STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285104	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE CARE CENTER OF PLATTSMOUTH	602 SOUTH 18TH STREET PLATTSMOUTH, NE 68048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 4 conducted with the facility Administrator. During the interview, a review of the CSIS sheets for Employees I, J, K, L, M, N and O dated 6/28/20 and 6/29/20 was completed. The facility Administrator confirmed there should have been follow up evaluations regarding employee temperatures and was not. J. Record review of the DSM Covid 19 sign in sheet dated 6-29-2020 at 11:25 AM revealed the DSM did not have a new or worsening cough. On 6-29-2020 at 1:05 PM an observation of the facility staff providing the lunch meal revealed the facility Dietary Services Manager (DSM) had a surgical mask on. The DSM started coughing in a hard deep manor exited through the kitchen. On 6-29-2020 at 1:08 PM an interview was conducted with the DSM. During the interview when asked 3 times if the cough was new, the DSM stated "yes". During the interview the DSM confirmed a possible sign or symptom of COVID 19 was a new or worsening cough. When asked what should have happened, the DSM reported the facility Administrator should have been notified and was not. On 6-29-2020 at 1:40 PM a follow up interview was conducted with the DSM. During the interview the DSM confirmed the cough was new. K. A record review of facility policy titled "Zones and PPE (personal protective equipment refers to protective clothing, gloves, goggles, facemasks designed to protect the wearer from spread of infection)" indicated that the policy was implemented on 6/22/20. The policy identified a "Gray Zone" (Transitional zone) for residents being transferred from the hospital/outside	F 880	hand hygiene. Education was provided to all housekeeping staff on cleaning high-touch areas such as light switches, call lights, doorknobs, and toilets/sinks to ensure sanitary conditions. All licensed and non-licensed nursing, housekeeping, and laundry staff will be in-serviced on the facility□s policy Infection Control. The Administrator hired an outside consultant to improve the facility□s infection control program within the facility. The Staff Development Coordinator or designee will oversee infection prevention and control education for all new hires. The employee COVID-19 sign-in sheet was restructured. Any symptoms will be called directly to the Administrator or designee. Education to all team members regarding proper PPE per CDC guidelines. Cleanable surface education signs placed in residents□ room or bathroom, for PPE reference guide Competency fair conducted on 8/4/2020 for PPE practice Education to the entire facility team members as follows:	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285104	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE CARE CENTER OF PLATTSMOUTH	602 SOUTH 18TH STREET PLATTSMOUTH, NE 68048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 5 facilities or homes but have no known exposure to COVID -19 are admitted to the Gray Zone. All staff who enter resident rooms in the Gray Zone are to wear the following PPE: gown, gloves, eye protection (face shield) and N95 masks a disposable respirator that is intended to filter particles out of the air you breathe). Observation on 6/29/20 at 12:20 PM revealed that Resident 2 resided in the facility Gray Zone. Observation on 6/29/2020 at 12:25PM revealed Employee Q entered Resident 2's room in the Gray Zone with the lunch tray wearing a surgical mask instead of an N95 mask. Interview on 6/29/2020 at 1: 10 PM with Employee Q revealed that surgical masks were the only masks available to staff. Observation on 6/29/2020 at 1:45 PM revealed Employee P took a mug of water into Resident 2's room wearing only a surgical mask for PPE. Interview on 6/29/2020 at 12:50 PM with Employee P revealed that all employees took a surgical mask at the beginning of their shift and no N95 masks were provided.	F 880	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 COVID-19- sign in education, all personal have been notified to contact administrator or designee with any sign or systems prior to entering. Doors remain locked until further notice. 5.How the corrective action(s) will be monitored to ensure the practice will not recur: The Infection Preventionist or designee is monitoring the 24□COVID-19 report to ensure that any resident/guest/team members with signs and symptoms of COVID-19 is immediately placed on transmission-based precautions or not allowed into the facility. Monitoring will continue daily for 3 months. 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	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE CARE CENTER OF PLATTSMOUTH	602 SOUTH 18TH STREET PLATTSMOUTH, NE 68048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6	F 880	from the audits/monitoring processes. Findings will be reported at the monthly QAA meeting for a minimum of 3 months. DON/Designee will present any negative findings for monthly review and recommendations to the QAPI committee.	

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Pete Ricketts, Governor

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 examp

  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:

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 NEW 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 https://dab.efile.hhs.gov/, 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 OSDABImmediateOffice@hhs.gov. If you have questions about using the DAB e-file System, please visit: https://dab.efile.hhs.gov/appeals/to_crd_instructions?locale=en.

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 this office.

Sincerely,

Connie F Vogt RN,BSN

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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Pete Ricketts, Governor

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 E Vogt RN,BSN

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

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Pete Ricketts, Governor

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 E Vogt RN,BSN

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

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Pete Ricketts, Governor

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 E Vogt RN,BSN

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

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Pete Ricketts, Governor

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 E Vogt RN,BSN

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

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Pete Ricketts, Governor

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 E Vogt RN,BSN

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

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

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

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285058	A. BUILDING _____ B. WING _____	04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CITY NURSING AND REHABILITATION	**7410 MERCY ROAD OMAHA, NE 68124**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on April 28, 2020. The facility was found not in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Facility census: 79 Sample size: 6	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		

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

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285058	A. BUILDING _____ B. WING _____	04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CITY NURSING AND REHABILITATION	7410 MERCY ROAD OMAHA, NE 68124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 1 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CITY NURSING AND REHABILITATION	7410 MERCY ROAD OMAHA, NE 68124

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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: Based on interview and record review, the facility failed to maintain an effective ongoing infection control program that identified, tracked, and trended infections including residents that had the potential to be affected by COVID-19. Specifically, the facility failed to: -Accurately track infections in February 2020, when a Resident (R1) developed [redacted] and the facility documented that R1 had a [redacted] -Accurately document the onset dates of infections for R3 and R4 in March, 2020. -Indicate the site of infections for R5 and R6, who had documented infections in March 2020. -Accurately document onset dates of the infections on the Infection Control Log for R1 and R2 who developed infections in the month of April 2020. -Ensure that ongoing trending of infections was completed, when the facility failed to complete any trending of March 2020 infections, and had not yet started trending of infections for April 2020 until 4/28/20. -Maintain an ongoing system to monitor the illnesses of employees, contractors, volunteers, or other people rendering services to the facility. This failure had the potential to affect all 79 residents that resided in the facility.	F 880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CITY NURSING AND REHABILITATION	7410 MERCY ROAD OMAHA, NE 68124

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F 880	Continued From page 3 Findings include: 1. Review of the Infection Control Log for the month of February 2020 documented that the facility logged 14 infections for the month. Of the 14 infections, two were indicated to have a diagnostic test completed. The facility failed to indicate if the other 12 infections had diagnostic testing completed, or if testing was not indicated. The facility failed to indicate if the resident's infections originated in the facility or in the community. The facility failed to document signs or symptoms of infection for any of the 14 infections. All 14 infections were treated with antibiotics, however, the facility failed to indicate on the Infection Control Log if the ordered antibiotic was appropriate to treat the infectious organisms or infectious process. The facility failed to document if any of the infections resolved, or were ongoing. The facility failed to document the individual resident locations for the residents documented on the Infection Control Log. The Infection Control Log for February 2020 documented that R1 developed a [redacted] on 2/14/20. Review of a nursing note in R1's chart, dated 2/28/20, documented that R1 readmitted to the facility following hospitalization for [redacted] The Infection Control Log failed to indicate that R1 experienced [redacted] during the month. 2. Review of the Infection Control Log for March 2020 revealed that the facility logged 23 infections for the month. The facility failed to indicate if any of the 23 infections received any	F 880		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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RIVER CITY NURSING AND REHABILITATION	7410 MERCY ROAD OMAHA, NE 68124

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F 880	Continued From page 4 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 on the Infection Control Log. The Infection Control Log for March 2020 documented that R5 and R6 required antibiotics to treat facility-acquired 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 on 3/17/20, R3 required antibiotics to treat [redacted] Review of R3's progress notes, dated 3/7/20, ten days prior, documented that R3 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 on 3/23/20, R4 required antibiotics to treat [redacted] which she contracted in the community. Review of R4's progress notes, dated 3/17/20, documented that R4 began antibiotics for [redacted] on 3/17/20, 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 infections for the month. The facility failed to indicate if any infections received any diagnostic	F 880		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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RIVER CITY NURSING AND REHABILITATION	7410 MERCY ROAD OMAHA, NE 68124

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F 880	Continued From page 5 testing. The facility failed to indicate if any of the infections resolved, or were ongoing. The facility failed to document individual resident locations for the residents documented on the Infection Control Log. The Infection Control Log for April 2020 documented that on 4/15/20, R1 experienced [redacted], and required antibiotic treatment. Review of R1's progress notes, dated 4/12/20, three days prior, documented that R1 experienced [redacted] The Infection Control Log for April 2020 documented that on 4/23/20, R2 experienced [redacted], and was sent to the emergency room from his [redacted] appointment. Review of R2's progress notes, dated 4/7/20, documented that R2 experienced an increased temperature of 100.4F, and was put on isolation precautions. Review of an additional progress note, dated 4/9/20, documented that R2 went to the hospital with [redacted]. The Infection Control Log failed to indicate R2's hospitalization for [redacted] or that he was isolated following an increased temperature. 4. The facility tracked employee absences related to COVID-19 for the month of April 2020, but failed to provide any additional documentation for the months of February 2020 and March 2020. 5. On 4/28/20 at 3:45pm, the Director of Nursing (DON) indicated that the facility failed to complete infection trending for the month of March, and that the facility failed to initiate trending of infections for the month of April 2020 until earlier in the day. The DON indicated that she was	F 880		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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RIVER CITY NURSING AND REHABILITATION	7410 MERCY ROAD OMAHA, NE 68124

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F 880	Continued From page 6 aware that trending of infections was to be an ongoing process. 6. On 4/28/20 at 4:15pm, the DON indicated that the facility failed to document all required applicable information for infections, including but not limited to signs and symptoms of infection, resolution dates of infections, and if diagnostic testing was completed. The DON indicated that ongoing trending of infections would begin in May 2020, and that the facility failed to timely complete infection trending in the past. The DON indicated that tracking of employee illnesses was limited to what was related only to COVID-19, and began in the month of April 2020. 7. The facility policy, dated 10/2018, titled "Infection Prevention and Control Program," documented: "3. Surveillance: A system of surveillance is utilized for prevention, identifying, resorting, investigating, and controlling infections and communicable disease for all residents, staff, volunteers, visitors, and other individuals providing services. . . "	F 880		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CITY NURSING AND REHABILITATION	**7410 MERCY ROAD OMAHA, NE 68124**

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E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on April 28, 2020. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6).	E 000		

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

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Pete Ricketts, Governor

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 E Vogt RN,BSN

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

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

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/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 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 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

cc:
NE DHHS
Powers/Grimes

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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

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 E Vogt RN,BSN

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

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Pete Ricketts, Governor

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 E Vogt RN,BSN

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

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Pete Ricketts, Governor

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 E Vogt RN,BSN

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

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Pete Ricketts, Governor

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 E Vogt RN,BSN

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

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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 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 QIO Program Website: https://qioprogram.org/covid-19. 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: https://qioprogram.org/locate-your-qio.

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

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Pete Ricketts, Governor

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 E Vogt RN,BSN

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

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Pete Ricketts, Governor

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 E Vogt RN,BSN

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

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

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

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Pete Ricketts, Governor

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 examp

  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:

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 NEW 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 https://dab.efile.hhs.gov/, 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: ROkcm
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 OSDABImmediateOffice@hhs.gov. If you have questions about using the DAB e-file System, please visit: https://dab.efile.hhs.gov/appeals/to_crd_instructions?locale=en.

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 this office.

Sincerely,

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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Pete Ricketts, Governor

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 E Vogt RN,BSN

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

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Pete Ricketts, Governor

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 E Vogt RN,BSN

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

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

Rita Raffety, Administrator
St. Joseph Rehabilitation & Care Center
401 North 18th 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 QIO Program Website: https://qioprogram.org/covid-19. 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: https://qioprogram.org/locate-your-qio.

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

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

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/qso-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 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

cc:
NE DHHS
Powers/Grimes

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Pete Ricketts, Governor

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 E Vogt RN,BSN

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

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Pete Ricketts, Governor

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 E Vogt RN,BSN

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

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

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 E Vogt RN,BSN

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
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CV/kd

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285102	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANTON HEALTH CENTER	**P O BOX 407, 301 17TH STREET STANTON, NE 68779**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in compliance with the Emergency Preparedness tag at E0024.	E 000		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

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 examp

  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:

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 NEW 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 https://dab.efile.hhs.gov/, 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 OSDABImmediateOffice@hhs.gov. If you have questions about using the DAB e-file System, please visit: https://dab.efile.hhs.gov/appeals/to_crd_instructions?locale=en.

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 this office.

Sincerely,

Connie F Vogt RN,BSN

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

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285102	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANTON HEALTH CENTER	**P O BOX 407, 301 17TH STREET STANTON, NE 68779**

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F 000	INITIAL COMMENTS References to Title 175 of the Nebraska Administrative Code, Chapter 12 "Regulations Governing Licensure of Skilled Nursing Facilities, Nursing Facilities, and Intermediate Care Facilities" have been included in the survey report as they apply to deficient practices identified.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

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F 880	Continued From page 1 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Licensure Reference Number 175 NAC 12-006.17B	F 880		

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F 880	Continued From page 2 Based on observations, interview, and record review; the facility failed to implement infection control precautions to prevent the spread of COVID-19 as: 1) residents on the Memory Care Unit (MCU-secured area used to protect and better meet dementia residents needs and to address behaviors associated with dementia) did not maintain at least 6 feet distance between residents and/or wear masks (the facility reported 12 residents reside in the MCU); 2) staff failed to perform correct use and procedures for use of personal protective equipment (PPE) for residents in isolation; and 3) staff failed to perform appropriate handwashing and gloving. The sample size was 6 and the facility census was 56. Findings are: A. The Centers for Medicare and Medicaid Services (CMS) memorandum dated March 13, 2020 provided guidance for all facilities nationwide to 1) Cancel communal dining and all group activities, such as internal and external group activities, and 2) Remind residents to practice social distancing and perform frequent hand hygiene. B. The Center for Disease Control and Prevention (CDC) "Considerations for Memory Care Units in Long Term Care Facilities", updated May 12, 2020 stated that nursing homes providing memory care should 1) Try to keep environment and routines as consistent as possible while still reminding and assisting with frequent hand hygiene, social distancing, and use of cloth face coverings (if tolerated), and 2) limit the number of residents or space residents at least 6 feet apart as much as feasible when in a common	F 880		

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F 880	Continued From page 3	F 880		

area where resident and staff spend time, and carefully redirect residents who are ambulatory and are in close proximity to other residents.

C. On 6/30/20 at 9:35 AM surveyor entered the MCU (memory care unit), noted 2 staff members wearing masks and 3 residents unmasked sitting at a table all within 2 feet of each other. Two other residents were noted sitting in easy chairs in the commons area and were not wearing masks.

On 6/30/20 at 12:00 PM all MCU residents were observed sitting in the dining room of the MCU and staff were serving the residents lunch. No social distancing noted. Three tables were present in the room with 5 residents at one table, 3 residents at one table, and 4 residents at one table all sitting within 2 feet or another resident.

An interview on 6/30/20 at 9:40 AM with Medication Aide (MA)-A confirmed that MCU residents were not being monitored for or encouraged to social distance and continued to have communal dining.

D. On 6/30/20 at 10: 15 AM NA-G removed a used face mask and placed it in the clean isolation caddy located on Resident 3's door, and on top of the clean garbage bags located in the caddy. The Director of Nursing (DON) prompted the NA-G to retrieve the face mask from the isolation caddy and instructed NA-G to "put it in your pocket" which NA-G did and entered Resident 3's room.

E. On 6/30/20 at 11:40 AM Housekeeper-E was noted to be in the hallway with cleaning cart. Housekeeper-E was wearing gloves, gathered

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F 880	Continued From page 4 some cleaning supplies and entered a resident room, upon leaving the room the gloves were removed and disposed of, new clean gloves were put on without washing or sanitizing hands and Housekeeper-E proceeded to enter the next resident room for cleaning. F. On 6/30/20 at 11:45 AM NA-F was observed standing in the doorway of Resident 1's room (who was on isolation) and put on a gown that was handed to NA-F by NA-G from the hallway. NA-F entered the room, retrieved a face shield from a zip lock bag, and put on the face shield. NA-F grabbed the dirty laundry from the bin within the resident room, but then set the dirty laundry bag back into the bin when NA-G reported that the receiving laundry bin was "overflowing". NA-F then grabbed a clean laundry bag from the isolation caddy on the resident's door without changing gloves or sanitizing hands. NA-F lifted the dirty laundry from the bin and placed a new laundry bag in the bin. NA-F waited approximately 3 minutes and when no one came to assist, removed the face shield and placed it back into a zip lock bag. NA-F then removed the gown and gloves and place them in the laundry and trash receptacles, picked up the soiled laundry bag along with the baggie (containing the dirty face shield) rubbing up against the dirty laundry bag. NA-F left the resident room without washing or sanitizing hands. NA-F carried the laundry bag with the baggie continuing to rub against it, to a storage area to dispose of it. The laundry receptacle was full. After waiting for assistance for approximately 3 minutes, no one arrived so NA-F set the bag down, returned to the facility hallway, went into a bathing area currently being utilized for supplies and placed the baggie containing the dirty face shield into an unlabeled	F 880		

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F 880	Continued From page 5 box containing 6 other baggies with masks and face shields in them. NA-F then washed hands and left the room. G. An interview with the DON on 6/30/20 at 12:45 PM confirmed: 1) Hand hygiene should be performed before and after gloving; 2) Used face masks and face shields should not be placed on clean surfaces or in staff pockets, and 3) Soiled face shields need to be discarded or properly disinfected and not stored with clean face shields.	F 880		

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/qso-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 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 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

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

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

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285232	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE COUNTRY MANOR	**PO BOX A, 610 224TH STREET MILFORD, NE 68405**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted by Healthcare Management Solutions, LLC on behalf of the Centers for Medicare & Medicaid Services (CMS) on 5/18/2020 - 5/19/2020. The facility was found not to be in substantial compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Survey Census: 67 Sample Size: 5 Supplemental: 0	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		

LABORATORY D RECTOR'S OR PROV DER/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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 1 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 2 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure visitors complied with infection control screening procedures and staff screenings were reviewed to rule out any possible communicable disease signs and/or symptoms prior to working with the residents. This screening failure had the potential to expose any of the 67 people residing in the facility and/or staff members working to possible communicable diseases. Findings include: Observation on 5/18/2020 at 1:25 PM showed Hospice Registered Nurse (RN) enter the locked entrance door code, enter the facility, stop at the visitor and staff screening table and fill out the visitor screening form. Hospice RN then left the area and entered Room 102 without taking a temperature. In an interview on 5/18/2020 at 1:30 PM, Hospice RN stated she wrote down her "temperature from earlier today." In an interview on 5/18/2020 at 1:35 PM, the Director of Nursing (DON) stated staff and contractors taking their own temperature was okay but using a temperature from another time was not acceptable.	F 880		

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F 880	Continued From page 3 Observation of the screening table on 5/18/2020 at 1:47 PM showed a food delivery person enter the locked entrance door security code and enter the building. The delivery person stood at the screening table and waited until someone came to the desk to pick up/pay for the food, then exited the building. In an interview on 5/19/2020 at 12:16 PM, the Infection Preventionist RN (IP) stated the employee screening logs are reviewed by her "when I get here and before I leave." At 12:20 PM, the IP clarified her normal hours were 7:00-7:30 AM to 4:00-4:15 PM five days per week. Review of the facility policy "Coronavirus Disease (COVID-19) - Facility Entrance Screening," dated 5/2020, stated: " ...ENTRY PROCEDURE: Entrance to the facility will be restricted to essential facility staff and contract workers (exceptions may be made for end of life). All doors to the facility will remain locked. A keypad at the main entrance will be available for essential workers. The keypad code will be changed at least monthly or with any observed noncompliance. All individuals entering the facility are required to pass through a screening station prior to entry. The screening station will be comprised of the following: -Hand sanitizing stations -Temperature check -Screening questionnaire regarding COVID-19 exposure and symptoms -Facemask distribution area Essential staff whose temperature is above 100 degrees Fahrenheit or that answer YES to any of	F 880		

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F 880	Continued From page 4 the known exposure or symptom screening questions are instructed to go outside and contact charge nurse, infection preventionist, or DON for further instruction. The screening station will be monitored by the infection preventionist upon arrival and departure as well as randomly throughout the day. (Weekends will be monitored at the same frequency by the charge nurse)." Review of the three-ring binder with the employee self-screening logs dated 5/17/2020 (a Sunday), 5/18/2020, and 5/19/2020 showed the initials of the IP in the lower right corner of the page. In an interview on 5/19/2020 at 3:14 PM regarding the employee self-screening logs, the IP confirmed there was no documentation that the weekend Charge Nurse reviewed the logs and stated, "The Charge Nurse may not have done it, I can't say for sure. When I come in, I still go over it." The IP continued to clarify that she reviewed the 5/17/2020 Sunday form "Yesterday [Monday]. As a general rule, when I come in every Monday, I grab them all to review." When asked if there is documentation regarding what is reviewed, the IP stated "No, I don't make any notes. [DON's name], [Administrator's name], and I talk about it, but I don't know that anybody takes notes."	F 880		

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E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Centers for Medicare & Medicaid Services (CMS) on 5/18/2020 - 5/19/2020. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6).	E 000		

LABORATORY D RECTOR'S OR PROV DER/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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285277	A. BUILDING _____ B. WING _____	07/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUTTON COMMUNITY HOME, INC.	1106 NORTH SAUNDERS SUTTON, NE 68979

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS References to Title 175 of the Nebraska Administrative Code, Chapter 12- "Regulations Governing Licensure of Skilled Nursing Facilities, Nursing Facilities, and Intermediate Care Facilities" have been included in survey report as they apply to deficient practices identified.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		7/23/20

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically 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.

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F 880	Continued From page 1 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Licensure reference number 175 NAC 12-006.17	F 880	Residents did not experience any negative outcomes as none of the	

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SUTTON COMMUNITY HOME, INC.	1106 NORTH SAUNDERS SUTTON, NE 68979

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F 880	Continued From page 2 Based on observations, interviews and record reviews, the facility failed to implement infection control practices and Centers for Medicare and Medicaid Services (CMS) guidelines to prevent potential cross contamination including the spread of COVID-19 (a mild to severe respiratory illness that is caused by a coronavirus) the facility failure to verify screening results for facility employees, failure to ensure the screening sheets contained full staff identifying information including first and last names and titles, failure to ensure follow up of symptoms indicated on screening sheets and failure to prevent self screening. The facility failure had the potential to affect all residents in the building. The facility identified a census of 25. Findings are: A. A record review of the Covid-19 Staff Symptoms Evaluation sheet (SSE, a screening tool for Covid-19 symptoms and exposure) dated 07/03/20 for Employee A revealed no temperature was documented prior to allowing Employee A to work. Further review of the SSE for Employee A revealed there was no evidence of a follow up evaluation prior to allowing Employee A to work. B. A record review of the SSE dated 07/02/20 for Employee B revealed an "x" documented in the columns indicating Covid-19 exposure and a fever. Further review of the SSE for Employee B revealed there was no evidence of a follow up evaluation prior to allowing Employee B to work. C. A record review of the SSE dated 07/01/20 for Employee C revealed the SSE had been left	F 880	residents have had any signs or symptoms throughout the building. Screening of all employees is conducted before the employee's shift begins by nursing staff to assure residents are protected against any symptomatic employee. Self screening will not be allowed. If any symptoms are shown, the employee will be sent home immediately and Infection Control nurse or charge nurse will follow up with employee later in the day and if still symptomatic will be sent to either Clinic or Test Nebraska for a Covid test to be completed. Sutton Community Home will ensure that no residents come in contact with any symptomatic employee by all employees being screened before their shift by a member of the nursing staff. Screening will take place at the west entrance prior to employee clocking in for their shift. Any symptom responses of concern will be brought immediately to the charge nurse on duty by the nurse doing the screening. Self screening is not allowed. Any staff that have any "out of the ordinary" symptoms will be immediately sent home and will be followed up by the Infection Control nurse or charge nurse within that day of being sent home and if still symptomatic will be sent to either the Clinic or Test Nebraska for a Covid test to be completed. Employee will not return to work until Covid test results are in and negative. If Employee tests positive, employee will not be allowed to return to work until the employee tests negative	

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F 880	Continued From page 3 blank regarding Covid-19 symptoms. Further review of the SSE for Employee C revealed there was no evidence of a follow up evaluation prior to allowing Employee C to work. D. A record review of the SSE dated 07/01/20 for Employee D revealed the SSE had been left blank regarding Covid-19 symptoms. Further review of the SSE for Employee D revealed there was no evidence of a follow up evaluation prior to allowing Employee D to work. E. A record review of the SSE dated 07/01/20 for Employee E revealed Employee E had indicated having a headache. Further review of the SSE for Employee E revealed there was no evidence of a follow up evaluation prior to allowing Employee E to work. F. A record review of the SSE dated for the Director of Nursing (D.O.N.) indicated the D.O.N. had completed their own screen. G. On 07/06/20 at 12:00 P.M. an interview was conducted with the facility D.O.N.. During the interview, a review of the SSE sheets for Employees A, B, C, D, and E was completed. The facility D.O.N. confirmed there should have been follow up evaluations regarding employee symptoms and was not. H. On 07/06/20 at 12:00 P.M. an interview was conducted with the facility Administrator and the facility D.O.N.. During the interview, a review of the SSE for the D.O.N. dated 6/26/20 was completed. The facility D.O.N. confirmed that self screening had occurred	F 880	twice with tests being at 24 hrs or more hours apart or per CDC guidelines for return to work. All Staff have viewed the 5 CMS DPOE videos. Charge Nurse will review sheets each day to assure no symptomatic employees are or have been working. DON or designee will audit the staff screening sheets to assure all questions are being answered and documented appropriately as per guidelines. A copy of the audit sheet is attached. DON or designee will bring audit sheets to QAPI monthly for 3 months.	

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

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 examp

  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:

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 NEW 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 https://dab.efile.hhs.gov/, 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 OSDABImmediateOffice@hhs.gov. If you have questions about using the DAB e-file System, please visit: https://dab.efile.hhs.gov/appeals/to_crd_instructions?locale=en.

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 this office.

Sincerely,

Connie F Vogt RN,BSN

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

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

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 examp

  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:

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 https://dab.efile.hhs.gov/, 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 OSDABImmediateOffice@hhs.gov. If you have questions about using the DAB e-file System, please visit: https://dab.efile.hhs.gov/appeals/to_crd_instructions?locale=en.

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 this office.

Sincerely,

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

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285288	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABITHA AT THE LANDING	**6120 SOUTH 34TH STREET LINCOLN, NE 68516**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS References to Title 175 of the Nebraska Administrative Code, Chapter 12- "Regulations Governing Licensure of Skilled Nursing Facilities, Nursing Facilities, and Intermediate Care Facilities" have been included in survey report as they apply to deficient practices identified.	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		8/4/20

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically 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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 1 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Licensure Reference Number 175 NAC 12-006.17B	F 880	By 8/1/2020 all staff in the facility will have completed education on zoning	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 2 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. 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; 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 wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. Testing at the end of this period can be considered to increase certainty that the resident is not infected. Record review of Resident 1's electronic health record revealed the resident had admitted to the facility on [redacted]. Further review noted the following. Staff attempted to ambulate the resident out of the "Observation" or "Quarantine" room to the	F 880	definitions, processes to be followed when providing care to any resident in the residents designated zone and the Closely Monitoring Residents video was assigned by the Director of Nursing or designee. All staff were educated on when a resident resides in Transitional Zone (resident□s private room) resident will need to remain in the room for all activity. If a resident needs to leave the facility for a medical appointment, resident will need to have a facemask on while moving from their room (Transitional Zone) to exit the facility. Staff will ensure that no other residents are present in the hallway or immediate area while the resident is being transported to the nearest exit. Telehealth appointments will be set up when available. The charge nurse will complete rounds during their shift to observe the Transitional Zone resident and ensure compliance of remaining in rooms, the nurse will document the results of their findings on the provided auditing tool. Director of Nursing or Designee will monitor the documentation in the electronic health record and the audit performed by the nurse. The Director or Designee will report findings to the QAPI subcommittee team weekly, including trends &/or findings. Adjustments will be directed as deemed necessary by the QAPI subcommittee team. The QAPI team will review quarterly and will recommend continuation or	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 3 "Green" zone on 6/19/2020 but the resident refused. The resident was assisted to ambulate out of the "Observation" or "Quarantine" room to the "Green" zone on 6/20/2020 at 10:07 AM and 9 PM. 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 "Observation" or "Quarantine" room to the "Green" zone on 6/22/2020 at 9:57 AM and 9:08 PM. The resident was assisted to ambulate out of the "Observation" or "Quarantine" room to the "Green" zone on 6/23/2020 at 9:55 AM and 2:43 PM. The resident was assisted to ambulate out of the "Observation" or "Quarantine" room to the "Green" zone on 6/24/2020 at 9:50 AM and 6:19 PM. The resident was assisted to ambulate out of the "Observation" or "Quarantine" room to the "Green" zone on 6/25/2020 at 9:38 AM and 9:59 PM. The resident was assisted to ambulate out of the "Observation" or "Quarantine" room to the "Green" zone on 6/26/2020 at 10:15 AM and 9:11 PM. The resident was assisted to ambulate out of the "Observation" or "Quarantine" room to the "Green" zone on 6/27/2020 at 9:47 AM and 2:58 PM. The resident was assisted to ambulate out of the "Observation" or "Quarantine" room to the "Green" zone on 6/28/2020 at 10:34 AM and 7:52 PM. The resident was assisted to ambulate out of the	F 880	discontinuation of the study.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285288	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABITHA AT THE LANDING	**6120 SOUTH 34TH STREET LINCOLN, NE 68516**

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F 880	Continued From page 4 "Observation" or "Quarantine" room to the "Green" zone on 6/29/2020 at 10:31 AM and 6:13 PM. The resident was assisted to ambulate out of the "Observation" or "Quarantine" room to the "Green" zone on 6/30/2020 at 10:10 AM. Interview with NA 1 on 6/30/2020 at 3:50 PM revealed the staff member had assisted Resident 1 to ambulate in the room. NA 1 had not assisted Resident 1 out of the room as the resident is in isolation and should not be out of the room. Hospice had performed bed baths as the resident could not go to the whirlpool tub. When anxious Resident 1 enjoyed talking with family on the phone or working on a puzzle in the room. Interview with Director of Nursing on 6/20/2020 at 1:50 PM confirmed Resident 1 had left the "Observation/Quarantine" area multiple times and at various times of the day to go on walks in the facility. All other residents in the Harbor house were considered to be in the "Green" or Covid free area of the facility.	F 880		

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

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 examp

  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:

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 NEW 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 https://dab.efile.hhs.gov/, 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 OSDABImmediateOffice@hhs.gov. If you have questions about using the DAB e-file System, please visit: https://dab.efile.hhs.gov/appeals/to_crd_instructions?locale=en.

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 this office.

Sincerely,

Connie F Vogt RN,BSN

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

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285283	A. BUILDING _____ B. WING _____	07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABITHA NURSING CENTER AT CRETE	1800 EAST 13TH STREET CRETE, NE 68333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS References to Title 175 of the Nebraska Administrative Code, Chapter 12- "Regulations Governing Licensure of Skilled Nursing Facilities, Nursing Facilities, and Intermediate Care Facilities" have been included in survey report as they apply to deficient practices identified.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		7/29/20

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically 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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285283	A. BUILDING _____ B. WING _____	07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABITHA NURSING CENTER AT CRETE	1800 EAST 13TH STREET CRETE, NE 68333

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F 880	Continued From page 1 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Licensure Reference Number 175 NAC 12-006.17A	F 880	-How will corrective action be accomplished for those residents found to	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285283	A. BUILDING _____ B. WING _____	07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABITHA NURSING CENTER AT CRETE	**1800 EAST 13TH STREET CRETE, NE 68333**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observations, interviews and record reviews, the facility failed to implement infection control practices and Centers for Medicare and Medicaid Services (CMS) guidelines to prevent the potential spread of COVID by failing to ensure staff wore available N95 masks to provide care for residents admitted within the prior 2 weeks. The census was 35 and sample size was 6. A. Record review of direction from the Centers for Disease Control titled "Preparing for Covid-19 in Nursing Homes" dated June 25, 2020 revealed the following. Facilities should create a plan for managing new admissions and readmissions whose Covid-19 status is unknown. Health care personnel should wear an N95 or higher-level respirator if available, eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Review of a document titled "Tabitha Health Care Services Personal Protective Equipment (PPE) Status" dated July 7, 2020 revealed the following. The Tabitha Corporation had 10,565 N95 masks in stock for use in Green/Yellow/and Gray zones. The Tabitha Corporation had 1800 N95 masks in stock for Red zone use. Bulleted at the bottom of the form was the following "Green/Yellow/Transitional Zones are very close to 100%, and Supply Chain will order 3000 N95 masks and 3000 disposable gowns to reach full capacity." The form also directed that N95 masks "need to be used for red, yellow and gray zone activity." Review of an untitled document provided by the facility on 7/8/2020 concluded the facility would require 200 N95 masks per week.	F 880	have been affected by the deficient practice: Staff identified in this report, received training to ensure the proper procedures for wearing N95 masks and PPE for new admits for 14 days. The staff will wear a N95 mask, eye protection, gloves and gown when caring for any new admission for 14 days from date of admission. -How will the facility identify other residents having the potential to be affected by the same deficient practice: Training and education for all staff on proper Infection Control procedures with wearing of N95 masks for new admissions and continue with the proper PPE practices that are already in place. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: At least three unannounced observations will be conducted on proper use of N95 masks in the residences monthly. Variance on amount of observations will depend on number of residents in the transitional zone. -How will the facility monitor performance to make sure the solutions are sustained: At least three unannounced observations	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABITHA NURSING CENTER AT CRETE	1800 EAST 13TH STREET CRETE, NE 68333

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F 880	Continued From page 3 Review of N95 mask requests made from Tabitha of Crete to Corporate revealed requests of 20 masks were made on 5/8, 5/14, 6/11, 6/18 and 6/25. Requests of PPE were made on 5/21 but there were no requests of N95 masks made at this time. The total of all N95 requests made to Tabitha Corporate based upon information provided was a total of 100 N95 masks or the equivalent of a half week of the facility's reported need of N95 masks. Observation of therapy staff member A exiting transitional/gray room # 11 of house #2 at 10:27 AM on 7/8/2020 revealed the staff member had been wearing a surgical mask rather than an available N95 mask to provide care to Resident 2 who had admitted within the prior 2 weeks. Observation of facility Personal Protective Equipment storage on 7/8/2020 at 11:00 AM with Administrator and Director of Nursing (DON) revealed the facility had approximately 8 boxes of unused N95 or KN95 masks with 20 masks per box. Interview with LPN B on 7/8/2020 at 9:00 AM revealed the resident #2 was newly admitted as of [redacted] and remained in 2 weeks of isolation in a transition room. N95 masks were available but were not used in transitional rooms unless the resident would have tested positive. There was plenty of PPE. Staff were to wear a surgical mask, gown, goggles, and gloves when in a transitional room. Interview with RN C on 7/8/2020 at 10:20 AM revealed the difference between gray zones and transitional zones was that gray zones required	F 880	will be conducted on proper use of N95 masks in the residences monthly. Any identified areas of concern will be addressed immediately. The Director of Nursing (or his/her designee) will be responsible for the review, the results of the observations, and direct corrective action as needed. A summary of the audit findings will be submitted to the facilities Performance Improvement Team quarterly, including trends and/or corrective action. Adjustments will be directed as deemed necessary by the Performance Improvement committee. The Performance Improvement Committee will recommend continuation or discontinuation of the study.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285283	A. BUILDING _____ B. WING _____	07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABITHA NURSING CENTER AT CRETE	**1800 EAST 13TH STREET CRETE, NE 68333**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 4 N95 masks and transitional zones only required the use of surgical masks. Interview with the Infection Control Preventionist on 7/8/2020 at 10:40 AM revealed the facility wanted to use CDC guidance to not use N95 masks for new admissions as the facility has not been able to secure enough N95 masks required for transitional zones. The staff person didn't know the current number of N95 masks available at the facility. Supplies were ordered weekly from Corporate by the DON and Infection Control Preventionist. B. Observation on 7/8/20 at 10:21 AM revealed that NA D and NA E where wearing surgical masks and goggles and went into nurses' station and washed hands and then came out and put on gowns, gloves and went into Resident 1's room. Upon exiting Resident 1's room, both NA D and NA E removed gown and gloves and discarded them into trash container sitting by doorway inside of room. NA D and NA E then used hand sanitizer and then removed goggles and mask, then exited room and immediately outside room put on new surgical mask and pair of goggles and then went to nurses' station and washed hands.	F 880		

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

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 E Vogt RN,BSN

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

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

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 E Vogt RN,BSN

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

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

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 E Vogt RN,BSN

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

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

IMPORTANT NOTICE – PLEASE READ CAREFULLY

June 19, 2020

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

CMS Certification Number: 285127

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/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:
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

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285263	A. BUILDING _____ B. WING _____	C 05/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTFIELD QUALITY CARE OF AURORA	**PO BOX 166, 1313 1ST STREET AURORA, NE 68818**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS References to Title 175 of the Nebraska Administrative Code, Chapter 12- "Regulations Governing Licensure of Skilled Nursing Facilities, Nursing Facilities, and Intermediate Care Facilities" have been included in survey report as they apply to deficient practices identified.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		7/20/20

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 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.

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F 880	Continued From page 1 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Licensure Reference Number 175 NAC 12-006B	F 880	The facility denies that the alleged facts as set forth constitute a deficiency under	

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F 880	Continued From page 2 Based on observation, interview, and record review the facility failed; to follow implemented infection control practices and CMS (Centers for Medicare and Medicaid Services) guidelines to prevent potential cross contamination including the spread of COVID 19 (a highly contagious virus primarily spread from person to person through respiratory droplets, which can lead to serious illness and even death) related to lab personnel that were not screened upon facility entry and did not have PPE (Personnel Protective Equipment) masks in place per the facility practice. This had the potential to affect 1 resident 2 sampled (Resident 5). The facility census was 44. Findings are: AN observation on 5/29/20 at 1.50 PM revealed; LP (Lab Personnel) E and LP F had come to the nurse's desk after entering the building. LP E and F stood next to the screening station. It was observed that neither LP E nor LP F had a face mask during entry. LP-E gained information lab that required completion. LP E and F left the nurses station and entered the hallway for resident. Record review of Laboratory Results for Resident 5 revealed; the lab was drawn at 1:58 PM. Record review of Screening for LP (Lab Personnel) E dated 5/29/20 revealed; LP E had been screened at 2:00 PM. LP E had traveled from Omaha, had no symptoms, and was afebrile. LP E had contact with Covid 19. Record review of Screening for LP F dated	F 880	the interpretations of federal and state law. The preparation of the following plan of correction should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged, or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provision of state and federal law. Without waiving the forgoing statement, the facility states that regards to this citation: The Laboratory Personnel, in question, had been screened for COVID19 symptoms and known exposure that vary morning at Memorial Hospital prior to performing lab rounds at Westfield Quality Care of Aurora. Therefore, an extremely rare chance of any potential exposure to any residents of Westfield Quality Care of Aurora existed, which is the intent of all screening. All other records indicated that appropriate screening had taken place. To date, as of the receipt of this alleged deficiency 7-8-20, there are no new symptoms or positive tests of COVID19 at Westfield Quality Care of Aurora and since ALL residents and staff have been cleared of COVID19. The screening process in place has proven effective. The Laboratory Personnel were screened prior to the leaving the facility. They were screened by Westfield Quality Care of Aurora staff at 2:00PM. Many of the observations made by the survey team were made following the time that the laboratorians were screened.	

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F 880	Continued From page 3 5/29/20 revealed; LP F had been screened at 2:00 PM. LP F had not traveled, had no symptoms, and was afebrile. LP F had contact with Covid 19. Record review of Laboratory Result for Resident 4 revealed; the lab had been drawn at 2:22 PM. An observation on 5/29/20 at 2:02 PM of LP-E and LP-F in the front of the nurse's station without masks that were required in the resident areas. An interview on 5/29/20 at 2:02 PM with LP E confirmed; both LP-E and LP-F had not screened prior to drawing lab on a resident. They were unaware that there was a screening station and where the station was located. An interview on 5/29/20 at 2:03 PM with LPN (Licensed Practical Nurse) G revealed; LPN G was unaware that the lab personnel needed to fill out the paperwork on entry and be screened. The LPN reported there was a book for the Hospice and one for therapy, but was unaware if there was a book for the lab. An observation on 5/29/20 at 2:04 PM of the Screening station revealed; there was a binder that had Hospice and a binder for Therapy. An interview on 5/29/20 at 2:05 PM with the Interim DON (Director of Nurses) confirmed; lab personnel were to be screened on entry to the building. An observation on 5/29/20 at 2:30 PM of the 300 hall revealed; the hall had resident doors closed, staff had the N95 masks donned.	F 880	A laboratory personnel binder was prepared at the time of the incident where laboratorians are to sign-in upon arrival to the facility. Signs were posted at both entrances to the facility indicating that ANYONE entering the facility must be screened. Masks and hand sanitizer are available at both entrances to the facility. Nursing staff and laboratory staff have been educated on the need for and the process of screening the laboratory staff at the time of the incident. Additional education will be presented to staff on 7-15-20. Audits are being performed on the screening tools and follow-up by nursing should any outlier symptoms exist or reported travel present as a concern. These results are reporting to QA monthly.	

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F 880	Continued From page 4 An interview on 5/29/20 at 3:07 PM with Interim DON confirmed that the lab personnel had screened prior to leaving the facility. The interim DON reported that the previous lab personnel should have been screening and the staff were searching for that documentation. The Interim DON reported that there was not a binder for the Lab personnel. An interview on 5/29/20 at 4:15 PM with RN (Registered Nurse) H confirmed; lab personnel had come on 05/29/20 were not the normal lab personnel and the normal lab personnel that came was aware of the process and would stop and screen. RN H reported they were aware of the screening process and they had not remember to complete this with the lab personnel. Additional information provided by the facility: An interview on 6/2/20 at 2:36 PM with the Administrator revealed; the facility was unable to locate any past documentation related to Lab staff screening. Additional information provided by the facility	F 880		

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	285127	A. BUILDING _____ B. WING _____	06/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AMBASSADOR OMAHA	1540 NORTH 72ND STREET OMAHA, NE 68114

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 6/2/2020. The facility was found to not be in compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total residents: 80	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/13/2020

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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F 880	Continued From page 1 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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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: 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 screen staff, when the facility failed to ask CDC-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 wore disposable surgical facemasks, but failed to wear the masks appropriately. RN1 and RN2 each had their mask beneath their nose, leaving their noses exposed. Upon seeing the Federal surveyor, RN1 and RN2 pulled their facemasks over their noses. On 6/2/20 at 12:03pm, the Pediatrics Supervisor indicated that facemasks must be worn over the mouth and nose. The Pediatric Supervisor indicated that she was not aware of any issues with staff wearing facemasks inappropriately. On 6/2/20 at 12:17pm, RN1 and RN2 indicated that their facemasks had slipped beneath their noses. On 6/2/20 at 12:37pm, a housekeeper (H1)	F 880		

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F 880	Continued From page 3	F 880		

cleaned R1's room while R1 watched TV in the common area. H1 wore a disposable surgical facemask, however, H1's mask was pulled beneath her chin, leaving her mouth and nose exposed while she cleaned the room.

On 6/2/20 at 12:47pm, H1 indicated that she was too hot, so she pulled her mask down beneath her chin. H1 indicated that this was not appropriate mask wearing, and fixed her mask.

On 6/2/20 at 12:58pm, H1 swept R2's room, while R2 was present. H1 stood directly next to R2 and looked in the direction of R2's television, which played cartoons. H1's facemask was again pulled beneath her chin, leaving her mouth and nose exposed. H1 then exited the room and retrieved a dustpan, collected some floor debris, then exited R2's room. H1 failed to sanitize her hands after leaving the room and beginning to vacuum the hallway.

On 6/2/20 at 1:05pm, RN3 stood in R3's room and talked with the resident. RN3 wore a disposable surgical facemask, however, the mask was pulled down, leaving R3's nose exposed. Upon seeing the Federal surveyor, RN3 pulled her facemask over her nose.

On 6/2/20 at 1:22pm, RN3 indicated that her mask had slipped down, and that she had not fixed it yet. RN3 indicated that masks must be worn over the mouth and nose.

On 6/2/20 at 2:30pm, Licensed Practical Nurse (LPN1) indicated that facemasks must be worn over the mouth and nose at all times. LPN1 indicated that in the past, she had observed staff not wearing facemasks appropriately. This

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AMBASSADOR OMAHA	1540 NORTH 72ND STREET OMAHA, NE 68114

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 4	F 880		

happened occasionally, and LPN1 would complete on-the-spot education for staff who did not correctly wear their masks.

- Review of CMS guidance, dated 3/4/20, documented the following:

"How should facilities monitor or limit visitors? Facilities should screen visitors for the following:

1. International travel within the last 14 days to restricted countries. For updated information on restricted countries visit: https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html

2. Signs or symptoms of a respiratory infection, such as a fever, cough, and sore throat.

3. Has had contact with someone with or under investigation for COVID-19."

The guidance then stated:

"How should facilities monitor or restrict health care facility staff?

The same screening performed for visitors should be performed for facility staff (numbers 1, 2, and 3 above)."

On 6/2/20 at 11:15am, the Federal surveyor entered the facility. A receptionist sat at the desk. The Federal surveyor gave the reason and purpose for the visit, and the receptionist called the Director of Nursing (DON). The receptionist failed to screen the Federal surveyor. Approximately five minutes later, the DON arrived, and escorted the Federal surveyor to

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285127	A. BUILDING _____ B. WING _____	06/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AMBASSADOR OMAHA	1540 NORTH 72ND STREET OMAHA, NE 68114

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 5 floor 3R. The DON failed to screen the Federal surveyor. On 6/2/20 at 12:17pm, RN2 indicated that the facility screening process consisted of staff taking their own temperatures and logging the result. There were no screening questions to complete. On 6/2/20 at 12:28pm, the DON indicated that all floors in the facility were locked, so staff were either screened there or at the nursing stations, which were directly by the entry doors. Facility staff were to take their own temperatures and log them. The DON indicated that there were also screening questions staff were to complete. On 6/2/20 at 1:22pm, RN3 indicated that the facility screening process consisted of staff taking their temperatures and logging the result. Staff were asked if they had signs or symptoms of COVID-19, but there were no further screening questions. Review of staff screening sheets, dated 3/15/20 through the recent ones, documented facility staff had their temperatures taken, and answered a single question as to if they had signs or symptoms of a respiratory infection. There were no other screening questions present. The facility failed to provide any staff screening forms prior to 3/15/20.	F 880		

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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

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 E Vogt RN,BSN

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

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

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/qso-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 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

cc:
NE DHHS
Powers/Grimes

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Pete Ricketts, Governor

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 E Vogt RN,BSN

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

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Pete Ricketts, Governor

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 E Vogt RN,BSN

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

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Pete Ricketts, Governor

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 E Vogt RN,BSN

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

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
CMS Kansas City - Survey & Operations Group
601 East 12th Street, Room 355
Kansas City, Missouri 64106

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.

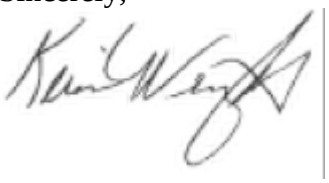
QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES
The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities

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 QIO Program Website: https://qioprogram.org/covid-19. 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: https://qioprogram.org/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

cc:
NE DHHS
Powers/Grimes

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Pete Ricketts, Governor

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 E. Vogt RN,BSN

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

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Pete Ricketts, Governor

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 E Vogt RN,BSN

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

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Pete Ricketts, Governor

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 examp

  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:

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 NEW 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 https://dab.efile.hhs.gov/, 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: ROkcm
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 OSDABImmediateOffice@hhs.gov. If you have questions about using the DAB e-file System, please visit: https://dab.efile.hhs.gov/appeals/to_crd_instructions?locale=en.

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 this office.

Sincerely,

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

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285263	A. BUILDING _____ B. WING _____	05/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTFIELD QUALITY CARE OF AURORA	**PO BOX 166, 1313 1ST STREET AURORA, NE 68818**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		7/20/20

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285263	A. BUILDING _____ B. WING _____	05/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTFIELD QUALITY CARE OF AURORA	**PO BOX 166, 1313 1ST STREET AURORA, NE 68818**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 1 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Licensure Reference Number 175 NAC 12-006B Based on observation, interview, and record review the facility failed; to follow implemented infection control practices and CMS (Centers for Medicare and Medicaid Services) guidelines to prevent potential cross contamination including the spread of COVID 19 (a highly contagious virus primarily spread from person to person through respiratory droplets, which can lead to serious illness and even death) related to lab	F 880	The facility denies that the alleged facts as set forth constitute a deficiency under the interpretations of federal and state law. The preparation of the following plan of correction should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged, or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provision	

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	285263	A. BUILDING _____ B. WING _____	05/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTFIELD QUALITY CARE OF AURORA	**PO BOX 166, 1313 1ST STREET AURORA, NE 68818**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 personnel that were not screened upon facility entry and did not have PPE (Personnel Protective Equipment) masks in place per the facility practice. This had the potential to affect 1 resident 2 sampled (Resident 5). The facility census was 44. Findings are: AN observation on 5/29/20 at 1.50 PM revealed; LP (Lab Personnel) E and LP F had come to the nurse's desk after entering the building. LP E and F stood next to the screening station. It was observed that neither LP E nor LP F had a face mask during entry. LP-E gained information lab that required completion. LP E and F left the nurses station and entered the hallway for resident. Record review of Laboratory Results for Resident 5 revealed; the lab was drawn at 1:58 PM. Record review of Screening for LP (Lab Personnel) E dated 5/29/20 revealed; LP E had been screened at 2:00 PM. LP E had traveled from Omaha, had no symptoms, and was afebrile. LP E had contact with Covid 19. Record review of Screening for LP F dated 5/29/20 revealed; LP F had been screened at 2:00 PM. LP F had not traveled, had no symptoms, and was afebrile. LP F had contact with Covid 19. Record review of Laboratory Result for Resident 4 revealed; the lab had been drawn at 2:22 PM. An observation on 5/29/20 at 2:02 PM of LP-E	F 880	of state and federal law. Without waiving the forgoing statement, the facility states that regards to this citation: The Laboratory Personnel, in question, had been screened for COVID19 symptoms and known exposure that vary morning at Memorial Hospital prior to performing lab rounds at Westfield Quality Care of Aurora. Therefore, an extremely rare chance of any potential exposure to any residents of Westfield Quality Care of Aurora existed, which is the intent of all screening. All other records indicated that appropriate screening had taken place. To date, as of the receipt of this alleged deficiency 7-8-20, there are no new symptoms or positive tests of COVID19 at Westfield Quality Care of Aurora and since ALL residents and staff have been cleared of COVID19. The screening process in place has proven effective. The Laboratory Personnel were screened prior to the leaving the facility. They were screened by Westfield Quality Care of Aurora staff at 2:00PM. Many of the observations made by the survey team were made following the time that the laboratorians were screened. A laboratory personnel binder was prepared at the time of the incident where laboratorians are to sign-in upon arrival to the facility. Signs were posted at both entrances to the facility indicating that ANYONE entering the facility must be screened.	

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F 880	Continued From page 3 and LP-F in the front of the nurse's station without masks that were required in the resident areas. An interview on 5/29/20 at 2:02 PM with LP E confirmed; both LP-E and LP-F had not screened prior to drawing lab on a resident. They were unaware that there was a screening station and where the station was located. An interview on 5/29/20 at 2:03 PM with LPN (Licensed Practical Nurse) G revealed; LPN G was unaware that the lab personnel needed to fill out the paperwork on entry and be screened. The LPN reported there was a book for the Hospice and one for therapy, but was unaware if there was a book for the lab. An observation on 5/29/20 at 2:04 PM of the Screening station revealed; there was a binder that had Hospice and a binder for Therapy. An interview on 5/29/20 at 2:05 PM with the Interim DON (Director of Nurses) confirmed; lab personnel were to be screened on entry to the building. An observation on 5/29/20 at 2:30 PM of the 300 hall revealed; the hall had resident doors closed, staff had the N95 masks donned. An interview on 5/29/20 at 3:07 PM with Interim DON confirmed that the lab personnel had screened prior to leaving the facility. The interim DON reported that the previous lab personnel should have been screening and the staff were searching for that documentation. The Interim DON reported that there was not a binder for the Lab personnel.	F 880	Masks and hand sanitizer are available at both entrances to the facility. Nursing staff and laboratory staff have been educated on the need for and the process of screening the laboratory staff at the time of the incident. Additional education will be presented to staff on 7-15-20. Audits are being performed on the screening tools and follow-up by nursing should any outlier symptoms exist or reported travel present as a concern. These results are reporting to QA monthly.	

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F 880	Continued From page 4 An interview on 5/29/20 at 4:15 PM with RN (Registered Nurse) H confirmed; lab personnel had come on 05/29/20 were not the normal lab personnel and the normal lab personnel that came was aware of the process and would stop and screen. RN H reported they were aware of the screening process and they had not remember to complete this with the lab personnel. Additional information provided by the facility: An interview on 6/2/20 at 2:36 PM with the Administrator revealed; the facility was unable to locate any past documentation related to Lab staff screening. Additional information provided by the facility	F 880		

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F 000	INITIAL COMMENTS References to Title 175 of the Nebraska Administrative Code, Chapter 12- "Regulations Governing Licensure of Skilled Nursing Facilities, Nursing Facilities, and Intermediate Care Facilities" have been included in survey report as they apply to deficient practices identified.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		7/20/20

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 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.

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F 880	Continued From page 1 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Licensure Reference Number 175 NAC 12-006B	F 880	The facility denies that the alleged facts as set forth constitute a deficiency under	

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NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

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 E Vogt RN,BSN

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

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

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 E Vogt RN,BSN

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

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 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 QIO Program Website: https://qioprogram.org/covid-19. 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: https://qioprogram.org/locate-your-qio.

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