STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285143	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH WAVERLY	**11041 NORTH 137TH ST WAVERLY, NE 68462**

(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 A COVID-19 Focused Emergency Preparedness Survey was conducted by the state agency. The facility was found not to be in compliance with 42 CFR483.73 related to E-0024 (b)(6).	E 000		
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by:	E 001		8/5/20

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/24/2020

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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E 001	Continued From page 1 Licensure Reference Number 175 Based on record reivew and interview the facility failed to ensure a Long- Term Care Covid-19 Phasing Plan was completed. This had the potential to affect all resident in the building. Record review of Covid-19 Phasing Plan dated 6/16/20 revealed that the facility did not have a facility created plan only using DHHS phasing guidance as there plan. An interview on 6/24/20 at 2:44PM with Administrator confirmed that the LTC COVID-19 PHASING Guidance from Department of Health and Human Services dated 6/15/20 is there Facility Phasing Plan.	E 001	Statement of Compliance: It is the intent of facility to ensure Long-Term Care Covid-19 Phasing Plan is completed. Correction to Resident(s) affected: Azria Waverly completed a COVID-19 Phasing plan on 6/19/20, this document was placed in the Covid Binder under tab 14 on 06/19/20. The facility completed the ICAR on 4/14/20. Policy Change/Re-education: Azria Waverly completed a COVID-19 Phasing plan on 06/19/20, this document was placed in the Covid Binder under tab 14 on 06/19/20. The facility Emergency Preparedness Plan was reviewed and revised by the Administrator on 07/17/20. Monitoring Process/Audits: Administrator or designee will audit plan for adherence to guidelines and implementation weekly for one month, then monthly for two months, then quarterly ongoing. Results of audits will be brought to monthly QAPI meeting for review and revision as needed.	

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

June 24, 2020

Ashley Johnson, Administrator
Azria Health Sutherland
P O Box 307, 333 Maple Street
Sutherland, NE 69165

CMS CERTIFICATION NUMBER: 285141

Dear Ms. Johnson:

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 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

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285130	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEATRICE HEALTH AND REHABILITATION	**1800 IRVING STREET BEATRICE, NE 68310**

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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=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		7/20/20

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

Electronically Signed | 07/11/2020

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	F880 A. Immediate Change:	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEATRICE HEALTH AND REHABILITATION	1800 IRVING STREET BEATRICE, NE 68310

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F 880	Continued From page 2 Based on observation, interview and record review; the facility failed to ensure Personal Protective Equipment was not worn from Gray Zone (A Transitional zone where residents who are being transferred from the hospital/outside facilities are usually kept in this zone for 14 days and if remain asymptomatic will be moved to Green Zone) to Green Zone (Covid-19 free zone) areas of resident care. The facility also failed to ensure that staff were not screening themselves upon entry into the facility which had the potential to expose residents to ill staff. These had the potential to affect all residents. The facility census was 65. A. At 10:00 AM on 6/22/2020 LPN A was observed assisting a Gray zone resident with a [redacted] The LPN was wearing an N95 mask during the provision of these cares. At the end of these cares all Personal Protective Equipment was removed except for the N95 mask which remained on. At 10:15 AM on 6/22/2020 LPN A was observed walking down the Green Zone hallway adjacent to the Gray Zone wearing the same N95 mask that had been worn caring for Gray Zone resident. Interview with LPN A at 10:18 on 6/22/2020 revealed staff were to wear the same N95 mask to care for Gray Zone residents and then care for Green Zone residents. Goggles are worn when caring for Gray zone residents which do not cover the mask. Interview with NA B at 11:00 AM on 6/22/2020 revealed staff wear the same N95 mask to care for Gray Zone residents and then care for Green	F 880	No specific resident identified. On 6/23/20 all goggles were replaced with face shields in the gray isolation zone. On 6/23/20 the Infection Control nurse replaced droplet signs outside of grey zone room. New signs list required PPE to include face shields instead of goggles. Potential to affect 65 residents. System Change: On 7/9/20 the DON updated facility Covid Infection Control policy to implement use of face shields instead of goggles in the grey zone. Update in this policy allows N95 to be worn in various zones without being changed. The DON provided education to staff in all departments. Education included change in policy to use face shields in isolation zones, proper removal and disinfecting of face shields prior to transitioning to other zones. To meet DPOC requirements, all staff have been assigned to complete the online "Lessons" (https://youtu.be/YYTATw9yav4) video. Completion date will be 7/20/20. Video viewing completion signature sheet will be uploaded to ePOC upon completion on 7/20/20. Monitoring: The Infection Control nurse or designee will audit 5 care transitions from staff leaving gray zone rooms to ensure face shields were worn and removed prior to transition of care in a green zone room. 5 audits weekly x 12 weeks	

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F 880	Continued From page 3 Zone residents. Goggles are worn when caring for Gray zone residents which do not cover the mask. Interview with the Director of Nursing and Infection Control and Preventionist at 1:26 PM on 6/22/2020 revealed N95 masks are worn throughout the facility. A staff person can care for a resident in a Gray Zone and move on to care for residents in the green zone wearing the same N95 mask. Review of an Infection Control Assessment and Promotion Program (ICAP) form revised 4/20/2020 revealed the following. If staff has to work in multiple zones, it will be preferred that they plan ahead and batch all the care-giving activities together in a way that they finish the work in one zone, to the extent possible, before moving on to the next zone. (Note: Extended use and reuse of PPE is not recommended when moving from red zone to yellow zone or yellow zone to green zone. Follow infection prevention and control procedures very strictly to avoid transmission between zones). B. Observation on 6/22/20 at 2:15pm revealed 2 evening staff members to be at nurse's station right next to entry door of facility, both staff members had a surgical mask on. Observed first staff member to take thermometer and take own temperature and write it down on log sheet in notebook. At this time there was a staff member in the nurses station but they were not paying attention to the staff who were screening. After first staff member finished, then staff member went down hallway of facility, the second staff member then checked own temperature and no other staff were present at the nurses station at	F 880	Results from above audits will be reported to the QAPI committee monthly x 3 months or until substantial compliance is determined. B. Immediate Change: On 6/23/20 at approximately 2:40 pm the Infection Control nurse verified that staff members who screened at 2:15pm were afebrile and asymptomatic. Potential to affect 65 residents. System Change: On 6/24/20 the DON initiated education to staff on the following screening requirements; all staff will be checked in by another staff member which includes the interview questions of any current symptoms or visit of COVID areas as well as taking that employee's temperature. An additional column was inserted at the end of the sign-in log to include the initials of staff member that executes the necessary interview and temp taken. Monitoring: The Infection Control nurse or designee will audit staff screening process 5 x week x 12 weeks to verify individual staff are not completing self-screening to prevent symptomatic staff or visitors from being in the facility. The results from the above audits will be reported to the QAPI committee monthly x 3 months or until substantial compliance is achieved.	

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F 880	Continued From page 4 this time. Second staff person then wrote information on the log sheet and then went down hallway of facility. Interview on 6/22/20 at 2:35pm with ADON/Infection Control Preventionist revealed that facility has staff self-screen when they come into facility for their shift. States that the staff have been educated about reporting if temp is greater than 100 degrees and if they answer yes to any questions that they are to find the DON or ADON and they aren't available then a charge nurse. Review of QSO-20-14-NH memo instructs facilities to implement active screening of residents and staff for fever and respiratory symptoms and to screen all staff at the beginning of their shift for fever and and respiratory symptoms. Actively take their temperature and document absence of shortness of breath, new or change in cough, and sore throat. Review of Infection Control Assessment and Promotion Program (ICAP) form revised 4/20/2020 revealed the following; initiate temperature and symptoms screen (for COVID-19) for anyone entering into the facililty and symptomatic individuals should not be allowed in the facility.	F 880		

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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 2, 2020

Spencer Morris, Administrator
Beatrice Health And Rehabilitation
1800 Irving Street
Beatrice, NE 68310 **CMS Certification No. 285130**

Subject: Survey Results
Cycle Start Date: June 23, 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 23, 2020, a survey was completed at Beatrice Health And Rehabilitation 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 12, 2020**, to the State Survey Agency Contact. **Failure to submit an acceptable PoC by July 12, 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 16, 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 23, 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
	285269	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAVER CITY MANOR	**P O BOX 70, 905 FLOYD STREET BEAVER CITY, NE 68926**

(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		7/10/20

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

Electronically Signed | 07/10/2020

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
	285269	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAVER CITY MANOR	**P O BOX 70, 905 FLOYD STREET BEAVER CITY, NE 68926**

(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 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	STATEMENT OF COMPLIANCE: This facility denies that the alleged facts as set	

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F 880	Continued From page 2 Based on observation, interview, and record review; the facility staff failed to implement Infection Control Practices and CMS (Center for Medicare and Medicaid Services) guidelines to protect 2 of 4 sampled resident (Resident 1 and Resident 2) from potential harm from cross contamination from the Covid-19 virus related to both residents being admitted to the same room who had a suspected exposure to Covid-19. The facility failed to provide hydration to residents at meal time in a safe sanitary manner to prevent contamination by not having the cups covered which had the potential to affect all of the residents. The facility census was 28 at the time of the survey. Findings are: A. On 6/22/2020 at 12:15 PM during a brief safety tour of the facility it was observed that an isolation cart was located in the hallway by the doorway to Room 115. On 6/22/2020 at 12:17 PM an observation was made, when the door was opened, neither of the residents in the room were wearing a face mask. An interview on 6/22/2020 at 2:50 PM with the ADM (Administrator) revealed that Resident 1 was admitted on [redacted]. The ADM confirmed that Resident 2 who had gone to the [redacted]. Review of the EHR (Electronic Health Record) for Resident 2 revealed that Resident 1 had been in Room 104 and was discharged to the [redacted] where Resident 2 had received	F 880	forth constitute a deficiency under the interpretations of federal and state law. The plan of correction prepared for this deficiency was executed solely because it is required by provision of state and federal law. Without waving the foregoing statement the facility states that with regards to the following tag: F880-Infection Prevention & Control Correction to Residents Affected: Education was provided to dietary aide working regarding infection control procedures, specifically relate to transporting drinks in the hallway. Resident 1 and Resident 2□s 14 isolation period ended on 06/24/20. Resident 2 was moved on 06/24/20 to a separate room. System Changes (Identification and Correction for Other Residents Potentially Affected): The facility has determined that all residents have the potential to be affected. To protect residents in similar situations the Dietary Manager reeducated all dietary employees on infection control procedures, specifically regarding proper transportation of drinks in the hallway. Education was completed on or before 06/26/20. The facility has determined that all residents have the potential to be affected. To protect residents in similar situations the facility's Novel Coronavirus Prevention and Response Policy was	

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F 880	Continued From page 3 [redacted] Resident 2 was also receiving upon and after Resident 1's return [redacted] Review of the EHR (Electronic Health Record) for Resident 1 revealed Resident 1 did not need nor receive [redacted]. Review of the progress notes for Resident 1 revealed that resident 1 went to a doctor's appointment on 6/8/2020 which was day 11 of Resident 1's 14 day isolation which would have ended 6/11/2020. This extended Resident 1's isolation period another 14 days. Review of the progress notes for Resident 2 revealed that Resident 2 returned from the [redacted] and was placed into [redacted] due to being a readmission with a potential suspected exposure to Covid-19. Review of the CDC (Centers for Disease Control and Prevention) Coronavirus Disease 2019 guideline Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings dated June 19, 2020 revealed page 7 of 13 revealed, "If admitted, place a patient with suspected or confirmed SARS-COV-2 (the virus that causes Coronavirus Disease) infection in a single-person room with the door closed. The patient should have a dedicated bathroom.	F 880	updated to reflect guidance given by CMS Coronavirus Disease 2019 guideline Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings dated 06/19/20. Specifically, any resident requiring isolation will be moved to a single occupant room for the duration of isolation period. Monitoring Process for the System Change Including Frequency and Person Responsible: Dietary Manager or designee will complete an infection control audit three (3) times a week for four (4) weeks, weekly for four (4) weeks, and monthly for four (4) months. Any identified issues will be forwarded to the QAPI committee for additional follow up. Administrator and Director of Nursing Services will be responsible for ensuring resident□s in isolation are in a private room. Room assignments will be reviewed weekly during the weekly risk meeting for 12 weeks and any issues that are identified will be forwarded to the QAPI committee for additional follow up.	

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F 880	Continued From page 4 Review of the CDC (Centers for Disease Control and Prevention) Coronavirus Disease 2019 guideline Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings dated June 19, 2020 revealed page 10 of 13 revealed, "Aerosol Generating Procedures; Some procedures performed on patients with suspected or confirmed SARS-COV-2 (the virus that causes Coronavirus Disease) infection could generate infectious aerosols. Procedures that pose such risk should be performed cautiously and avoided if possible. If performed, the following should occur: -The HCP (Healthcare Personnel) in the room should wear an N95 or equivalent or higher-level respirator, eye protection, gloves, and a gown. -The number of HCP present during the procedure should be limited to only those essential for patient care and procedure support. Visitors should not be present for the procedure. Review of the CDC (Centers for Disease Control and Prevention) guideline dated 6/5/2020; Healthcare Infection Prevention and Control FAQs (Frequently Asked Questions) for COVID-19 revealed page 3 of 11 for the question: Is a negative test for SARS-CoV-2, the virus that causes COVID-19, required before a hospitalized patient cab be discharged to a nursing home? The answer was No, a patient hospitalized for non-COVID-related illnesses whose COVID-19 status is not known can be transferred to a nursing home without testing. However, to ensure they are not infected, nursing homes should place the resident in Transmission-based Precautions in a separate observation area or in a	F 880		

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F 880	Continued From page 5 single-person room until 14 days have elapsed since admission. B. On 6/22/2020 at 5:40 PM the observation of drinks which consisted of juice and milk, were on a 3 tier cart in the hallway revealed the cup tops were uncovered and debris and contaminants could enter the beverages. None of the drinks were placed on ice to keep them cold until the residents received them. The drink were set up prior to them being brought down the hallway on the cart uncovered. An interview on 6/22/2020 at 5:43 PM with DA-B (Dietary Aide) revealed that the drinks were uncovered and not placed on ice to keep the cold. The drinks were brought from the kitchen through the dining room were some residents and staff were waiting for the dinner meal to be served. On 6/22/2020 at 5:55 PM an interview with the ADM revealed the drink when brought out to the resident's rooms at meal times are to be covered until placed in front of the residents.	F 880		

NEBRASKA
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Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 1, 2020

Angela Woodring, Administrator
Beaver City Manor
P O Box 70, 905 Floyd Street
Beaver City, NE 68926-0070 **CMS Certification No. 285269**

Subject: **Survey Results**
Cycle Start Date: June 23, 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 23, 2020, a survey was completed at Beaver City Manor 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 23, 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 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

Enclosures: CMS 2567

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

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Pete Ricketts, Governor

April 27, 2020

David Young, Administrator
Belle Terrace
1133 North Third St
Tecumseh, NE 68450

Dear Mr. Young:

An offsite investigation was conducted to investigate a complaint at Belle Terrace on April 9, 2020-April 14, 2020, by representatives of the Department of Health and Human Services Division of Public Health. The investigative process included review of facility and resident records and interviews with staff.

ALLEGATION:
The facility fails to implement CMS directives related to COVID-19.

FINDINGS:
The facility did follow CMS (Centers for Medicare and Medicaid) protocol for COVID-19 prevention. Interviews with Administrative staff revealed the facility implemented interventions for staff and resident protection without concerns. Record review of facility submitted documents revealed staff had completed education related to COVID 19 and were aware of the facility protocol for staff and residents. The facility was found to be in compliance with relevant regulatory requirements

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

August 14, 2020

Samantha Jones, Administrator
Belle Terrace
1133 North Third St
Tecumseh, NE 68450

CMS CERTIFICATION NUMBER: 285237

Dear Ms. Jones:

This is to acknowledge the results of the Infection Control survey conducted at your facility on April 14, 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

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285237	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLE TERRACE	1133 NORTH THIRD ST TECUMSEH, NE 68450

(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 728 SS=F	Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual-	F 728		

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

Electronically Signed

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

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F 728	Continued From page 1 (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 6 Staff Members (Staff Members G, H, I, J, K, and L) working in the facility as nurse aides were provided training and assessed for competency. This had the potential to affect all residents residing in the facility. The facility had a total census of 46 residents. The findings are: A review of Active Employee Listing provided by the facility revealed Staff Members G, H, I, J, K, and L were identified as temporary nurse aides. A review of facility training documentation did not reveal any training documentation or competency assessments related to nurse aide duties for Staff Members G, H, I, J, K, and L. In interviews on 6/23/20 at 1:17 PM and 1:50 PM the DON (Director of Nursing) reported facility was unable to locate any documentation of training or competency assessments for Staff Members G, H, I, J, K, and L. The DON confirmed Staff Members G, H, I, J, K, and L had been working with residents performing all nurse aide duties.	F 728		
F 880	Infection Prevention & Control	F 880		

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F 880 SS=F	Continued From page 2 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	F 880		

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F 880	Continued From page 3 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 Numbers 175 NAC 12-006.17A and 12-006.17B Based on observation, interview, and record review; the facility failed to implement staff and resident screening for COVID-19 in accordance with CMS guidelines, failed to ensure that staff did not screen themselves for signs and symptoms of COVID-19, failed to prevent potential cross-contamination related to proper	F 880		

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F 880	Continued From page 4 PPE (Personal Protective Equipment) usage in isolation rooms and proper hand hygiene after resident contact and failed to place 1 resident (Resident 9) receiving [redacted] This had the potential to affect all residents residing in the facility. The resident sample was 11. The facility had a total census of 46 residents. The findings are: Implementing Staff/Resident Screening A. A review of CMS Memo QSO-20-14-NH, last revised 3/13/20 revealed the following guidance for nursing homes: "2. Implement active screening of residents and staff for fever and respiratory symptoms. 4. Screen all staff at the beginning of their shift for fever and respiratory symptoms. Actively take their temperature and document absence of shortness of breath, new or change in cough, and sore throat. If they are ill, have them put on a facemask and self-isolate at home." B. A review of facility documentation of staff screening of signs and symptoms related to COVID-19 did not reveal any documentation prior to 3/31/20. In an interview on 6/23/20 at 12:17 PM, the DON (Director of Nursing) confirmed the facility did not have any documentation of staff screenings prior to 3/31/20. C. A review of documentation provided by the facility of resident screenings for signs and symptoms related to COVID-19 did not reveal any	F 880		

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F 880	Continued From page 5	F 880		

documentation prior to 4/17/20. Documentation was not consistently done from 4/17/20 - 5/21/20 and there was no documentation of screening of COVID-19 symptoms from 5/21/20 - 6/22/20.

In an interview on 6/24/20 at 2:40 PM, the DON confirmed resident screenings for signs and symptoms related to COVID-19 were not done consistently prior to 6/23/20. The DON also reported the earliest documentation found for resident screening was on 4/3/20.

Staff Self-Screening

D. In an interview on 6/23/20 at 12:25 PM, the DON reported the off-going shift was to screen the staff for the on-coming shift for signs and symptoms of COVID-19.

In an interview on 6/23/20 at 11:00 AM, Staff Member G reported staff screen themselves in the vestibule and then alert a nurse if they have a fever or respiratory symptoms. Staff Member G stated if staff had a fever when checking their own temperatures in the vestibule they would wait for someone to walk in the door and get a nurse for them, as there is no way to call someone from the vestibule.

In an interview on 6/23/20 at 11:08 AM, LPN A reported the on-coming or off-going nurse would screen the staff coming on shift in the front vestibule.

Cross-Contamination/PPE Usage in Isolation Rooms

E. Observations on 6/23/20 between 10:45 AM and 1:45 PM revealed blue and green dots outside the doors of resident rooms.

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F 880	Continued From page 6 An observation on 6/23/20 at 11:19 AM of a sign hanging by the front entrance of the building revealed the following: "Attention Staff - Please date your masks! Masks are to be thrown away after 1 week, if soiled, or if you have gone into a quarantine/isolation room. Please be diligent on replacing your masks as needed." A review of a COVID Floor Plan provided by the facility revealed the following: -Designated COVID Positive Room was Room 201 (Red) -COVID Signs and Symptoms Rooms were Rooms 202, 203, 204 (Yellow) -Quarantine Rooms - Individuals Returning from Hospital, Asymptomatic (Blue) -Asymptomatic Residents Residing in Assigned Rooms (Green) An observation on 6/23/20 at 11:40 AM revealed MA (Medication Aide)-M exiting room 201 (a "blue-dot" room) wearing a procedure mask. MA-M then entered room 205 (a "green-dot" room) wearing the same mask, and then entered room 206 (a "green-dot" room) while still wearing the same mask. In an interview on 6/23/20 at 11:45 AM MA-M reported the resident in room 201 was in quarantine because of a recent [redacted] MA-M stated that the proper PPE for quarantine rooms was a facemask and gloves and a gown would be added if resident contact was going to be made. MA-A also confirmed MA-A wore the same mask in room 201, 205, and 206 and stated that staff do not change masks in between "blue-dot" rooms and "green-dot" rooms.	F 880		

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F 880	Continued From page 7 In an interview on 6/23/20 at 11:08 AM, LPN-A reported the only PPE required in "blue-dot" rooms was a mask and gloves. LPN-A also stated the same procedure mask was worn in "blue-dot" rooms as was worn by staff throughout the rest of the building and rooms. In an interview on 6/23/20 at 11:00 AM, Staff Member G reported the only PPE required in "blue-dot" rooms was a mask and gloves. Staff Member G stated the mask would be the same mask staff where everywhere else in the building and other rooms. An observation on 6/23/20 at 11:55 AM revealed Staff Member G entered room 110 (a "blue-dot" room) to answer a call light in a cloth mask and no other PPE. Staff Member G exited room 110 and then entered room 115 (a "green-dot" room) wearing the same cloth mask. In an interview on 6/23/20 at 2:25 PM, the DON confirmed there was a potential for cross-contamination with staff going into "blue-dot rooms" and "green-dot rooms" wearing the same masks. The DON also confirmed the staff were not wearing the correct PPE in isolation/quarantine (blue-dot) rooms. Hand Hygiene F. An observation on 6/23/20 at 2:50 PM revealed Staff Member I adjusted Resident 10's mask up on (gender) face. Staff Member I then adjusted (gender) own mask and went on to adjust Resident 11's mask up on (gender) face. No hand hygiene was ever performed.	F 880		

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F 880	Continued From page 8 G. Screening: Observation on 6/23/20 at 10:30 AM revealed a large sign on the front door which read: To all venders: Please complete COVID-19 self-screening at the entrance table before entering the building. If you have a temperature or respiratory symptoms do not enter. Interview on 6/23/20 at 10:40 AM with the facility Director of Nursing confirmed that the sign should not be there and venders are to be screened by staff. Interview on 6/23/20 at 10:45 AM with the facility Maintenance Supervisor revealed that staff screen themselves when they come in to work. They enter the front door, take their temperature and log it on the log sheet inside the exterior door. They also circle yes or no to a series of questions on the log. They are to perform hand hygiene with antiseptic hand wash and put a mask on at the start of the shift. The MS stated that if they have a temperature, they call the nurses and tell them before coming into the building. Interview on 6/23/20 at 11:00 AM with Housekeeper B revealed that at the start of the shift, the staff come in the front door and take their own temperatures and answer questions on the log. They document the temperature on the log and circle yes or no for the questions on the log. If they have a temperature, they are to call the charge nurse before coming into the building. Observation on 6/23/20 at 1:40 PM revealed NA C entered the exterior door of the facility into the	F 880		

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alcove between doors. NA C took a temperature on the forehead and logged those results on the log sheet on a table in the alcove. NA C answered the questions on the sheet, got a mask out of a set of masks on the table, placed the mask over the mouth and nose and performed hand hygiene with antiseptic hand wash. NA C then entered the building.

Interview on 6/23/20 at 1:42 PM with NA C confirmed that staff perform their own screening when they come on shift and log their results on the log sheet in the alcove. NA C stated they are to wear the same mask all shift and place it into a paper bag at the end of the shift and hang in the front activity room.

Observation on 6/23/20 at 1:45 PM revealed NA D entered the building through the front door into the alcove. NA D took a temperature on the forehead and logged the results and the answered the questions on the log sheet on the table in the alcove. At this point, the owner of the facility entered the alcove and stopped NA D, retook NA D's temperature and visited with the NA. The NA then entered the building, went directly to the administrator's office and closed the door.

Interview on 6/23/20 at 2:10 PM with the Dietary Manager revealed that the dietary staff screen themselves at the front door. If they have a fever, they are to notify the Dietary Manager prior to entering the building.

H. Cross contamination / PPE

Record review of a facility policy entitled

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F 880	Continued From page 10 Handwashing / Hand Hygiene dated revised August 2015 revealed the following: - 2. All personnel shall follow the hand washing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. - 7. Use an alcohol based hand rub containing at least 62% alcohol or, alternatively, soap and water for the following situations: b. Before and after coming in contact with residents. k. After handling used dressing, contaminated equipment l. after contact with objects in the immediate vicinity of the resident. n. before and after entering isolation precaution settings. - 8. Hand Hygiene is the final step after removing and disposing of personal protective equipment [PPE]. Observation on 6/23/20 between 11:50 AM and 11:58 AM revealed Nurse Aide [NA] E came out of room 304, a green room. NA E had a surgical mask over the nose and mouth which had been worn since the beginning of the shift. The mask did not fully cover the nostrils. Without changing the mask or performing hand hygiene, NA E stood outside Room 301, a blue quarantine room. NA E placed an isolation gown over their clothes, untied, and donned gloves. NA E entered room 301 with the meal and a garbage bag and delivered the meal tray to the resident. NA E then removed the gown and gloves, rolled them and put them into the bag and exited the room with no hand hygiene performed. NA E took the garbage	F 880		

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bag to the hopper room, opened the door [touched the door handle] threw the bag into the room, exited the hopper room. NA E walked into the dining area, touched a dietary tray paper, left the room and walked to Room 110, a blue quarantine room. NA E entered Room 110 with no personal protective equipment in place and no hand hygiene performed, stood and talked for 1 minute then turned and walked out of room 110. NA E walked to the break room, opened the door by touching the door handle and went in and performed hand hygiene.

Interview on 6/23/20 at 2:20 PM with the DON confirmed that they should change their mask after coming out of a quarentine room, wear a gown, gloves and mask in the blue quarentine rooms and perform hand hygeine before entering and after leaving a blue quarentine room

I. Hand hygeine after direct resident contact

Observation on 6/23/20 at 1:20 PM revealed that the DON approached Resident 7 in the hallway near the nurses station, adjusted the Resident mask by grasping it on the outside of the mask with hands [no gloves present] and placed it up on the residents face over the nose. The DON then proceeded to walk to the medication room. With no hand hygiene completed, the DON touched the handle of the door and opened the door, got a key out of the medication room, walked to the beauty shop and placed the key into the lock and opened the door to the beauty shop. The DON retrieved a set of supplies from the beauty shop, closed and relocked the beauty shop, handed the supplies to Licensed Practical Nurse [LPN] and returned the key to the medication room after opening the door. The

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F 880	Continued From page 12 DON then performed hand hygiene while in the medication room. Observation on 6/23/20 at 1:25 PM revealed the DON approached Resident 8 in the hallway near the nurses station, adjusted the resident's mask by grasping it on the outside of the mask with hands [no gloves present] and placed it up on the residents face over the nose. With no hand hygiene performed, the DON grasped the handles of Resident 8's wheelchair and proceeded to push the wheelchair down the hallway. The DON stopped and entered [redacted] wrapped a electrical cord around a oxygen concentrator and placed it into the hallway. The DON went back into [redacted] got a wrist blood pressure cuff and took it to the nurses station and wiped it down with a sanitizer cloth. The DON then performed hand hygiene in the medication room. Interview on 6/23/20 at 2:20 PM with the DON confirmed that staff should use antiseptic hand wash or perform hand washing after a residents mask is touched and before anything else is touched. J. [redacted] Record review of Center for Medicare and Medicaid services Memo QSO-20-28NH revealed that for resident appointments that are considered necessary [redacted] the facility should monitor the resident upon return for fever and signs and symptoms of respiratory infection for 14 days after the outside appointment (preferably in a space dedicated for	F 880		

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F 880	Continued From page 13 observation of asymptomatic residents) [i.e. a blue zone room. Interview on 6/23/20 at 10:50 AM with the Director of Nursing [DON] revealed one resident (Resident 9) was [redacted] for treatment. Observation on 6/23/20 at 12:00 PM revealed Resident 9 resided in a room that had a green dot outside the door and was not in an isolation room or under transmission based precautions. Interview on 6/23/20 at 12:17 PM with the DON confirmed that Resident 9 was not in an isolation zone or under transmission based precautions and resided in a green room.	F 880		

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O 191	12-006.10A3 Provision of Medication by Unlicensed Person When the facility utilizes persons other than a Licensed Health Care Professional in the provision of medications, the facility must follow 172 NAC 95 and 96. Each facility must establish and implement policies and procedures: a. To ensure that medication aides who provide medications are trained and have demonstrated the minimum competency standards specified in 172 NAC 95-004; b. To ensure that competency assessments and/or courses for medication aides have been completed in accordance with the provisions of 172 NAC 96-005; c. That specify how direction and monitoring will occur when the facility allows medication aides to perform the routine/acceptable activities authorized by 172 NAC 95-005 and as follows: (1) Provide routine medication; and (2) Provide medications by the following routes: (a) Oral, which includes any medication given by mouth, including sublingual (placing under the tongue) and buccal (placing between the cheek and gum) routes and oral sprays; (b) Inhalation, which includes inhalers and nebulizers, including oxygen given by inhalation; (c) Topical application of sprays, creams, ointments, and lotions and transdermal patches; and (d) Instillation by drops, ointments, and sprays into the eyes, ears, and nose; d. That specify how direction and monitoring will occur when the facility allows medication aides to perform the additional activities authorized by 172 NAC 95-007, which include but are not limited to: (1) Provision of PRN medications; (2) Provision of medications by additional	O 191		

Licensure Unit

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

Electronically Signed

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O 191	Continued From page 1 routes including but not limited to gastrostomy tube, rectal, and vaginal; and/or; (3) Participation in monitoring; e. That specify how competency determinations will be made for medication aides to perform routine and additional activities pertaining to medication provision; f. That specify how written direction will be provided for medication aides to perform the additional activities authorized by 172 NAC 95-009; g. That specify how records of medication provision by medication aides will be recorded and maintained; and h. That specify how medication errors made by medication aides and adverse reactions to medications will be reported. The reporting must be: (1) Made to the identified person responsible for direction and monitoring; (2) Made immediately upon discovery; and (3) Documented in the resident's medical record. This Standard is not met as evidenced by: 12-006.10A3 Based on interview and record review, the facility failed to ensure an unlicensed person (CNA-F) did not pass medications prior to being on the registry as a 40 hour Medication Aide. This had the potential to affect all residents residing in the facility. The facility had a total census of 46 residents. The findings are: A review of Active Employee Listing provided by the facility revealed CNA-F was identified as a temporary Medication Aide.	O 191		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454001	A. BUILDING: _____ B. WING _____	06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLE TERRACE	1133 NORTH THIRD ST TECUMSEH, NE 68450

(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) COMPLETE DATE
O 191	Continued From page 2 A review of the Nebraska Department of Health and Human Services License Search website accessed on 6/23/20 revealed CNA-F was not on the registry as a 40 hour Medication Aide A review of the facility "as worked" schedule revealed CNA-F had passed medications on 6/11/20, 6/12/20, 6/13/20, 6/14/20, 6/15/20, 6/17/20, 6/18/20, 6/19/20, and 6/22/20. In an interview on 6/24/20 at 1:47 PM, the DON (Director of Nursing) reported CNA-F had completed the temporary Medication Aide training and had turned in the application to the facility scheduler, but it had not ever been mailed in. The DON confirmed CNA-F had been passing medications in the facility prior to mailing in the application or being on the registry.	O 191		

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Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 15, 2020

Samantha Jones, Administrator
Belle Terrace
1133 North Third St
Tecumseh, NE 68450 **CMS Certification No. 285237**

Subject: **Survey Results**
Cycle Start Date: June 24, 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 24, 2020, a survey was completed at Belle Terrace 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 14, 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 24, 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 10, 2020

Amy Grube, Administrator
Bertrand Nursing Home
Po Box 97, 100 Minor Avenue
Bertrand, NE 68927

CMS CERTIFICATION NUMBER: 285258

Dear Ms. Grube:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 1, 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

Robert Tank, Administrator
Bethany Home, Inc.
515 West First Street
Minden, NE 68959-0150

CMS CERTIFICATION NUMBER: 285270

Dear Mr. Tank:

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

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
	285259	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE VALLEY LUTHERAN NURSING HOME	P O BOX 166, 220 PARK AVENUE HEBRON, NE 68370

(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		7/30/20

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

Electronically Signed | 07/17/2020

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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BLUE VALLEY LUTHERAN NURSING HOME	P O BOX 166, 220 PARK AVENUE HEBRON, NE 68370

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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 and 12-006.17B	F 880	1. Failure to disinfect Hoyer lift before reuse on another resident.	

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F 880	Continued From page 2 Based on observation, interview, and record review, the facility failed to disinfect a Hoyer lift before reuse on another resident (Resident 7) and maintain at least 6 feet distance between residents eating in the dining rooms at meals to prevent the potential spread of COVID-19. The facility reported 50 residents eat in the dining rooms for meals. The facility also failed to screen 91 facility staff members and 1 contracted staff (OT-H) for signs and symptoms of COVID-19 immediately upon entrance to the facility. This had the potential to affect all residents that resided in the facility. The facility had a census of 55 residents. The findings are: Disinfecting Reusable Equipment A. An observation on 6/16/20 at 11:33 AM revealed CNA (Certified Nursing Assistant)-C and CNA-D exiting Resident 6's room. CNA-D was pushing Resident 6 in a wheelchair and CNA-C was pushing a Hoyer lift (an assistive device used to help move residents from surface to surface) out of the room. Continued observation revealed CNA-C pushed the Hoyer lift across the hall and into Resident 7's room and stopped next to Resident 7's bed. In an interview on 6/16/20 at 11:34 AM, CNA-C and CNA-D reported the Hoyer lift was not disinfected prior to reuse for Resident 7. CNA-D stated it was supposed to be disinfected in between use on different residents. In an interview on 6/16/20 at 1:45 PM, the DON (Director of Nursing) and Administrator confirmed	F 880	On June 16, 2020 during the infection control specific survey, the Hoyer lift was in fact cleaned and disinfected before reuse on resident #7. The state surveyor identified the deficient practice and the Hoyer was cleaned and disinfected before reuse. Facility policy and procedure on cleaning and disinfection of resident care items and equipment was updated on Friday June 19th 2020. All nursing staff were in serviced on the updated Policy and Procedure of cleaning and disinfection of resident care items and equipment and signed off on completion by June 30, 2020. It is the job duties of the DON or their designee to complete the yearly competency on lift disinfecting and cleaning. This competency is completed yearly on all nursing staff. For a time of 3 months, the DON or their designee will audit lift cleaning use between residents. This will be done randomly twice weekly. The DON will meet with the administrator twice monthly for a time period of 3 months to go over data. All this data will be reviewed at the monthly Q.A. meeting to assure compliance. This will stay on the agenda for a period of one year, and will start at the July 2020 Q.A. meeting.	

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F 880	Continued From page 3 the Hoyer lift was supposed to be disinfected before reuse on another resident. A review of the facility's Cleaning and Disinfection of Resident-Care Items and Equipment Policy dated 4/7/2020 revealed the following: -"Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard. -3) Durable Medical Equipment (DME) must be cleaned and disinfected before reuse by another resident." Dining B. Observations of meals on 6/16/20 between 7:56 AM and 12:16 PM revealed the following: -"Activity Room" dining area had 5 round tables set up with 2 residents observed sitting across from each other at 4 of the 5 tables. -"Sunroom" dining area had 4 round tables set up with 2 residents observed sitting across from each other at 1 of the 4 tables. -"Memory Care" dining area had 5 round tables set up with 3 residents observed sitting next to each other at 1 table and 2 residents observed sitting across from each other at 3 of the tables. -"Main Dining" dining area had 8 round tables and 2 square tables set up with 2 residents observed sitting across from each other at 4 of the round tables and 1 of the square tables. An observation on 6/16/20 at 8:10 AM revealed signage posted outside of the dining areas stated residents are supposed to sit 2 to a table, 6 feet apart.	F 880	2. Failure to maintain at least 6 feet distance between residents eating in the dining room at meals to prevent the potential spread of COVID-19. Dining room tables were rearranged, turned, moved, tables were taken away, we made more space for residents. The end result was a distance of at least 6 feet between residents from all angels. This was done on June 17. Barriers were installed on each table. Each table that has 2 people has a barrier that measures 2ft by 3 ft. This barrier sits directly between the residents on the table. This was done because the tables are anywhere from 3 feet to 4 feet across. This plan was approved by the survey team prior to their departure on June 16. All the barriers were on the tables and completed by June 26. It is the job of the dietary manager to make sure the tables and the resident chairs are in their proper position and all the residents remain 6 feet apart at all times during meals. The infection control nurse will audit the placement of tables, chairs, and the overall distance apart of the residents in the dining room. For a period of 3 months (as long as the rules and regulations for COVID remain for that time frame) the infection control nurse will audit this 3 x a week for a period of 3 months. The infection control nurse will check the	

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F 880	Continued From page 4 An observation and interview with the Administrator and Maintenance Supervisor on 6/16/20 at 9:15 AM revealed the round tables measured approximately 4 feet in diameter and the square tables measured approximately 3.5 feet across. The Administrator confirmed that would not keep the residents separated by at least 6 feet while dining. Staff Screening C. A review of an email dated 3/23/20 from the Administrator to Facility Department Heads revealed the following: "-All employees are to be screened daily for risk of coronavirus infection. It will be your job as department heads to do this to each of your employees daily. You will be given the sheet with the questions to be asked of each employee daily as they prepare to start their shift. You will need to take and record their temperature daily before they start their shift. It will be the responsibility of the office manager to screen and check all office, administration staff, and essential health care staff daily during business hours. It is the responsibility of the charge nurse during non-business hours. -You will be given stickers that the employee is to wear on the front of their shirt that will show that they have been screened for that day. -In absence of the department head (such as weekend or a scheduled day off), in dietarty the responsibility would fall to the assistant dietary manager or the head cook or first cook. All others will fall under the responsibility of the charge nurse." In interviews on 6/16/20 at 9:15 AM and 10:15 AM, RN (Registered Nurse)-A reported staff are	F 880	distance between residents, and will check the barriers on the tables. This will be reported to the administrator the results of this audit on a weekly basis for the time frame of three months. All this data will be reviewed monthly at the Q.A. meeting to assure compliance. It will stay on the agenda for a period of 1 year starting at the July 2020 Q.A, meeting. 3. The facility failed to screen staff and contract staff for signs and symptoms of COVID-19 immediately upon entry to the facility. As of June 17, the screening station at BVLH was moved to immediately inside the front door as opposed to the front office as it was previously placed. BVLH COVIC-19 screening policy was reviewed and updated on June 17 to include where the screening is to take place. Screen policy: Blue Valley Lutheran Homes COVID-19 screening policy 1. All staff at entry to the building to begin their shift will be screened for COVID-19. (screening parameters have changed over time. The sheet out front at the screen station will be up to date. The infection control nurse is in charge of having the screening sheet updated as needed). 2. You need to be screened immediately	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE VALLEY LUTHERAN NURSING HOME	P O BOX 166, 220 PARK AVENUE HEBRON, NE 68370

(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 screened in their respective department areas in the building. Nursing staff are screened in the nursing office in the memory care unit. In an interview on 6/16/20 at 12:20 PM, CNA-J reported that nursing staff are all screened at the nurses' station in the memory care unit. An observation and interview on 6/16/20 at 12:21 PM with Dietary Staff B revealed the dietary staff screening log was kept in the middle of the kitchen. Dietary Staff B reported dietary staff take their own temperatures upon arrival to work in the kitchen and fill out the screening form. An observation on 6/16/20 at 1:15 PM revealed OT (Occupational Therapist)-H walked in the front door of the facility and to the business office where (gender) was screened by the Office Manager. Observations during this time revealed OT-H walked by 2 residents sitting in the great room on the way to the business office. An observation on 6/16/20 at 1:40 PM revealed CNA-I walked in the front door of the facility and to the business office where (gender) was screened by the Office Manager. Observations during this time revealed CNA-I walked by 1 resident sitting in the great room on the way to the business office. An observation and interview with the ADON (Assistant Director of Nursing) on 6/16/20 at 1:25 PM revealed the screening log for the nursing staff was kept in the nursing office located at the end of the hall in the memory care unit. The ADON reported that staff come to the nursing office when they arrive for their shift and are screened by the charge nurse.	F 880	upon entrance to the building. 3. You cannot screen yourself. 4. Staff will be scheduled to screen during the high staff changeover time on M-F. When there isn□t a designated staff there at the door to screen, there are phone numbers listed to call and specific days and times for those numbers for someone to come and screen you. 5. You must wear your mask immediately upon entering the building. 6. Any one staff member can screen each other. 7. The screening results are to be audited/monitored by the DON and Infection control nurse or their designee. Weekend screening sheets results will be audited/monitored by the charge nurse. The location of the screening, and the schedule of employees who will be screening during the high staff changeover time will be done by and overseen by the DON. This was started as of June 17. The screening sheets/screening results will be monitored/audited daily by the infection control nurse or their designee. On weekends it will be the duty of the charge nurse to monitor/audit the sign in sheets/screening results as of June 17. The DON will further audit the screening sheets 2 times a week for the duration of the COVID-19 screening period. The DON will report the results to the Administrator monthly for a duration of 3	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285259	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE VALLEY LUTHERAN NURSING HOME	**P O BOX 166, 220 PARK AVENUE HEBRON, NE 68370**

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F 880	Continued From page 6 In an interview on 6/16/20 at 1:43 PM, the DON stated the Office Manager does staff screening in the business office from 7:30 AM until 4:00 PM and outside of those hours the staff have to go down to the nursing office on the memory care unit to be screened. The DON also reported most of the nursing staff change shifts at 6:00 AM and 6:00 PM. In an interview on 6/16/20 at 1:45 PM, the Administrator and DON confirmed that staff walking through the building and into resident care areas to be screened could be a potential infection control issue. The DON and Administrator also confirmed staff should not be screening themselves.	F 880	months. The data from the screening sheets, the location of the screening, and the staff schedule for the screening will be reviewed monthly at the Q.A. meeting to assure compliance. It will stay on the Q.A. agenda for a period of 1 year, or for the duration of the COVID-19 screening period, whichever lasts longer. this will begin at the July 202o Q.A. meeting. please see attached documents, which include documents and pictures. and see attached DPOC which attached in full and completed by this date 7-30-2020.	

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

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 8, 2020

Doug Chos, Administrator
Blue Valley Lutheran Nursing Home
P O Box 166, 220 Park Avenue
Hebron, NE 68370-0166 **CMS Certification No. 285259**

Subject: Survey Results
Cycle Start Date: June 16, 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 16, 2020, a survey was completed at Blue Valley Lutheran Nursing Home 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

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 22, 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 16, 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 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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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

June 26, 2020

Jennifer Beisheim, Administrator
Brighton Gardens Of Omaha
9220 Western Avenue
Omaha, NE 68114

CMS CERTIFICATION NUMBER: 285274

Dear Ms. Beisheim:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 12, 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

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285226	A. BUILDING _____ B. WING _____	06/11/2020

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BROOKEFIELD PARK	**1405 HERITAGE DRIVE ST PAUL, NE 68873**

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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=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		7/8/20

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

Electronically Signed | 07/08/2020

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.

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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 12-006.17D	F 880	Past noncompliance: no plan of correction required.	

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F 880	Continued From page 2 Based on observation, interview, and record review the facility failed to ensure that staff performed hand hygiene (hand washing using soap and water or an alcohol based hand rub (ABHR) to remove germs for reducing the risk of transmitting infection among patients and health care personnel) before and after putting on gloves to prevent the potential for cross contamination for 5 residents (Residents 3, 4, 5, 6, and 7) and failed to assist residents with performing hand hygiene to prevent the potential for illness for 1 resident (Resident 5). The facility census was 48. Findings are: A. Record review of the facility document titled COVID-19 Guidelines dated 5-19-2020 revealed: Prevention Measures: -The facility maintains an Infection Prevention and Control Program. Everyday standard precautions and preventive actions should be used and include appropriate hand hygiene. Record review of the facility Hand Hygiene Competency dated 12.2019 revealed the Procedure Hand Hygiene section When to wash hands: -Before each resident contact -After touching a resident or handling their belongings -After handling contaminated items (linens/garbage/briefs, etcetera). -Before and after gloving Observation on 6/10/20 at 10:27 AM revealed that Nursing Assistant-A (NA-A) and Nursing	F 880		

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F 880	Continued From page 3 Assistant-B (NA-B) entered the room of Resident 3. Resident 3 was lying on the bed. The Nursing Assistants checked [redacted] Resident 3. [redacted] Resident 3 from the bed into the wheelchair. NA-A removed the disposable gloves and did not perform hand hygiene. NA-A removed the mechanical total body lift from the room and parked the lift just outside of the resident's room. NA-A re-entered the resident's room and straightened the bedding and pillow on the resident's bed. NA-A exited the resident's room and pushed the mechanical total body lift toward the room of Resident 4 and performed hand hygiene with ABHR. Observation on 6/10/20 at 10:45 AM at the room of Resident 4 revealed that NA-A and NA-B transferred the resident to the wheelchair with the mechanical total body lift. NA-B performed hand hygiene with ABHR and put on disposable gloves and wiped the total body lift with a disinfectant wipe. NA-B removed the disposable gloves and did not perform hand hygiene. NA-B pushed the total body lift to the storage area near the nurse's station. NA-A picked up the used trash bag from the trash can in the resident's room and carried the trash to the soiled room by the nurse's station, opened the soiled room door and disposed of the trash. NA-A then performed hand hygiene with	F 880		

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F 880	Continued From page 4 ABHR. Observation on 6/10/20 at 10:48 AM in the room of Resident 5 revealed that NA-A and NA-B performed hand hygiene with ABHR. NA-B pushed the mechanical sit to stand lift (a mechanical assistive device used to transfer a resident with difficulty standing up on their own from a seated position) into the room. NA-A placed the mechanical sit to stand lift sling (a fabric device with straps that is placed around the back of a resident when a mechanical assistive device is used to transfer a resident with difficulty or inability to stand up on their own from a seated position)around the back of Resident 5 and the nursing assistants connected the mechanical lift sling to the sit to stand lift. The nursing assistants transferred Resident 5 into the bathroom. At 10:58 AM on 6/10/20 Resident 5 was transferred from the bathroom into the wheelchair beside the bed. NA-A removed the sit to stand lift sling from behind the resident and moved the sit to stand lift out of the room and parked it just outside of the resident's room. NA-A put on disposable gloves without performing hand hygiene. NA-A wiped the sit to stand lift using a disinfectant wipe. NA-A removed the disposable gloves and performed hand hygiene with ABHR. Observation on 6/10/20 at 11:01 AM in the room of Resident 6 revealed NA-A and NA-B transferred Resident 6 out of the bathroom using the sit to stand lift and seated the resident in the wheelchair. NA-A handed a doll to the resident. NA-B removed the lift sling from behind the resident and entered the bathroom and performed hand washing with soap and water. NA-B moved the sit to stand lift toward the door and picked up the used trash bag. NA-B pushed	F 880		

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F 880	Continued From page 5 the sit to stand lift outside of the resident's room and put on gloves with no hand hygiene performed. NA-B wiped the lift with a disinfectant wipe. NA-A exited the resident's room and performed hand hygiene with ABHR. NA-B removed the disposable gloves and did not perform hand hygiene. NA-B pushed the lift to the lift storage area near the nurse's station. NA-B performed hand hygiene with ABHR. Observation on 6/10/20 at 11:37 AM revealed Licensed Practical Nurse-C (LPN-C) at the treatment cart outside of Resident 7's room. LPN-C placed a paper towel on the top of the treatment cart and removed the [redacted] from a drawer of the treatment cart. LPN-C wiped off the [redacted] with a disinfectant wipe and laid the [redacted] on the paper towel. LPN-C removed the [redacted] from the cart and primed the [redacted] for use. LPN-C reviewed the [redacted] order for Resident 7 and verified the order for [redacted]. LPN-C put on disposable gloves without performing hand hygiene and entered Resident 7's room and obtained a finger stick blood sample and applied a drop of blood on the test strip of the [redacted]. The [redacted] for Resident 7. LPN-C exited the resident's room and placed the [redacted] on the paper towel and removed the disposable gloves and did not perform hand hygiene. LPN-C put on disposable gloves without performing hand hygiene and wiped off the [redacted] with a disinfectant wipe and placed the [redacted] in the drawer of the treatment cart with the	F 880		

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F 880	Continued From page 6 disinfectant wipe underneath the [redacted] LPN-C removed the disposable gloves and performed hand hygiene with ABHR. Interview on 6/10/20 at 11:47 AM with the facility Director of Nursing (DON) confirmed that the expectation for performing hand hygiene is for staff to perform hand hygiene before putting on gloves and immediately after removing gloves. Staff should not do any tasks after removing gloves without performing hand hygiene immediately. B. Record review of the facility document titled Infection Prevention Audit dated 9/2017 revealed item 11. Team members encourage and assist residents to complete handwashing when appropriate. Observation on 6/10/20 at 10:48 AM in the room of Resident 5 revealed that Nursing Assistant-A (NA-A) and Nursing Assistant-B (NA-B) transferred Resident 5 into the bathroom using the sit to stand mechanical lift. At 10:58 AM on 6/10/20 Resident 5 was transferred from the bathroom into the wheelchair beside the bed. NA-A removed the sit to stand lift sling from behind the resident and moved the sit to stand lift out of the room and parked it just outside of the resident's room. Interview with Resident 5 on 6/10/20 at 11:05 AM revealed that the resident was seated in the wheelchair working on a word puzzle book while holding a pen. Resident 5 confirmed that the resident was assisted by staff to use the bathroom with the sit to stand lift. Resident 5 confirmed that hand washing was not provided by	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
	285226	A. BUILDING _____ B. WING _____	06/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKEFIELD PARK	**1405 HERITAGE DRIVE ST PAUL, NE 68873**

(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 7 staff after using the bathroom. Resident 5 confirmed that hand washing is not provided for the resident prior to meals. Interview on 6/11/20 at 4:10 PM with the facility Director of Nursing (DON) confirmed that the expectation for resident hand hygiene when being assisted by staff is to perform resident hand hygiene upon resident wakening, at mealtimes, when hands are visibly soiled, at bedtime or anytime needed, and with toileting.	F 880		

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 1, 2020

Brenda Ewers-Nordhues, Administrator
Brookefield Park
1405 Heritage Drive
St Paul, NE 68873 **CMS Certification No. 285226**

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 Brookefield Park 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.

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 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 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

NEBRASKA
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Pete Ricketts, Governor

August 13, 2020

Stacie Brueggeman, Administrator
Brookestone Gardens
2615 West 11th Street
Kearney, NE 68845

CMS CERTIFICATION NUMBER: 285305

Dear Ms. Brueggeman:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 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 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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Pete Ricketts, Governor

August 13, 2020

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Brookestone Gardens
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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

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Pete Ricketts, Governor

June 24, 2020

John Turner, Administrator
Brookestone Meadows Rehabilitation And Care Center
600 Brookestone Meadows Plaza
Elkhorn, NE 68022

CMS CERTIFICATION NUMBER: 285276

Dear Mr. Turner:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 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

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Pete Ricketts, Governor

July 2, 2020

Andrew Wismer, Administrator
Brookestone Village
4330 South 144th Street
Omaha, NE 68137

CMS CERTIFICATION NUMBER: 285242

Dear Mr. Wismer:

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

Madison Guthrie, Administrator
Brookestone View
850 Laurel Parkway Drive
Broken Bow, NE 68822

CMS CERTIFICATION NUMBER: 285297

Dear Ms. Guthrie:

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

Nicole Woznick, Administrator
Brookestone Acres
4715 38th Street
Columbus, NE 68601

CMS CERTIFICATION NUMBER: 285291

Dear Ms. Woznick:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 25, 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

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285180	A. BUILDING _____ B. WING _____	07/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUTTE SENIOR LIVING	210 BROADWAY BUTTE, NE 68722

(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 This facility is in compliance with CMS Infection Control Protocols and the associated regulations for Focused Infection Control surveys.	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 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		8/31/20

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

Electronically Signed | 08/06/2020

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
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F 880	Continued From page 1 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 Based on interview and record review; the facility failed to 1) prevent the potential spread of	F 880	F 880 PLAN OF CORRECTION Butte Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute	

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 COVID-19 by allowing employees with temperatures of 100 degrees or greater to work in the facility; 2) ensure dishes were properly sanitized; and 3) develop a Response Planning Tool that included the necessary items including a plan for COVID-19 testing. This had the potential to affect all residents. The sample size was 5 and the facility census was 22. Findings are: A. Review of The Centers for Medicare and Medicaid Services (CMS) Center for Clinical Standards and Quality, Safety and Oversight Group dated 3/13/20 revealed the following guidance for infection control and prevention of Coronavirus Disease 2019 (COVID-19): -The facility should regularly monitor the CDC (Centers for Disease Control) website for information and resources. -Per the CDC, prompt detection, triage, and isolation of potentially infectious residents is essential to prevent unnecessary exposures among residents and healthcare personnel. Review of the CDC guidelines "Preparing for COVID-19 in Nursing Homes" dated 6/25/20 revealed the following guidance for infection control and prevention of COVID-19: - The facility should screen all healthcare workers at the beginning of their shift for fever and symptoms of COVID-19, - actively take the employee's temperature, and - a fever is either a measured temperature of 100 degrees or greater or a subjective fever. Review of the COVID-19 Employee Screening Logs dated 4/16/20 through 6/27/20 revealed the following:	F 880	an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 880, prevention of the potential spread of COVID-19 by allowing employees with temperatures of 100 degrees or greater to work in the facility. Butte Senior Living corrected the deficiency by updating the minimum temperature requirement to 100.0 degrees Fahrenheit on the employee screening forms/logs. 2. To correct the deficiency and to ensure the problem does not recur the Director of Nursing Services and/or designee will audit the employee screening forms/logs daily for 4 weeks and then weekly to ensure employees with a temperature of 100.0 degrees Fahrenheit are not being allowed to work. 3. As part of Butte Senior Livings ongoing commitment to quality assurance, the DNS and/or designee will report identified	

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F 880	Continued From page 3 -On 6/25/20 2 employees were allowed to work with temperatures greater than 100 degrees (100.1 degrees and 100.2 degrees). - On 6/27/20 an employee was allowed to work with a temperature of 100.1 degrees. An interview with the Director of Nursing on 7/7/20 at 11:30 AM confirmed the facility did not restrict staff from working unless their temperature was greater than 100.4 degrees. B. Review of the facility's yearly "Temp for Dishwasher" Log (a record of dishwasher temperatures for both wash and rinse cycles used to monitor sanitation of dishes) revealed no temperatures were recorded for dishwasher wash and rinse cycles on 3/15/20, 3/21/20, 3/22/20, 4/4/20, 4/12/20 through 4/20/20, 5/2/20, 5/3/20, 5/11/20, 5/17/20, 5/24/20, 5/30/20 and 6/29/20. C. Review of the Department of Health and Human Services "Long-Term Care COVID-19 Response Planning Tool" dated 5/29/20 revealed facilities could take steps to assess and improve their preparedness for responding to COVID-19 and were to develop a comprehensive Response Planning Tool by 6/22/20. This would include a plan for gradual return to standard practices of the facility based on meeting critical benchmarks. One component of the plan would address the facilities plan for testing based on contingencies informed by the CDC that, at a minimum, should consider the following components: -The capacity for all nursing home residents to receive a single baseline COVID-19 test. Similarly, the capacity for all residents to be tested upon identification of an individual with symptoms consistent with COVID-19, or if a staff member tests positive for COVID-19.	F 880	concerns through the community's QA Process. F 880 PLAN OF CORRECTION Butte Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.	

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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BUTTE SENIOR LIVING	210 BROADWAY BUTTE, NE 68722

(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 -Capacity for continuance of weekly re-testing of all nursing home residents until all residents test negative. -The capacity for all nursing home staff (including volunteers and vendors who are in the facility on a weekly basis) to receive a single baseline COVID-19 test, with appropriate re-testing. -An arrangement with laboratories to process tests able to detect COVID-19. -A procedure for addressing residents or staff that decline or are unable to be tested. -Access to payment for appropriate testing. Review of the facility's "Guidance on Phased Easing of Restrictions" dated 6/22/20 revealed baseline testing was not required for residents or staff and there was no evidence this component of the plan would be included. An interview with the Administrator on 7/10/20 at 12:25 PM confirmed the facility's plan titled "Guidance on Phased Easing of Restrictions" dated 6/22/20 did not include a plan for baseline testing of staff and/or residents.	F 880	1. In continuing compliance with F 880, ensuring dishes were properly sanitized. Butte Senior Living corrected the deficiency by implementing a new dietary sanitation dish machine temperature log. 2. To correct the deficiency and to ensure the problem does not recur all dietary staff were educated on 07/21/2020 on the importance of logging sanitization dish machine temperatures accurately to ensure dishes are being properly sanitized by the Dietary Manger. The Dietary Manger and/or designee will perform random audits of the dietary sanitation dish machine logs weekly for 4 weeks to ensure accuracy. 3. As part of Butte Senior Livings ongoing commitment to quality assurance, the Dietary Manager and/or designee will report identified concerns through the community's QA Process.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285180	A. BUILDING _____ B. WING _____	07/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUTTE SENIOR LIVING	210 BROADWAY BUTTE, NE 68722

(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	F 880	F 880 PLAN OF CORRECTION Butte Senior Living denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 880, develop a Response Planning Tool that includes the necessary items including a plan for COVID-19 testing. Butte Senior Living corrected the deficiency by updating the Response Planning Tool to include COVID-19 testing plan. 2. To correct the deficiency and to ensure the problem does not recur Executive Director and/or designee will monitor any updates from the Department of Health and Human Services regarding process	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285180	A. BUILDING _____ B. WING _____	07/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUTTE SENIOR LIVING	210 BROADWAY BUTTE, NE 68722

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F 880	Continued From page 6	F 880	changes/recommendations regarding phasing guidelines. Executive Director and/or designee will attend virtual meetings monthly thru the Nebraska Healthcare Association, Leading Age, and he Department of Health and Human Services to assure any new recommendations are discussed with the Accura Resource Clinical Team and any necessary updates implemented as needed. 3. As part of Butte Senior Livings ongoing commitment to quality assurance, the Executive Director and/or designee will report identified information/updates through the community's QA Process.	

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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 15, 2020

Tammy Boettcher, Administrator
Butte Senior Living
210 Broadway
Butte, NE 68722 **CMS Certification No. 285180**

Subject: **Survey Results**
Cycle Start Date: July 10, 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 10, 2020, a survey was completed at Butte Senior Living 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 10, 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

Department of Health and Human Services
Division of Public Health
State of Nebraska

Notice of Disciplinary Action
Against a Health Care Facility

Notification is hereby given of **Disciplinary Action** against Skilled Nursing Facility/Nursing Facility License #104002, issued by the Department of Health and Human Services, Division of Public Health to Callaway Good Life Center, Inc, located at PO Box 250, 600 West Kimball Street, Callaway, Nebraska 68825-0250.

The Disciplinary Action being imposed is as follows:

A. The facility is **Prohibited from Admitting** residents to this facility until you have demo

B. The facility's license will be placed on **Probation for a Period of 90 days beginning July 31, 2020.** During this probationary period, the facility may continue to operate under the following terms and conditions of the probation:

The facility must submit a Plan of Correction that establishes and implements a proce include:

- The method and frequency of assessment to identify residents at risk, including identifying risk and causal factors and the person responsible for the assessments;
- Guidance to staff related to suggested interventions and the time frame for implementatio
- The method utilized to ensure that identified interventions are documented on the care plan and implemented by staff;
- The method utilized to ensure that the process is implemented and routinely reviewed to e
- The person responsible for the implementation and evaluation of the process.

The **basis** for this Disciplinary Action is violation of Neb. Rev. Stat. §71-448 which states that the Department may take disciplinary action against a license issued under the Health Care Facility Licensure Act on any of the following grounds:

(1) Violation of any of the provisions of the ….Health Care Facility Licensure

Act…..or the rules and regulations adopted and promulgated under such Act;
(3) Conduct or practices detrimental to the health or safety of a person residing in ……the health care facility….

These violations were evidenced by the facility's failure to implement infection control practices to prevent the spread of COVID 19 in the facility including failure to isolate and quarantine new admissions for 14 days.

The CMS-2567 Report for the survey dated June 10, 2020 specifies the manner by which the violations were evidenced. The CMS-2567 Report is incorporated by this reference and made part of this notification.

If you fail to correct the violation or comply with the disciplinary action, the Department may take additional disciplinary action, as specified in Neb. Rev. Stat. §71-449, against your license.

This Notice of Disciplinary Action is being sent as required by Neb. Rev. Stat. §71-451. The Disciplinary Action in this Notice shall become final on **July 31, 2020**, which is 15 days after the mailing date of this Notice unless you make a written request within such 15 days for either an informal conference or a hearing.

This Notice requires a response to the Director of the Division of Public Health, Department of Health and Human Services. **Any such response needs to be made and sent to Connie Vogt, RN, BSN at the address previously provided in this notice.** The written response needs to indicate that you:

1. Desire to contest the Notice and request an informal conference with a repres

2. Desire to contest the Notice and request a hearing; or

3. Do not contest the Notice.

Dated this ____ day of July, 2020.

Gary J. Anthone, MD
Chief Medical Officer
Director, Division of Public Health
Department of Health and Human Services

Becky Wisell, Administrator
Licensure Unit
301 Centennial Mall South
Lincoln, NE 68509-4986

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing Notice of Disciplinary Action was sent to the Facility and to the person or entity who is the licensee for this Facility at the last known address of record, by certified United States mail with sufficient postage paid on this ____ day of July, 2020.

_____

Linda Stenvers, Staff Assistant II
Office of Long Term Care Facilities
Licensure Unit, Division of Public Health
Department of Health and Human Services

Callaway Good Life Center, Inc
Po Box 250, 600 West Kimball Street
Callaway, NE 68825-0250

SURVEY EXIT DATE: June 10, 2020

PROBATION EFFECTIVE DATE: July 31, 2020

SCHEDULED EXPIRATION DATE: October 31, 2020

TEAM: Kearney Team

DATE LIFTED: _____

_____ Report #1	_____ Report #2
_____ Report #3	_____ Report #4
_____ Report #5	_____ Report #6
_____ Report #7	_____ Report #8
_____ Report #9	_____ Report #10
_____ Report #11	_____ Report #12
_____ Report #13	_____ Report #14

Lyn Carradine, Registered Nurse
Pascual Ramirez, Social Worker

NE Dept. of HHS
Division of Public Health
Licensure Unit

Data Bank Reporting Worksheet for Health Care Facilities & Services

Instructions:
Program Managers are to ensure the completion and submission of this form to the Licensure Unit Administrator's Office within five working days of any of the following actions:

1. A License is disciplined (revocation, suspension, probation, limitation, prohibition on
2. A license is denied or refused renewal for any reason(s) other than non-payment of the

Name of Entity Being Reported_____Callaway Good Life Center, Inc_____

Address of the Entity Being Reported___Po Box 250, 600 West Kimball Street, Callaway 68825-0250

Federal Employer Identification (FEIN) Number of Entity Being Reported____453972301_____

Type of Adverse Action Being Reported:

- License Disciplined:
  1. Probation__x_ Length of Probation_____90 days_____
  2. Limitation___ Length of Time_____ Indefinite_____
  3. Suspension___ Length of Time _____
  4. Prohibition on Admissions/Readmissions__x____ Length of Time_until corrected_____
- License Denied_____
- License Refused Renewal_____

Date Adverse Action Taken ____July 16, 2020_____
Effective Date of Adverse Action___July 31, 2020_____

Attach to this Worksheet a Copy of the Notice of Disciplinary Action or Letter that informs the subject of the Adverse Action.

Form Completed by____Linda Stenvers_____ Date____July 16, 2020_____

Established: April 2010
Updated: October 2010; August 2014

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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 16, 2020

Vicky Hendricks, Administrator
Callaway Good Life Center, Inc
Po Box 250, 600 West Kimball Street
Callaway, NE 68825-0250 **CMS Certification No. 285200**

Subject: Survey Results
Cycle Start Date: June 10, 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 10, 2020, a survey was completed at Callaway Good Life Center, 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 26, 2020**, to the State Survey Agency Contact. **Failure to submit an acceptable PoC by July 26, 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 facilities 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, 2020 which is 30 days after the date of the enforcement letter 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

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 10, 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
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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
	285200	A. BUILDING _____ B. WING _____	06/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALLAWAY GOOD LIFE CENTER, INC	PO BOX 250, 600 WEST KIMBALL STREET CALLAWAY, NE 68825

(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=J	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		7/30/20

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

Electronically Signed | 07/27/2020

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

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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: License Reference Number: 175 NAC 12-006.17B Based on record reviews and interviews, the facility failed to implement infection control precautions to prevent the spread of COVID in the facility including failure to isolate new admissions for 14 days and place these residents in a gray zone for 1 resident (Resident #1), Resident #1 was admitted from [redacted] without 14 days isolation with Resident #2 both	F 880	STATEMENT OF COMPLIANCE: Preparations and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the	

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F 880	Continued From page 2 residents [redacted] This had the potential to affect all of the residents of the facility. Findings are: Family interview on 6-10-20 at 12:20 p.m. Resident #2's child verified that Resident #2 had been placed with another resident who had just been discharged from [redacted]. Resident #2's child verified that the resident who had been [redacted] was moved into the facility and right in with Resident #2. Resident #2's child confirmed how Resident #2 was on hospice services prior to having this new roommate move in. Resident #2's child confirmed that Resident #2's roommate was sent back to [redacted] but was not told why. Resident #2's child confirmed how it was reported that Resident #1 who was the roommate to Resident #2 had been [redacted] On 4-5-20 Resident #2's child was informed by staff that Resident #2 would be tested [redacted] and how the family would be informed of the results once they were received. Resident #2's child confirmed the next day [redacted] Resident #2's child confirmed later that evening around 6:30 p.m. or so Resident #2's parent had passed away. Resident #2's child reported how upset this made the family especially when they had been informed that Resident #2 had been [redacted] Resident #2's child verified how the family had been notified by the funeral home that their loved one died [redacted]	F 880	center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 73058 of the State Operations Manual. CORRECTION TO RESIDENTS AFFECTED: Resident #1 was transferred [redacted] and did not return. Resident #2 Expired on [redacted]. SYSTEM CHANGES (IDENTIFICATION AND CORRECTION FOR OTHER RESIDENTS: Facility QA committee met every morning Monday through Friday beginning 4-5-2020 to discuss changes and needs of the facility to prevent the spread of COVID-19 to residents, staff and the community. 4-7-2020 The Administrator staying on the grounds available 24 hours a day. As of 6-22-2020 QA and management meet every Monday, Wednesday and Friday mornings to discuss changes and Plan of Actions to prevent the spread and COVID-19 and other contagious illnesses. 3-9-2020 meeting and Action Plan for COVID-19 3-10-2020 Action Plan for EVS Review Guidance for infection Control and Prevention of COVID-19 in nursing homes developed. 3-12-20 QA meeting with Medical	

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F 880	Continued From page 3 Record review on 6-10-2020 of Resident #2's face sheet confirmed Resident #2 was admitted to Callaway Good Life Center on [redacted]. Record review on 6-10-2020 of Resident #2's progress notes. Nursing note dated [redacted] at 12:46 completed by social services stated: Notified Resident #2 that room #1 is clean and ready for Resident 2 to move back. Offered bed #2 by the window this time. Resident #2 agreed. Asked Resident #2 if could move belongings this afternoon. Resident #2 agreed. Also notified that will have a roommate tomorrow. Notified Resident # 2 family of roommate change today and new roommate moving in tomorrow. No concerns voiced. Record review on 6-10-2020 of Resident #2's progress note dated [redacted] Record review on 6-10-202 or Resident #2's progress note dated [redacted] Nurse contacted Resident #2's child and notified family of resident [redacted] they would like the resident to remain at the facility [redacted] family reported they wanted Resident #2 to remain at the facility. Record review on 6-10-2020 of Resident progress note dated [redacted] Nursing staff reported that at 6:30 p.m. Resident #2 vital signs were unable to obtain vital signs. 6:42 p.m. nursing staff contacted Resident #2's family and notified them of the resident's death. Funeral home was notified. Progress note indicated that	F 880	Director, Hospital CEO,Hospital DNS, Facility DNS, Administrator and EVS/EPP Director for COVID Plan 4-1-2020 QA COVID-19 Re-assessment Meeting [redacted] Resident #2 placed in Isolation/Quarantine in Room #1. All residents assumed to be positive and treated as such following CDC guidelines for isolation/quarantine to prevent spread of virus. Education on PPE donning and doffing given to staff. Review of infection prevention strategies with proper hand hygiene reviewed. Donning and Doffing of PPE reviewed with staff. 4-5-2020 Testing of Residents and staff initiated following guidance from ICAP. All of the facility was placed into a yellow zone and treated as having exposure to someone testing [redacted] Appropriate PPE were doned by staff at all times in all areas of the facility following guidance from ICAP/CDC/CMS and the local Health Department. Signage was put into place to identify what PPE was required in the specific area. PPE carts were place strategically in the facility to allow for ease of donning and doffing PPE. 4-6-2020 Resident #2 expired, notification received of [redacted] Room #1 sealed off and labeled red zone awaiting terminal cleaning. 4-10-2020 8 [redacted] returned. All on south wing. Zones established following guidance from ICAP and CDC. 4-10-20 Plan of Action for cleaning south	

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F 880	Continued From page 4 at 6:46 p.m. facility was notified that Resident #2 had [redacted] Record review on 6-10-2020 of Resident #1 Face Sheet, admission date was [redacted] Record review on 6-10-2020 of Resident #1 progress note dated [redacted] Resident # 1 was admitted to skilled Medicare services at this facility as skilled care is available. Record review on 6-10-2020 of Resident #1 progress notes dated [redacted] confirmed resident condition worsening and resident #1's primary care physician being contacted. Resident #1 was sent to the [redacted] for evaluation. Nursing staff later informed by the hospital that Resident #1 was being admitted for [redacted] Staff interview on 6-10-2020 at 2:15 p.m. Administrator confirmed that Resident #1 was transferred from the Hospital to general population and placed with Resident #2 [redacted] Resident was not placed in 14 day isolation as Resident #1 did not have a [redacted] when discharged from [redacted] and Administrator reported having been informed by their consultant that they did not have to place Resident #1 in isolation upon admission. Administrator and Director or Nursing did present the QSO-20-14-NH dated 3-13-20 which indicated "Nursing homes should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of [redacted] was/is present. Also, if possible, dedicate a unit/wing exclusively for any	F 880	hallway developed [redacted] and one resident with symptoms transferred to [redacted] for Care. Resident testing [redacted] transferred by ambulance to limit exposure to those [redacted] Zones reestablished. 4-12-2020 2 residents [redacted] per ambulance for care. 4-13-2020 Continued with zones waiting for terminal cleaning of areas per ICAP/CDC guidance. 4-15-2020 resident with S/S only returned with [redacted] Placed in private room gray zone for 14 days to observe and monitor following CDC guidance. 4-24-2020 New zones created to allow for a red zone, dedicated wing for return of [redacted] residents from [redacted] placed in room by self in gray zone for 14 days following ICAP/CDC guidelines. Negative COVID test received prior to readmission. 5-1-2020 NETEC (The National Emerging Special Pathogen Training and Education Center) came to facility per invitation of our QA program to provide technical assistance in our policies and procedures for COVID-19 Unit and the rest of the facility. [redacted] placed in room by self in gray zone for 14 days following ICAP/CDC guidelines. [redacted] received prior to readmission.	