective actions tak	en by the facility.					
	§483.80(e) Linens.						
		le, store, process, and					
		to prevent the spread of					
	infection.						
	§483.80(f) Annual rev	/iew					
		ct an annual review of its					
		r program, as necessary.					
	100 000 0000 000 000 000 000 000 000	is not met as evidenced					
	by:	Number 175 NAC 12-006B			The facility denies that the alloged fact		
		NUMBEL 175 NAC 12-006B			The facility denies that the alleged fact as set forth constitute a deficiency und		

Facility ID: 410102

If continuation sheet Page 2 of 5

		ID HUMAN SER∀ICES MEDICAID SER∀ICES				FORM	): 08/18/2020 APPROVED 0. 0938-0391
STATEMENT OF DEFIC ENCIES (X1) PROVIDER/SUPP		(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		285263	B. WING			en de	C 29/2020
NAME OF PR	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		8
WESTEIEI	D QUALITY CARE OF A	URORA		P	0 BOX 166, 1313 1ST STREET		
				A	URORA, NE 68818		2
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIJ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	review the facility faile infection control pract Medicare and Medica prevent potential cross the spread of COVID virus primarily spread through respiratory di serious illness and eve personnel that were r entry and did not have Equipment) masks in practice. This had the resident 2 sampled (F census was 44. Findings are: AN observation on 5/ LP (Lab Personnel) E nurse's desk after ent F stood next to the so observed that neither mask during entry. L that required complet nurses station and en resident. Record review of Lab 5 revealed; the lab wa Record review of Scre	h, interview, and record ed; to follow implemented tices and CMS (Centers for aid Services) guidelines to as contamination including 19 (a highly contagious I from person to person roplets, which can lead to ven death) related to lab not screened upon facility e PPE (Personnel Protective place per the facility e potential to affect 1 Resident 5). The facility 29/20 at 1.50 PM revealed; E and LP F had come to the tering the building. LP E and creening station. It was LP E nor LP F had a face P-E gained information lab ion. LP E and F left the netered the hallway for poratory Results for Resident as drawn at 1:58 PM. eening for LP (Lab /29/20 revealed; LP E had 0 PM. LP E had traveled	F	380	the interpretations of federal and state law. The preparation of the following p of correction should not be interpreted an admission nor an agreement by the facility of the truth of the facts alleged, conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was execu- solely because it is required by provisi- of state and federal law. Without waivin the forgoing statement, the facility state that regards to this citation: The Laboratory Personnel, in question had been screened for COVID19 symptoms and known exposure that va- morning at Memorial Hospital prior to performing lab rounds at Westfield Qua- Care of Aurora. Therefore, an extreme rare chance of any potential exposure any residents of Westfield Quality Care Aurora existed, which is the intent of a screening. All other records indicated to appropriate screening had taken place date, as of the receipt of this alleged deficiency 7-8-20, there are no new symptoms or positive tests of COVID1 Westfield Quality Care of Aurora and since ALL residents and staff have bee cleared of COVID19. The screening process in place has proven effective. The Laboratory Personnel were screen prior to the leaving the facility. They we screened by Westfield Quality Care of Aurora staff at 2:00PM. Many of the	lan as or of ted on ng es ary ality ly to e of il that To 9 at en ned ere	
	afebrile. LP E had co	eening for LP F dated			observations made by the survey team were made following the time that the laboratorians were screened.	1	
	Record review of Sch	coming for Li i dated			appraising were screened.		s

Event ID: ZMXR11

Facility ID: 410102

If continuation sheet Page 3 of 5

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				PRINTED: 08/18/2020 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFIC ENCIES (X1) PROVIDER/SUPPLIER/CLI IDENT FICATION NUMBER			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285263	B. WING	<u></u>	C 05/29/2020
NAME OF PROVIDER OR SUPPLIER		2.03 R	STREET ADDRESS, CITY, STATE, ZIP CODE	
WESTFIELD QUALITY CARE	DF AURORA	10	PO BOX 166, 1313 1ST STREET AURORA, NE 68818	
PREFIX (EACH DEFIC	Y STATEMENT OF DEFIC ENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
<ul> <li>2:00 PM. LP F has symptoms, and w with Covid 19.</li> <li>Record review of 4 revealed; the late An observation or and LP-F in the frimasks that were in An interview on 5 confirmed; both L prior to drawing late unaware that there where the station.</li> <li>An interview on 5 (Licensed Practice was unaware that out the paperwork The LPN reported Hospice and one there was a book.</li> <li>An observation of Screening station that had Hospice.</li> <li>An interview on 5 (Interim DON (Dire personnel were to building.</li> <li>An observation of Screening station of Screening station that had Hospice.</li> </ul>	LP F had been screened at d not traveled, had no as afebrile. LP F had contact Laboratory Result for Resident b had been drawn at 2:22 PM. A 5/29/20 at 2:02 PM of LP-E ont of the nurse's station without required in the resident areas. (29/20 at 2:02 PM with LP E P-E and LP-F had not screened ab on a resident. They were e was a screening station and was located. (29/20 at 2:03 PM with LPN al Nurse) G revealed; LPN G the lab personnel needed to fill c on entry and be screened. I there was a book for the for therapy, but was unaware if	F 880	<ul> <li>A laboratory personnel binder was prepared at the time of the incident we laboratorians are to sign-in upon arrive the facility.</li> <li>Signs were posted at both entrancess the facility indicating that ANYONE entering the facility must be screened.</li> <li>Masks and hand sanitizer are available both entrances to the facility.</li> <li>Nursing staff and laboratory staff have been educated on the need for and the process of screening the laboratory staff or 7-15-20.</li> <li>Audits are being performed on the screening tools and follow-up by nurse should any outlier symptoms exist or reported travel present as a concern. These results are reporting to QA monthly.</li> </ul>	val to to d. ole at re he staff n

If continuation sheet Page 4 of 5

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391
STATEMENT OF DEFIC ENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENT FICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT A. BUILDIN	INSTRUCTION	(X3) DATE SURVEY COMPLETED C		
	285263 B. WING		25	0.000	29/2020		
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
WESTFIEI	D QUALITY CARE OF A	URORA			OX 166, 1313 1ST STREET ORA, NE 68818		2
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	DON confirmed that it screened prior to leave DON reported that the should have been screened searching for that doe DON reported that the Lab personnel. An interview on 5/29/2 personnel and the no came was aware of the and screen. RN H in the screening process remember to complete personnel. Additional information An interview on 6/2/2 Administrator revealed locate any past documents	20 at 3:07 PM with Interim the lab personnel had ving the facility. The interim e previous lab personnel reening and the staff were cumentation. The Interim ere was not a binder for the 20 at 4:15 PM with RN I confirmed; lab personnel 0 were not the normal lab rmal lab personnel that he process and would stop reported they were aware of s and they had not	F8	80			

Facility ID: 410102

If continuation sheet Page 5 of 5





July 16, 2020

Barbara Dreyer, Administrator Wilber Care Center 611 North Main Wilber, NE 68465

#### CMS CERTIFICATION NUMBER: 285172

Dear Ms. Dreyer:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 6, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555

CV/kd





July 16, 2020

Jonathan Brandow, Administrator Wisner Care Center 1105 9th Street Wisner, NE 68791

### CMS CERTIFICATION NUMBER: 285151

Dear Mr. Brandow:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 6, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie Ellegt KNASN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986 (402) 471-3324, FAX: (402) 471-0555

CV/kd



### MIDWEST DIVISION OF SURVEY AND CERTIFICATION

July 15, 2020

Joseph Jay Colburn, Administrator York General Hearthstone P O Box 159, 2600 North Lincoln Avenue York, NE 68467-0159

CMS Certification No: 285131

Dear Mr. Colburn:

## SUBJECT: SURVEY RESULTS Cycle Start Date: June 26, 2020

## SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-20-All*, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

### SURVEY RESULTS

On June 26, 2020, the Centers for Medicare & Medicaid Services (CMS) completed a COVID-19 Focused Survey at York General Hearthstone to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was in substantial compliance with participation requirements and no deficiencies were cited. The findings from this survey are documented on the enclosed form CMS 2567.

No additional action is required on the facility's part.

## **QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES**

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at <u>QIO Program Website</u>: <u>https://qioprogram.org/covid-19</u>. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance

related to infection control. QIOs per state can be found at <u>Locate Your QIO</u>: <u>https://qioprogram.org/locate-your-qio</u>.

# **CONTACT INFORMATION**

If you have any questions please contact Lisa Hauptman, Principal Program Representative at (816) 426-2011.

Sincerely,

Lisa Hauptman

Lisa Hauptman Long Term Care Branch Survey & Operations Group Center for Clinical Standards & Quality CMS Kansas City

cc: NE DHHS Power/Grimes