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

MIDWEST DIVISION OF SURVEY AND CERTIFICATION

June 21, 2020

Shawn Leach, Administrator
Good Samaritan Society - St Luke's Village
2201 East 32nd Street
Kearney, NE 68847-3999

CMS Certification No: 285192

Dear Mr. Leach:

SUBJECT: SURVEY RESULTS
Cycle Start Date: June 11, 2020

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

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

SURVEY RESULTS
On June 11, 2020, the Centers for Medicare & Medicaid Services (CMS) completed a COVID-19 Focused Survey at Good Samaritan Society – St. Luke's Village to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was in substantial compliance with participation requirements and no deficiencies were cited. The findings from this survey are documented on the enclosed form CMS 2567.

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

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

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

Sincerely,

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

cc:
NE DHHS
Allen/Grimes

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

Pete Ricketts, Governor

July 24, 2020

Lucas Kaup, Administrator
Alpine Village Retirement Center
706 James Street
Verdigre, NE 68783

CMS CERTIFICATION NUMBER: 285190

Dear Mr. Kaup:

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

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

Pete Ricketts, Governor

July 22, 2020

Lisa McDermed, Administrator
Arbor Care Centers-Franklin Llc
1006 M Street
Franklin, NE 68939

CMS CERTIFICATION NUMBER: 285096

Dear Ms. McDermed:

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

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

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 20, 2020

Megan Wieck, Administrator
Arbor Care Centers-Fullerton Llc
Po Box 648, 202 North Esther
Fullerton, NE 68638-0648 **CMS Certification No. 285115**

Subject: Survey Results
Cycle Start Date: July 14, 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 14, 2020, a survey was completed at Arbor Care Centers-Fullerton Llc 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 30, 2020**, to the State Survey Agency Contact. **Failure to submit an acceptable PoC by July 30, 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, September 3, 2020 in accordance with the statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal regulations at 42 CFR §488.417. Your Medicare Administrative Contractor will be notified of the date the denial of payment begins. DPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated.

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 14, 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
	285115	A. BUILDING _____ B. WING _____	07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-FULLERTON LLC	PO BOX 648, 202 NORTH ESTHER FULLERTON, NE 68638

(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 | 07/29/2020

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
	285115	A. BUILDING _____ B. WING _____	07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-FULLERTON LLC	PO BOX 648, 202 NORTH ESTHER FULLERTON, NE 68638

(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	A-1. All Facility health care personnel were re-educated on 7/15/2020 on	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285115	A. BUILDING _____ B. WING _____	07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-FULLERTON LLC	PO BOX 648, 202 NORTH ESTHER FULLERTON, NE 68638

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observations, interviews and record reviews, the facility failed to implement infection control practices and Centers for Medicare and Medicaid Services (CMS) guidelines to prevent potential cross contamination including the spread of COVID-19 (a mild to severe respiratory illness that is caused by a coronavirus) related to the facility failure to ensure staff wore surgical masks within the facility, failure to ensure staff were able to identify eye protection was required when caring for residents in a grey zone (a transitional zone for asymptomatic residents who have been in an outside facility), failure to ensure staff temperatures were accurate, failure to follow up on questions indicated on screening sheets, and failure to ensure accurate information was documented on the screening tool. The facility failure had the potential to affect all residents in the building. The facility identified a census of 69. Findings are: A. Observation on 7/14/20 at 8:05 AM revealed the DON (Director of Nursing) was wearing a cloth mask. A box of cloth masks and a bin labeled for disposal of used cloth masks was noted near the screening station. The DON offered the surveyors a cloth mask after being screened. An observation on 7/14/20 at 8:20 A.M. revealed Employee E to have a cloth mask on. Observation on 7/14/20 at 8:45 AM revealed the ADM (Administrator) was wearing a cloth mask. Observation on 7/14/20 at 9:10 AM - 9:20 AM revealed some staff were wearing cloth masks	F 880	wearing surgical/procedural facemasks regardless of their position. A-2 DNS and ED will monitor the CDC website weekly for information and resources. Per the CDC, health care personnel should wear a facemasks at all times while they are in the facility, and cloth face covering should not be worn by HCP instead of a respirator or facemask if PPE is required. A-3 System change- The DNS and/or ED will monitor the CDC website weekly and take any new information and resources and share them with all staff to assure staff knowledge of all aspects of infection control resources to ensure resident safety. A-4 Audits will be conducted by the DNS and/or designee to ensure essential healthcare personnel, regardless of their position, who may interact with residents or enter resident□s rooms, will wear surgical/procedural facemasks. Audits will be completed weekly for two months. The results of the audits will be reported to the monthly QAPI meeting to ensure compliance. QAPI will determine frequency of audits if needed past two months. DNS/Designee are accountable for the process. A-5 Completion Date: 7/30/2020 B-1 All facility staff were re-educated on	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285115	A. BUILDING _____ B. WING _____	07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-FULLERTON LLC	PO BOX 648, 202 NORTH ESTHER FULLERTON, NE 68638

(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 3 and some staff were wearing surgical masks. Observation on 7/14/20 at 9:19 AM revealed Employee A was wearing a cloth mask. Interview on 7/14/20 at 9:19 AM with Employee A revealed they had been wearing cloth masks since staff were told cloth masks were acceptable to wear in the facility. Interview on 7/14/20 at 10:15 AM with Employee B revealed cloth masks were acceptable to wear in the facility, but Employee B preferred a surgical mask due to being easier to breathe. Interview on 7/14/20 at 1:25 PM with the ADM revealed the facility switched to using cloth masks in the past few weeks to conserve PPE (Personal Protective Equipment). The ADM revealed the facility did have enough PPE in the facility, and the facility's home office also has a stockpile that would be dispersed to the facility as required. The ADM revealed a PPE calculation was sent to the facility's home office every Friday. Review of the Establishing Zones COVID Policy dated 6/2020 revealed Green Zone (COVID free zone) PPE included surgical or cloth masks. Review of the Optimizing PPE policy dated 4/20 revealed cloth masks are a barrier, not personal protective equipment. Review of the CDC's Preparing for COVID-19 in Nursing Homes website page dated 6/25/20 revealed HCP (Healthcare Personnel) included nurses, nursing assistants, and persons not directly involved in patient care, but who could be exposed to infectious agents that could be	F 880	7/15/2020 on what PPE is required in the grey zone. B-2 Proper signage is now used on the resident□s rooms to ensure that all staff were aware of the necessary infection control steps that need to be taken for residents in the grey zone and appropriate PPE for the grey zone. B-3 System Change: Appropriate signage is in place to identify the necessary infection control steps that need to be taken to care for residents in the grey zone as well as what PPE should be used. B-4 An audit will be conducted by the DNS and/or designee to ensure staff are wearing the appropriate PPE designated for the Grey Zone. Audits will be completed weekly for two months. The results of the audits will be reported to the monthly QAPI meeting to ensure compliance. QAPI will determine frequency of audits if needed past two months. DNS/designee are accountable for the process. B-5 Completion Date: 7/30/2020 C-1 Facility health care personnel were re-educated on 7/15/2020 on proper screening for signs and symptoms that all symptoms should be acknowledged and legible.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285115	A. BUILDING _____ B. WING _____	07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-FULLERTON LLC	PO BOX 648, 202 NORTH ESTHER FULLERTON, NE 68638

(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 transmitted in the healthcare setting, including dietary, laundry, environmental services, and administration. CDC guidance revealed HCP should wear a facemask at all time while they are in the facility, and cloth face covering should not be worn by HCP instead of a respiratory or facemask if PPE is required. B. The interview with Employee E on 7/14/20 at 8:20 A.M revealed that staff would wear a surgical mask in the gray zone with no mention of eye protection or face shield. Interview on 7/14/20 at 10:15 AM with Employee B revealed PPE required to care for residents in a Grey Zone included N95 masks, gloves, and gown, but eye protection was not required. Review of the undated facility education for Recommendations for PPE revealed the Standard Precaution heading listed mask, eye protection, and/or face shield recommended for procedures and patient care activities likely to generate splashes or sprays of blood, body fluids, and secretions. No note of eye protection was listed under the Contact, Droplet, or Airborne Precaution headings. Review of the undated Droplet Precaution sign revealed eye protection was not included in the list of required PPE. Review of the undated Airborne Precaution sign revealed eye protection was not included in the list of required PPE. Review of the undated facility Phasing Plan revealed the facility would isolate residents in a Grey Zone and PPE (Personal Protective	F 880	C-2- Thermometer has been replaced that gave low readings and staff was educated that if a low temp was taken to use a different thermometer to achieve an accurate temperature. C-3 System change: The DNS/ED/or designee will monitor staff sign in sheet multiple times throughout each day to ensure symptoms are properly addressed and monitored. C-4 Audits will be conducted by the DNS/ED/or designee to ensure staff symptoms and temperatures are monitored properly. Audits will be completed weekly for two months. The results of the audits will be reported to the monthly QAPI meeting to ensure compliance. QAPI will determine frequency of audits if needed past two months. DNS/ED/Designee are accountable for the process. C-5: Completion Date will be 7/30/2020 D-1 Facility health care personnel were re-educated on 7/15/2020 on proper screening for signs and symptoms that all symptoms should be acknowledged and legible. D-2- Thermometer has been replaced that gave low readings and staff was educated that if a low temp was taken to use a different thermometer to achieve an accurate temperature.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285115	A. BUILDING _____ B. WING _____	07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-FULLERTON LLC	PO BOX 648, 202 NORTH ESTHER FULLERTON, NE 68638

(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 Equipment) required for the Grey Zone include gown, gloves, eye protection, and N95 mask. If an N95 mask was not available, the facility would use surgical masks with a face shield. Review of the undated Review of Zones and PPE information sheet revealed the Grey Zone required gown, gloves, eye protection, and N95 mask. If an N95 mask was not available, the facility would use surgical masks with a face shield. C. A record review of the facility Covid-19 screening logs titled Staff Screening Sign In Sheet (SSSIS) dated 7/9/20 through 7/14/20 revealed staff documenting if the screening occurred upon entry to the facility or exit of the facility by an "in" or "out" response. The review of the SSSIS's revealed staff were placing this information in the column that was intended to address Covid-19 symptoms of Headache or Dizziness. A review of the SSSIS's for 7/10/20 revealed an entry with an illegible name and no temperature documented. The review revealed an SSSIS on 7/10/20 with no staff name documented. The review of the SSSIS's dated 7/9/20 through 7/14/20 revealed temperatures below 95.0 F had been documented 25 times with no evidence of a follow up evaluation. The review of the SSSIS's dated 7/9/20 through 7/14/20 revealed no date indicated on 10 occurrences.	F 880	D-3 System change: The DNS/ED/or designee will monitor staff sign in sheet multiple times throughout each day to ensure symptoms are properly addressed and monitored. D-4 Audits will be conducted by the DNS/ED/or designee to ensure staff symptoms and temperatures are monitored properly. Audits will be completed weekly for two months. The results of the audits will be reported to the monthly QAPI meeting to ensure compliance. QAPI will determine frequency of audits if needed past two months. DNS/ED/Designee are accountable for the process. D5- Completion date will be 7/30/20	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285115	A. BUILDING _____ B. WING _____	07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-FULLERTON LLC	PO BOX 648, 202 NORTH ESTHER FULLERTON, NE 68638

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6 The review of the SSSIS's dated 7/9/20 through 7/14/20 revealed no time indicated on 3 occurrences D. An interview on 7/14/20 at 10:10 A.M. with the Administrator consisted of reviewing the facility staff screening sheets. During the interview, the Administrator confirmed that some forms were missing information such as a name or temperature readings. During the interview the Administrator confirmed that one of the thermometers had consistently low readings but was still being used. The interview confirmed that the facility required the staff to screen upon entering the facility but also prior to leaving the facility. The Administrator confirmed that several of the second temperature columns were blank. During the interview it was confirmed that the staff were indicating if the screen was upon entering or leaving the facility by documenting an "in" or "out" on the screening sheets. The interview confirmed that staff were writing their "in" or "out" in the column provided to address the symptom of Headache/Dizziness and that the symptom of Headache/Dizziness had not been answered.	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
	285115	A. BUILDING _____ B. WING _____	07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-FULLERTON LLC	**PO BOX 648, 202 NORTH ESTHER FULLERTON, NE 68638**

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

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

Electronically Signed | 07/29/2020

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
	285088	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-HARTINGTON LLC	PO BOX 107, 401 DARLENE STREET HARTINGTON, NE 68739

(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 the survey report as they apply to deficient practices identified.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		8/1/20

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

Electronically Signed | 07/30/2020

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
	285088	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-HARTINGTON LLC	PO BOX 107, 401 DARLENE STREET HARTINGTON, NE 68739

(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	Hartington A-1. DNS and ED will monitor the CDC	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285088	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-HARTINGTON LLC	PO BOX 107, 401 DARLENE STREET HARTINGTON, NE 68739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observation, record review, and interview; the facility failed to ensure that standard of practice regarding personal protective equipment (PPE) for residents on Transmission Based Precautions were in place to protect residents from COVID-19 (a highly contagious virus primarily spread from person to person through respiratory droplets, which can lead to serious illness and even death) for 3 of 3 sampled Residents (Residents 1, 2, and 3) and failed to ensure approved face masks were worn for health care providers which had the ability to affect all residents. The total sample size was 6 and the facility census was 21. Findings are: A. Review of The Center for Medicare and Medicaid Services (CMS) Center for Clinical Standards and Quality and Oversight Group dated 3/13/20 revealed the following guidance for infection control and prevention of COVID-19: -Facilities should regularly monitor the Center for Disease Control (CDC) website for information and resources. -Prompt detection, triage, and isolation of potentially infectious residents are essential to prevent unnecessary exposures among residents and healthcare personnel. B. Review of Infection Control Assessment and Promotion Program (ICAP) zone recommendations revealed: - The "Red Zone" was for residents that were either positive or presumptive positive for COVID-19. PPE requirements included gown, gloves, eye protection, and N95 mask (N95 preferred, if no N95, then a surgical mask with a	F 880	website weekly for information and resources. A-2. DNS and ED will monitor the CDC website weekly for information and resources. Per the CDC, prompt detection, triage, and isolation of potentially infectious residents essential to prevent unnecessary exposures among residents and healthcare personnel. A-3. System change □ The DNS and/or ED will monitor the CDC website weekly and take any new information and resources and share them with all staff to assure staff knowledge of all aspects of infection control resources to ensure resident safety. A-4. Audits will be developed and conducted by the DNS and/or designee to ensure any new recommendations coming out from the CDC are followed through. Audits will be completed weekly for two months. The results of the audits will be reported to the monthly QAPI meeting to ensure compliance. QAPI will determine frequency of audits if needed past two months. DNS/Designee are accountable to the process. A-5. Completion date: 8/1/2020 B-1. Zone recommendations from ICAP will be used by facility to establish appropriate PPE to be worn by staff in the different designated zones (red zone,	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285088	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-HARTINGTON LLC	PO BOX 107, 401 DARLENE STREET HARTINGTON, NE 68739

(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 3 face shield). - The "Yellow Zone" was for residents that were asymptomatic but had been exposed to COVID-19. PPE requirements included gown, gloves, eye protection, and N95 mask (N95 preferred, if no N95, then a surgical mask with a face shield). - The "Grey Zone" was for residents that were transferred from the hospital or an outside facility but had no known COVID-19 exposure. PPE requirements included gown, gloves, eye protection, and N95 mask (N95 preferred, if no N95, then a surgical mask with a face shield). - The "Green Zone" was for asymptomatic residents without any exposure to COVID-19. PPE requirements included a surgical mask and other PPE per standard precautions. C. Review of the Nebraska Department of Health and Human Services Long-Term Care COVID-19 Phasing Guidance revealed if a facility was in "Phase 1" the facility needed to provide universal source control and PPE. All facility staff and essential healthcare personnel, regardless of their position, who may interact with residents or enter resident rooms, should wear a surgical/procedural facemask. D. Observations of facility Staff Member-H on 7/15/20 from 9:00 AM to 11:00 AM revealed the staff member walking in the hallways of the building. The staff member wore a cloth face covering. Staff Member-H also held a professional license, which would make it possible that the staff member would need to assist with resident care if an emergent situation was to arise. E. Review of Resident 1's Progress Notes	F 880	yellow zone, grey zone and green zones). If a resident is present in the building, appropriate signage will be placed around and/or on resident□s doorway to ensure staff are aware of necessary infection control measures to be used in the different zones. B-2. Facility health care personnel were re-educated on 7-16-20 and again on 7/27/20 on appropriate PPE to be worn in the different zones and proper signage used on the resident□s rooms to ensure that staff were aware of the necessary infection control steps that need to be taken prior to entering residents rooms. B-3. System change- Color coded stop signs were placed on resident□s rooms 7-16-20 to indicate which zone the residents are in and appropriate infection control measures that need to taken by staff when entering resident□s rooms in the different zones. B-4. An audit will be conducted by the DNS and/or designee to ensure that color coded stop signs are placed on residents doorways that denote the infection control measures that need to be implemented for residing resident and appropriate infection control precautions are to be implemented for any staff caring for those designated residents. Audits will be completed weekly for two months. The results of the audits will be reported to the monthly QAPI meeting to ensure compliance. QAPI will determine frequency of audits if needed past two	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285088	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-HARTINGTON LLC	PO BOX 107, 401 DARLENE STREET HARTINGTON, NE 68739

(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 revealed:  On 7/15/20 from 10:20 AM to 10:25 AM, Nursing Assistant (NA)-G was observed entering Resident 1's room wearing a surgical mask, face shield, disposable gown, and gloves. F. Interviews with the Director of Nursing (DON) on 7/15/20 from 8:30 AM to 11:00 AM confirmed Resident 1 had been placed in "Red Zone" isolation due to having symptoms consistent with potential COVID-19 [redacted] Further interview revealed there was a recent positive COVID-19 case in the community so the facility has remained in "Phase 1". The DON stated the facility did not have a shortage of PPE and did have N95 masks available but they were not using them at this time as they were "saving" them. G. Observation of Resident 3 on 7/15/20 at 8:50 AM revealed Resident 3 attempted to leave the resident's room and Registered Nurse (RN)-B immediately intervened and asked Resident 3 to return to the resident's room. NA-G stepped in to help and while RN-B distracted Resident 3, NA-G put on a gown and gloves (a surgical mask was already in place), and assisted Resident 3 back into the room. NA-G did not apply a face shield,	F 880	months. DNS/Designee are accountable to the process. B-5. Completion date: 8/1/20 C-1. The facility will provide universal source control and PPE. All facility staff and essential healthcare personnel, regardless of their position, who may interact with residents or enter resident□s rooms, will wear surgical/procedural facemasks. C-2. Facility health care personnel were re-educated on 7-16-20 and again on 7-22-20 on wearing surgical/procedural facemasks regardless of their position. C-3. Facility health care personnel were re-educated on 7-16-20 and again on 7-22-20 on wearing surgical/procedural facemasks regardless of their position. C-4. An audit will be conducted by the DNS and/or designee to ensure essential healthcare personnel, regardless of their position, who may interact with residents or enter resident□s rooms, will wear surgical/procedural facemasks. Audits will be completed weekly for two months. The results of the audits will be reported to the monthly QAPI meeting to ensure compliance. QAPI will determine frequency of audits if needed past two months. DNS/Designee are accountable to the process.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285088	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-HARTINGTON LLC	PO BOX 107, 401 DARLENE STREET HARTINGTON, NE 68739

(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 goggles, or an N95 mask. H. Observation of RN-B on 7/15/20 at 10:10 AM revealed RN-B responded to Resident 2's call for assistance. RN-B put on a gown and gloves (a surgical mask was already in place). RN-B entered the resident room and conversed with the resident from the bedside. RN-B then removed the gloves and gown inside the resident room, placed the gloves and gown in the trash, exited the room, and used hand sanitizer. Immediately after RN-B exited the room, Resident 2 called from the bed requesting to visit with RN-B. RN-B put on a gown and glove (the surgical mask was already in place) and re-entered Resident 2's room. After conversing with Resident 2 RN-B removed the gloves, and gown, placed the gloves and gown in the trash, exited the room, and used hand sanitizer. RN-B did not apply a face shield, goggles or an N95 mask. I. Interview with the DON on 7/15/20 at 11:00 AM revealed the facility had N95 masks available, but were not requiring N95 mask use by staff during care of residents in the Red Zone, Yellow Zone, or Grey Zone. Staff were using face shields and a surgical mask in the Red Zone and Yellow Zone, but were only using a surgical masks in the Grey Zone (unless an aerosol creating procedure was anticipated).	F 880	C-5. Completion date: 8/1/2020. D-1. Staff member H was re-educated on 7-16-20 and again on 7-22-20 on wearing surgical/procedural facemasks regardless of their position. D-2. Facility health care personnel were re-educated on 7-16-20 and again on 7-22-20 on wearing surgical/procedural facemasks regardless of their position. D-3. Facility health care personnel were re-educated on 7-16 -20 and again on 7-22-20 on wearing surgical/procedural facemasks regardless of their position. D-4. An audit will be conducted by the DNS and/or designee to ensure essential healthcare personnel, regardless of their position, who may interact with residents or enter resident□s rooms, will wear surgical/procedural facemasks. Audits will be completed weekly for two months. The results of the audits will be reported to the monthly QAPI meeting to ensure compliance. QAPI will determine frequency of audits if needed past two months. DNS/Designee are accountable to the process. D-5. Completion date: 8-1-2020 E-1. Resident #1 was in the facilities Red Zone due to symptoms. Signage was posted on or around the resident□s door/doorway 7-12-20 to indicate the	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285088	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-HARTINGTON LLC	PO BOX 107, 401 DARLENE STREET HARTINGTON, NE 68739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6	F 880	resident was in the red zone and isolation equipment will be placed in or around the resident□s doorway to indicate the need for transmission-based precautions and what PPE needs to be worn in the red zone. Resident #1 was returned to standard precautions on 7-24-2020. NA-G has been re-educated on 7-16-20 and again on 7/27/20 on residents that require transmission-based precautions in the red zone and what PPE is required in the red zone. E-2. Facility health care personnel were re-educated on 7-16 -2020 and again on 7/27/20 on proper signage used on the patient□s rooms to ensure that all staff were aware of the necessary infection control steps that need to be taken for residents in the red zone and appropriate PPE for the red zone. E-3. System change: Appropriate signage is in place to identify the necessary infection control steps that need to be taken to care for residents in the red zone. DNS and/or designee will review daily to assess any changes in resident status and/or discuss any residents changes that may require red zone criteria. E-4. An audit will be conducted by the DNS and/or designee to ensure residents are appropriately placed in the red zone and appropriate transmission-based precautions are implemented for any resident requiring the red zone. Audits will be completed weekly for two	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285088	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-HARTINGTON LLC	PO BOX 107, 401 DARLENE STREET HARTINGTON, NE 68739

(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	F 880	months. The results of the audits will be reported to the monthly QAPI meeting to ensure compliance. QAPI will determine frequency of audits if needed past two months. DNS/Designee are accountable to the process E-5. Completion date: 8-1-2020. F-1. DON will follow the Zone recommendations from ICAP will be used by facility to establish appropriate PPE to be worn by staff in the different designated zones (red zone, yellow zone, grey zone and green zones). If a resident is present in the building, appropriate signage will be placed around and/or on resident□s doorway to ensure staff are aware of necessary infection control measures to be used in the different zones and that N95s are to be worn in the red zone unless there is documentation to prove an N95 shortage. F-2. Facility health care personnel were re-educated on 7-16-2020 and again on 7/27/20 on proper signage used on the patient□s rooms to ensure that all staff were aware of the necessary infection control steps that need to be taken for residents in the red zone and appropriate PPE for the red zone to include N95s. F-3. System Change; Appropriate signage is in place to identify the necessary infection control steps that need to be taken to care for residents in the red zone, to include use of N95 masks. DNS and/or designee will review	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285088	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-HARTINGTON LLC	PO BOX 107, 401 DARLENE STREET HARTINGTON, NE 68739

(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 8	F 880	daily to assess any changes in resident status and/or discuss any residents changes that may require red zone criteria. F-4. An audit will be conducted by the DNS and/or designee to ensure residents are appropriately placed in the red zone, and transmission-based precautions are implemented for any resident requiring the red zone to include the use of N95s. Audits will be completed weekly for two months. The results of the audits will be reported to the monthly QAPI meeting to ensure compliance. QAPI will determine frequency of audits if needed past two months. DNS/Designee are accountable to the process F-5. Completion date: 8-1-2020. G-1. Resident #3 was in the facilities Grey Zone. Signage was be posted on or around the resident□s door/doorway 7-13 -20 to indicate the resident was in the grey zone and isolation equipment will be placed in or around the resident□s doorway to indicate the need for transmission-based precautions and what PPE needs to be worn in the grey zone. Resident #3 was returned to standard precautions on 7-27-2020. Nurse (RN)B has been re-educated on 7-21-20 on residents that require transmission-based precautions in the grey zone and what PPE is required in the grey zone. G-2. Facility health care personnel were	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285088	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-HARTINGTON LLC	PO BOX 107, 401 DARLENE STREET HARTINGTON, NE 68739

(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 9	F 880	re-educated on 7-16-2020 and again on 7/27/20 on proper signage used on the patient□s rooms to ensure that all staff were aware of the necessary infection control steps that need to be taken for residents in the grey zone and appropriate PPE for the grey zone. G-3. System change: Appropriate signage is in place to identify the necessary infection control steps that need to be taken to care for residents in the grey zone. DNS and/or designee will review daily to assess any changes in resident status and/or discuss any residents changes that may require grey zone criteria. G-4. An audit will be conducted by the DNS and/or designee to ensure residents are appropriately placed in the grey zone and appropriate transmission-based precautions are implemented for any resident requiring the grey zone. Audits will be completed weekly for two months. The results of the audits will be reported to the monthly QAPI meeting to ensure compliance. QAPI will determine frequency of audits if needed past two months. DNS/Designee are accountable to the process G-5. Completion date: 8-1-2020 H-1. Resident #2 was in the facilities Grey Zone. Signage was be posted on or around the resident□s door/doorway 7-13 -20 to indicate the resident was in the grey zone and isolation equipment will be	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285088	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-HARTINGTON LLC	PO BOX 107, 401 DARLENE STREET HARTINGTON, NE 68739

(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 10	F 880	placed in or around the resident□s doorway to indicate the need for transmission-based precautions and what PPE needs to be worn in the grey zone. Resident #2 was returned to standard precautions on 7-27-2020. Nurse (RN)B has been re-educated on 7-21-20 on residents that require transmission-based precautions in the grey zone and what PPE is required in the grey zone. H-2. Facility health care personnel were re-educated on 7-16-2020 and again on 7/27/20 on proper signage used on the patient□s rooms to ensure that all staff were aware of the necessary infection control steps that need to be taken for residents in the grey zone and appropriate PPE for the grey zone. H-3. System Change: Appropriate signage is in place to identify the necessary infection control steps that need to be taken to care for residents in the grey zone. DNS and/or designee will review daily to assess any changes in resident status and/or discuss any residents changes that may require grey zone criteria. H-4. An audit will be conducted by the DNS and/or designee to ensure residents are appropriately placed in the grey zone and appropriate transmission-based precautions are implemented for any resident requiring the grey zone. Audits will be completed weekly for two months. The results of the audits will be	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285088	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-HARTINGTON LLC	PO BOX 107, 401 DARLENE STREET HARTINGTON, NE 68739

(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 11	F 880	reported to the monthly QAPI meeting to ensure compliance. QAPI will determine frequency of audits if needed past two months. DNS/Designee are accountable to the process H-5 Completion date: 8-1-2020 I-1. DON will follow the Zone recommendations from ICAP will be used by facility to establish appropriate PPE to be worn by staff in the different designated zones (red zone, yellow zone, grey zone and green zones). If a resident is present in the building, appropriate signage will be placed around and/or on resident□s doorway to ensure staff are aware of necessary infection control measures to be used in the different zones and that N95s are to be worn in the appropriate zones unless there is documentation to prove an N95 shortage. I-2. Facility health care personnel were re-educated on 7-16-2020 and again on 7/27/20 on proper signage used on the patient□s rooms to ensure that all staff were aware of the necessary infection control steps that need to be taken for residents in the different zones and appropriate PPE for the individual zones to include N95s. I-3. System Changes: Appropriate signage is in place to identify the necessary infection control steps that need to be taken to care for residents in the different zones, to include use of N95 masks. DNS and/or designee will review	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285088	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-HARTINGTON LLC	PO BOX 107, 401 DARLENE STREET HARTINGTON, NE 68739

(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 12	F 880	daily to assess any changes in resident status and/or discuss any residents changes that may require changes in zones and/or different PPE to be worn by staff. I-4. An audit will be conducted by the DNS and/or designee to ensure residents are appropriately placed in the different zones and transmission-based precautions are implemented for any resident requiring the according to the different zones to include the use of N95s. Audits will be completed weekly for two months. The results of the audits will be reported to the monthly QAPI meeting to ensure compliance. QAPI will determine frequency of audits if needed past two months. DNS/Designee are accountable to the process I-5. Completion date 8-1-2020 DPOC- 1. All staff will acknowledge, understanding and properly follow the CDC Covid-19 best practices after watching the following training videos: Sparkling Surfaces, Clean Hands, Closely Monitor Residents, Keep Covid-19 Out, and Use PPE Correctly for Covid-19. 2. Re-education will be provided for any deficient practices identified as to hand washing, cleaning surfaces and PPE usages. 3. System Change: The training videos will now be part of our orientation check	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285088	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-HARTINGTON LLC	**PO BOX 107, 401 DARLENE STREET HARTINGTON, NE 68739**

(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 13	F 880	list as well as annual staff training. Competencies will continue to be done regarding hand washing, surface cleaning and donning and doffing PPE. 4. Audits will be developed and conducted by the DNS and/or designee to ensure all CDC recommendations are being followed and new information/recommendations coming out from the CDC are followed. Audits will be completed weekly for two months. The results of the audits will be reported to the monthly QAPI meeting to ensure compliance. QAPI will determine frequency of audits if needed past two months. DNS/Designee are accountable to this process. 5. Completion date: 8-1-2020	

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

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 22, 2020

Lindsay Hutchinson, Administrator
Arbor Care Centers-Hartington Llc
Po Box 107, 401 Darlene Street
Hartington, NE 68739-0107 **CMS Certification No. 285088**

Subject: **Survey Results**
Cycle Start Date: July 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 July 16, 2020, a survey was completed at Arbor Care Centers-Hartington Llc 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 August 1, 2020**, to the State Survey Agency Contact. **Failure to submit an acceptable PoC by August 1, 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.

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

  Payment will be denied for all NEW Medicare and Medicaid admissions, August 21, 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 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

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 1, 2020

Matthew Burival, Administrator
Arbor Care Centers-O'Neill Llc
Po Box 756, 1102 North Harrison
O' Neill, NE 68763-0756 **CMS Certification No. 285108**

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 Arbor Care Centers-O'Neill Llc 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 at 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 45 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)

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 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 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
DPOC

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
	285108	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-O'NEILL LLC	PO BOX 756, 1102 NORTH HARRISON O' NEILL, NE 68763

(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 the survey report as they apply to deficient practices identified.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		7/24/20

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
	285108	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-O'NEILL LLC	PO BOX 756, 1102 NORTH HARRISON O' NEILL, NE 68763

(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	A-1. DNS and ED will monitor the CDC website weekly for information and	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285108	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-O'NEILL LLC	PO BOX 756, 1102 NORTH HARRISON O' NEILL, NE 68763

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observation, interview, and record view; the facility failed to 1) ensure visitors were screened for signs/symptoms of COVID-19 (A highly contagious virus primarily spread from person to person through respiratory droplets, which can lead to serious illness and even death); 2) ensure transmission-based precautions (the second tier of basic infection control and are to be used in addition to Standard Precautions for patients who may be infected with certain infectious agents for which additional precautions are needed to prevent infection) were implemented for Residents 1, 2, and 4; and 3) ensure staff wore masks in a manner to prevent potential cross-contamination. This had the potential to affect all residents. The sample size was 7 and the facility census was 45. 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 (Center for Disease Control) website for information and resources. Per the CDC, prompt detection, triage, and isolation of potentially infectious residents are essential to prevent unnecessary exposures among residents and healthcare personnel; -restriction of all visitors and non-essential healthcare personnel except for certain end of life situations; -implement active screening of residents for fever and respiratory symptoms;	F 880	resources. A-2. DNS and ED will monitor the CDC website weekly for information and resources. Per the CDC, prompt detection, triage, and isolation of potentially infectious residents essential to prevent unnecessary exposures among residents and healthcare personnel. Staff to acknowledge/view recommended CDC videos: Sparkling Surfaces, Clean Hands, Closely Monitor Residents, Lessons, Keep COVID-19 Out!, Lessons by 7/24/20. A-3. System change □ The DNS and/or ED will monitor the CDC website weekly and take any new information and resources and share them with all staff to assure staff knowledge of all aspects of infection control resources to ensure resident safety. A-4. Audits will be developed and conducted by the DNS and/or designee to ensure any new recommendations coming out from the CDC are followed through. Audits will be completed weekly for two months. The results of the audits will be reported to the monthly QAPI meeting to ensure compliance. QAPI will determine frequency of audits if needed past two months. DNS/Designee are accountable to the process. A-5. Completion date: 7/24/2020 B-1. Where the patient/resident was	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285108	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-O'NEILL LLC	PO BOX 756, 1102 NORTH HARRISON O' NEILL, NE 68763

(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 3 -screen all staff at the beginning of their shift for fever and respiratory symptoms. Actively take their temperatures and document the absence of shortness of breath, new or change in cough and sore throat. If they are ill, have them put on a mask and then self-isolate at home; and -the facility should identify staff that work at multiple facilities (such as agency staff) and actively screen and restrict them appropriately to ensure they do not place individuals in the facility at risk for COVID-19. B. Review of the CMS Clinical Standards and Quality, Safety and Oversight Group dated 3/23/20 revealed additional guidance. Where the patient/resident was sleeping at the health care facility, signage on the patient's room was important to ensuring that all staff were aware of the necessary infection control steps. C. Review of the facility "Infection Control during COVID-19 (New Admissions)" policy with a revision date of 3/2020 revealed: - New Admissions and re-admissions would be placed in a private room with private toileting facilities upon entry/re-entry to the facility. - Residents would be confined to their room for 14 days. - Staff would wear a mask during direct contact with the resident. - At the end of the 14 day period and if the resident had not displayed signs or symptoms of an infection the resident could be moved to their permanent place in the facility. D. Review of the facility policy "Monitoring Visitors related to COVID-19" with a revision date of 2/2020 revealed visitors would be screened by staff to determine if the visitor had traveled to a	F 880	sleeping at the health care facility, signage on the patient□s room is important to ensuing staff are aware of the necessary infection control steps. If a resident is present in the building, appropriate signage will be placed around and/or on resident□s doorway to ensure staff are aware of necessary infection control measures to be used in the different zones. B-2. Facility health care personnel were re-educated on 7-8-20 on proper signage used on the resident□s rooms to ensure that staff were aware of the necessary infection control steps that need to be taken prior to entering residents□ rooms. Staff to acknowledge/view recommended CDC videos: Closely Monitor Resident□s, Lessons, Keep COVID-19 Out! By 7/24/20. B-3. System change- Color coded stop signs were placed on resident□s rooms 7-8-20 to indicate which zone the residents are in and appropriate infection control measures that need to be taken by staff when entering resident□s rooms in the different zones. B-4. An audit will be conducted by the DNS and/or designee to ensure that color coded stop signs are placed on residents doorways that denote the infection control measures that need to be implemented for residing resident and appropriate infection control precautions are to be implemented for any staff caring for those designated residents.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285108	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-O'NEILL LLC	PO BOX 756, 1102 NORTH HARRISON O' NEILL, NE 68763

(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 restricted country in the last 14 days, had any signs or symptoms of a respiratory infection, and if they had contact with someone who had or was under investigation for COVID-19. If the visitors met any of the above criteria the facility may restrict their entrance in the facility. E. Review of Resident 2's Progress Note dated 6/5/20 revealed the resident was admitted to the facility from a community care home. Observation of Resident 2's room on 6/15/20 at 11:08 AM revealed no signage on or around the resident's door/doorway and no isolation equipment in or around the resident's doorway to indicate the need for transmission-based precautions. During an interview with Nursing Assistant (NA)-B on 6/15/20 at 11:10 AM, NA-B was unaware of anyone on the Memory Care Unit (MCU) that was to be on transmission-based precautions (NA-B was currently working on the MCU). F. Review of Resident 1's Progress Note dated 6/8/20 revealed the resident was re-admitted to the facility from the hospital. Observation of Resident 1's room on 6/15/20 at 10:23 AM revealed the resident was in a shared room with another resident. There was no signage in or around the doorway and there was also no isolation equipment in or around the resident's doorway to indicate the resident needed transmission-based precautions. G. Review of the Visitor Screening Logs 3/16/20 to 6/15/20 revealed the visitors were not always screened for signs/symptoms of COVID-19 as	F 880	Audits will be completed weekly for two months. The results of the audits will be reported to the monthly QAPI meeting to ensure compliance. QAPI will determine frequency of audits if needed past two months. DNS/Designee are accountable to the process. B-5. Completion date: 7/24/2020 C-1. New admissions and re-admissions would be placed in a private room (i.e., grey zone) with private toileting facilities upon entry/re-entry to the facility. -Residents would be confined to their room (i.e., grey zone) for 14 days. -Staff would wear a mask during direct contact with the resident. -At the end of the 14-day period and if the resident had not displayed signs or symptoms of an infection the resident could be moved to their permanent place in the facility. C-2. Facility health care personnel were re-educated on 7-8-20 on the facility infection Control during COVID-19 policies to include: ---New admissions and re-admissions would be placed in a private room (i.e., grey zone) with private toileting facilities upon entry/re-entry to the facility. ---Residents would be confined to their room (i.e., grey zone) for 14 days. ---Staff would wear a mask during direct contact with the resident and appropriate PPE worn in the grey zone. ---At the end of the 14 day period and if	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285108	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-O'NEILL LLC	PO BOX 756, 1102 NORTH HARRISON O' NEILL, NE 68763

(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 well as their temperature was not always taken prior to entry in the facility. H. On 6/15/20 at 11:10 AM NA-B was observed in a resident room on the MCU, NA-B's mask was below NA-B's nose (with bilateral nares visible). I. Interview with Registered Nurse (RN)-H (who was identified as the facility Infection Preventionist) confirmed residents that were new admission/re-admissions (including Residents 1 and 2) and those residents that needed to leave the facility for appointments (including Resident 4) should be put in "grey zone" transmission-based precautions. The staff should wear a gown and a mask when entering the room of residents on "grey zone" transmission-based precautions. The mask should be changed after finishing cares with a resident in the "grey zone". RN-H confirmed education to the staff on the "grey zone" and associated transmission-based precautions may not have been carried through as the facility had intended. Further interview confirmed re-admissions should be placed in a private room for 14 days but Resident 1 was not placed in a private room due to some miscommunication. RN-H confirmed any visitors that were allowed to visit for end-of-life situations should have been screened for signs/symptoms of COVID-19 and their temperature should have been taken. RN-H confirmed the facility expectation was for all staff to wear a face mask at all times while in the facility. J. Review of Resident 4's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care plan development) dated 4/22/20 revealed the resident was not receiving isolation/transmission based precautions.	F 880	the resident had not displayed signs or symptoms of an infection the resident could be moved to their permanent place in the facility. --Staff to acknowledge/view recommended CDC videos: Closely Monitor Residents, Keep COVID-19 Out!, Lessons by 7/24/20. C-3. System change: Residents that are to be monitored in the grey zone were identified and appropriate documentation can be found in the resident□s individual record. DNS has made a resident roster available at the nurse□s station designating those residents that are to be in the grey zone. Appropriate signage is in place to identify the necessary infection control steps that need to be taken to care for these residents. DNS and/or designee will review daily to assess any changes in resident status and/or discuss any residents changes that may require grey zone criteria. C-4. An audit will be conducted by the DNS and/or designee to ensure residents are appropriately placed in the grey zone□, and transmission-based precautions are implemented for any resident requiring the grey zone. Audits will be completed weekly for two months. The results of the audits will be reported to the monthly QAPI meeting to ensure compliance. QAPI will determine frequency of audits if needed past two months. DNS/Designee are accountable to the process. C-5. Completion date: 7/24/2020.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285108	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-O'NEILL LLC	PO BOX 756, 1102 NORTH HARRISON O' NEILL, NE 68763

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6 Review of Resident 4's Progress Notes from 3/11/20 through 6/15/20 revealed no indication the resident was in isolation/transmission based precautions. Review of Resident 4's Care Plan with a revision date of 6/3/20 revealed Resident 4 left the facility for [redacted] and there was no indication the resident was in transmission based precautions. Observation of Resident 4's room on 6/15/20 at 8:30 AM revealed no signage on the door to the resident's room alerting staff of transmission based precautions while caring for the resident. During an interview on 6/15/20 at 8:45 AM NA-B reported not being aware of residents that were in a "grey zone" and that no residents on the MCU (where NA-B was assigned) were on transmission based precautions. Interview on 6/15/20 at 9:00 AM with RN-C revealed the nurse was unaware of "grey zone" residents, and the policies and protocols for transmission based precautions for residents in the "grey zones". Interview on 6/15/20 at 10:15 AM with laundry/housekeeping supervisor revealed no knowledge of facility policies and procedures for "grey zone" residents or related laundry or cleaning protocols. Interview on 6/15/20 at 11:30 AM with NA-A revealed NA-A was unaware of which residents were in the "grey zone" and the associated infection control measures needed.	F 880	D-1. Visitors are screened by staff to determine if the visitors had traveled to a restricted country in the last 14 days, had any signs or symptoms of a respiratory infection, and if they had contact with someone who had or was under investigation for COVID-19. If the visitors met any of the above criteria the facility may restrict their entrance in the facility. D-2. Facility health care personnel were educated on 7-8-20 on the facility policy on monitoring visitors. Visitors are to be screened by staff to determine if the visitors had traveled to a restricted country in the last 14 days, had any signs or symptoms of a respiratory infection, and if they had contact with someone who had or was under investigation for COVID-19. If the visitors met any of the above criteria the facility may restrict their entrance in the facility. Staff to acknowledge/view recommended CDC videos: Keep COVID-19 Out!, Clean hands, Sparkling Surfaces by 7/24/20. D-3. System Change: DNS/Designee will oversee this process throughout the day to assure the screening form is properly filled out. Visitors are screened for signs/symptoms of COVID-19, this includes temperatures being taken at all entries/exits from the building. Staff understand visitors answering "yes" to any symptoms or a temperature over 100 degrees will not be allowed to enter facility.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285108	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-O'NEILL LLC	PO BOX 756, 1102 NORTH HARRISON O' NEILL, NE 68763

(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 Interview on 6/15/20 at 12:30 AM with the Infection Preventionist confirmed Resident 4 should have been placed in a "grey zone" with transmission based precautions.	F 880	D-4. An audit will be conducted by the DNS and/or designee to ensure that visitors are screened for signs/symptoms according to facility policy. Audits will be completed weekly for two months. The results of the audits will be reported to the monthly QAPI meeting to ensure compliance. QAPI will determine frequency of audits if needed past two months. DNS/Designee are accountable to the process. D-5. Completion date: 7/24/2020 E-1. Resident #2 admitted to the facility from a community care home environment. Residents admitted from a community care home- based environment will be admitted to the designated grey area in the facility. Signage will be posted on or around the resident□s door/doorway in the grey area and isolation equipment will be placed in or around the resident□s doorway to indicate the need for transmission-based precautions. Resident #2□s care plan and any residents admitted from a community care home-based environment will be updated at time of admit to demonstrate the changes in the resident□s status and change in care needs. Resident #2 was returned to standard precautions on 6/19/2020. NA-B has been on vacation since this was identified. NA-B is scheduled to return to work on 8/1/20 and will be re-educated on residents on MCU that require	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285108	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-O'NEILL LLC	PO BOX 756, 1102 NORTH HARRISON O' NEILL, NE 68763

(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 8	F 880	transmission-based precautions grey zone criteria prior to her returning to work to assure compliance. E-2. All facility health care personnel were re-educated on 7-8-2020 on proper signage used on the patient□s rooms to ensure that all staff were aware of the necessary infection control steps that need to be taken. Facility health care personnel were re-educated on 7/8/2020 on the facility infection Control during COVID-19 policies to include: ---New admissions and re-admissions would be placed in a private room (i.e., grey zone) with private toileting facilities upon entry/re-entry to the facility. ---Residents would be confined to their room (i.e., grey zone) for 14 days. ---Appropriate PPE worn for residents in the grey zone for transmission based precautions. ---At the end of the 14 day period and if the resident had not displayed signs or symptoms of an infection the resident could be moved to their permanent place in the facility. --Staff to acknowledge/view recommended CDC videos: Keep COVID-19 Out!, Clean hands, Sparkling Surfaces, Closely Monitor Residents by 7/24/20. E-3. System Change: Residents that are to be monitored in the grey zone were identified and appropriate documentation can be found in the resident□s individual	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285108	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-O'NEILL LLC	PO BOX 756, 1102 NORTH HARRISON O' NEILL, NE 68763

(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 9	F 880	record. DNS has made a resident roster available at the nurse□s station designating those residents that are to be in the grey zone. Appropriate signage is in place to identify the necessary infection control steps that need to be taken to care for these residents. DNS and/or designee will review daily to assess any changes in resident status and/or discuss any residents changes that may require grey zone criteria. E-4. An audit will be conducted by the DNS and/or designee to ensure residents are appropriately placed in the grey zone□, and transmission-based precautions are implemented for any resident requiring the grey zone. Audits will be completed weekly for two months. The results of the audits will be reported to the monthly QAPI meeting to ensure compliance. QAPI will determine frequency of audits if needed past two months. DNS/Designee are accountable to the process E-5. Completion date: 7/24/2020. F-1. Resident #1 was re-admitted to the facility [redacted] Resident placement revealed the resident was in a shared room with another resident. There was no signage in or around the doorway and to indicate the resident needed transmission-based precautions. Resident #1 was re-admitted to the facility [redacted] All residents re-admitted to the facility from	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285108	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-O'NEILL LLC	PO BOX 756, 1102 NORTH HARRISON O' NEILL, NE 68763

(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 10	F 880	[redacted] will be admitted to the designated grey area in the facility. Signage will be posted on or around the resident□s door/doorway in the grey area and isolation equipment will be placed in or around the resident□s doorway to indicate the need for transmission-based precautions. Resident was returned to standard precautions on 6-22-2020. F-2. Residents re-admitted to the facility from [redacted] will be readmitted to a private room. Resident□s readmitted will be placed in the facilities grey zone. Signage will be posted on or around the resident□s door/doorway in the grey area and isolation equipment will be placed in or around the residents doorway to indicate the need for transmission-based precautions. All facility health care personnel were re-educated on 7-8-20 on the facility infection Control during COVID-19 policies to include: ---New admissions and re-admissions would be placed in a private room (i.e., grey zone) with private toileting facilities upon entry/re-entry to the facility. ---Residents would be confined to their room (i.e., grey zone) for 14 days. ---Appropriate PPE that needs to be worn in the grey zone. ---At the end of the 14 day period and if the resident had not displayed signs or symptoms of an infection the resident could be moved to their permanent place in the facility. Facility health care personnel were	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285108	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-O'NEILL LLC	PO BOX 756, 1102 NORTH HARRISON O' NEILL, NE 68763

(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 11	F 880	re-educated on 7-8-2020 on proper signage used on the patient□s rooms to ensure that all staff were aware of the necessary infection control steps that need to be taken. --Staff to acknowledge/view recommended CDC videos: Closely Monitor Residents, Lessons, Keep COVID-19 Out!, Sparkling Surfaces by 7/24/20 F-3. System Change: Residents that are to be monitored in the grey zone were identified and appropriate documentation can be found in the resident□s individual record. DNS has made a resident roster available at the nurse□s station designating those residents that are to be in the grey zone. Appropriate signage is in place to identify the necessary infection control steps that need to be taken to care for these residents. DNS and/or designee will review daily to assess any changes in resident status and/or discuss any residents changes that may require grey zone criteria. F-4. An audit will be conducted by the DNS and/or designee to ensure residents are appropriately placed in the grey zone□, and transmission-based precautions are implemented for any resident requiring the grey zone. Audits will be completed weekly for two months. The results of the audits will be reported to the monthly QAPI meeting to ensure compliance. QAPI will determine frequency of audits if needed past two months. DNS/Designee are accountable to the process	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285108	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-O'NEILL LLC	**PO BOX 756, 1102 NORTH HARRISON O' NEILL, NE 68763**

(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 12	F 880	F-5. Completion date: 7/24/2020. G-1. Visitors Screening log will always include visitors screened for signs/symptoms of COVID-19 as well as their temperatures always taken prior to entry into the facility. G-2. Facility health care personnel were re-educated on 7-8-20 on the facility policy on monitoring visitors to include the visitor□s temperature. Visitors are to be screened by staff to determine if the visitors had any signs or symptoms of a respiratory infection, and if they had contact with someone who had or was under investigation for COVID-19. If the visitors met any of the above criteria the facility may restrict their entrance in the facility. Staff to acknowledge/view CDC recommended videos: Keep COVID-19 Out!, Clean Hands, Sparkling Surfaces by 7/24/20. G-3. System change: Visitors are screened for signs/symptoms of COVID-19, this screening includes visitor temperatures. The DON and/or her designee will oversee this process throughout the day to assure the screening form is properly filled out, staff understand a visitor answering yes to any symptom or a temperature over 100 degrees will not be allowed to enter the facility and all staff understand who they can refer to if there are any questions on the screening process.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285108	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-O'NEILL LLC	**PO BOX 756, 1102 NORTH HARRISON O' NEILL, NE 68763**

(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 13	F 880	G-4. An audit will be conducted by the DNS and/or designee to ensure that visitors are screened for signs/symptoms according to facility policy, to include visitors□ temperatures. Audits will be completed weekly for two months. The results of the audits will be reported to the monthly QAPI meeting to ensure compliance. QAPI will determine frequency of audits if needed past two months. DNS/Designee are accountable to the process. G-5. Completion date: 7/24/2020 H-1. On 6/15/20 observed in a resident room on the MCU, NA-B mask was below NA-B□s nose (with bilateral nares visible). This NA has been on vacation since this was identified. NA is scheduled to return to work on 8/1/20 and will be re-educated on proper mask use prior to returning to work to assure covering of bilateral nares. H-2. Staff were re-educated on 7-8-2020 on how to properly wear a mask. Staff to acknowledge/view recommended CDC videos: Lessons, Keep COVID-19 Out!, Clean Hands by 7/24/20. H-3. System Change: Staff will be re-educated how to properly wear masks. Masks will be properly applied when entering the building and checked throughout the day by the staff members supervisor. Any staff found to not be properly wearing their masks will be immediately re-educated.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285108	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-O'NEILL LLC	**PO BOX 756, 1102 NORTH HARRISON O' NEILL, NE 68763**

(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 14	F 880	H-4. An audit will be conducted by the DNS and/or designee to ensure that masks are worn by staff in a manner to prevent potential cross contamination. Audits will be completed weekly for two months. The results of the audits will be reported to the monthly QAPI meeting to ensure compliance. QAPI will determine frequency of audits if needed past two months. DNS/Designee are accountable to the process. H-5 Completion date: 7/24/2020 I-1. Resident 1 was returned to standard precautions on 6-22-2020. Resident 2 returned to standard precautions on 6-19-2020. Resident 4 was placed in the grey zone on 7-9-2020. RN-H is the ICP for the facility and has been working with the DNS re-education on Zoning, grey zone, transmission based precautions, visitor screening logs, appropriate face mask use, facility policy r/t new admissions/readmissions re-educations completed for facility personnel on 7-8-20. I-2. Staff were re-educated on the facility grey zone, transmission-based precautions, visitor screening logs, appropriate face mask use, facility policy r/t new admissions/readmissions re-educations. This re-education was completed for facility personnel on 7-8-20. Staff to acknowledge/view recommended CDC videos: Sparkling Surfaces,	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285108	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-O'NEILL LLC	PO BOX 756, 1102 NORTH HARRISON O' NEILL, NE 68763

(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 15	F 880	Lessons, Closely Monitor Residents, Keep COVID-19 Out!, Clean hands By 7/24/20. I-3. System Changes: Visitors are screened for signs/symptoms of COVID-19, this screening includes visitor temperatures. The DON and/or her designee will oversee this process throughout the day to assure the screening form is properly filled out, staff understand a visitor answering yes to any symptom or a temperature over 100 degrees will not be allowed to enter the facility and all staff understand who they can refer to if there are any questions on the screening process. Residents that are to be monitored in the grey zone were identified and appropriate documentation can be found in the resident□s individual record. DNS has made a resident roster available at the nurse□s station designating those residents that are to be in the grey zone. Appropriate signage is in place to identify the necessary infection control steps that need to be taken to care for these residents. DNS and/or designee will review daily to assess any changes in resident status and/or discuss any residents changes that may require grey zone criteria. Staff are aware of resident needing to be in the grey zone and appropriate transmission-based precautions that need to be taken and they are implemented for any residents in the grey zone, and masks are worn in a manner to prevent cross contamination.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285108	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-O'NEILL LLC	PO BOX 756, 1102 NORTH HARRISON O' NEILL, NE 68763

(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 16	F 880	Staff will be re-educated how to properly wear masks. Masks will be properly applied when entering the building and checked throughout the day by the staff members supervisor. Residents infection control status will be discussed at each resident□s care plan meeting. It will be the responsibility of the DNS and/or designee to ensure that residents requiring transmission-based precautions have been appropriately clinically assessed and have the appropriate documentation their medical records along with appropriate care plan interventions. Education provided on 7-8-2020 as to this process. I-4. An audit will be conducted by DNS and/or designee to ensure that transmission based precautions are implemented for any resident requiring the grey zone, and appropriate documentation is established to maintain infection prevention and an infection control program to prevent the development and transmission of communicable diseases and infections in the facility. Audits will be completed weekly for two months. The results of the audits will be reported to the monthly QAPI meeting to ensure compliance. QAPI will determine frequency of audits if needed past two months. DNS/Designee are accountable to the process. I-5. Completion date 7/24/2020 J. Review of Resident 4□s MDS dated 4-	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285108	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-O'NEILL LLC	**PO BOX 756, 1102 NORTH HARRISON O' NEILL, NE 68763**

(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 17	F 880	22-20 revealed the resident was not receiving isolation/transmission based precautions. J-2. Resident #4s MDS is correct. The resident□s status does not meet the coding criteria in the MDS manual to be able to code for isolation. MDS 3.0 Manual Page O-5 O0100M, Isolation for active infectious disease (does not include standard precautions) Code only when the resident requires transmission-based precautions and single room isolation (alone in a separate room) because of active infection (i.e., symptomatic and/or have a positive test and are in the contagious stage) with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. Do not code this item if the resident only has a history of infectious disease (e.g., s/p MRSA or s/p C-Diff - no active symptoms). Do not code this item if the precautions are standard precautions, because these types of precautions apply to everyone. Standard precautions include hand hygiene compliance, glove use, and additionally may include masks, eye protection, and gowns. Examples of when the isolation criterion would not apply include urinary tract infections, encapsulated pneumonia, and wound infections. Code for single room isolation only when all of the following conditions are met:	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285108	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-O'NEILL LLC	PO BOX 756, 1102 NORTH HARRISON O' NEILL, NE 68763

(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 18	F 880	1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. 2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect. 3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation. 4. The resident must remain in his/her room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.). Resident #4 progress notes have been updated beginning 7/10/20 to demonstrated resident is on transmission-based precautions in grey zone. Resident #4 care plan has a revision date of 6/26/20, revised 7/9/20 to demonstrated resident leaves for [redacted] with transmission-based precautions in place. Signage placed on resident #4 room on 7-8-20 to alert staff of transmission-based precautions while providing care in grey zone. Resident 4□s care plans, progress notes and signage will were updated on 7-9-2020. Resident 4 has been placed in	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285108	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-O'NEILL LLC	PO BOX 756, 1102 NORTH HARRISON O' NEILL, NE 68763

(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 19	F 880	grey zone with transmission-based precautions in place. NA-B on 6/15/20 reported not being aware of residents in grey zone and on transmission-based precautions. Staff member NA-B has been on vacation since this was identified. NA-B is scheduled to return to work on 8/1/20 and will be re-educated on identification of residents in grey zones with transmission-based precautions on MCU prior to returning to work to assure compliance in this area. RN-C revealed they were unaware of "grey zone" residents and policies/protocols for transmission-based precautions for grey zone residents. RN-C was Counseled on 7/8/20 regarding zone placement and policies for transmission-based precautions for residents in grey zone & other zones. Facility personnel re-education completed 7/8/20 r/t residents & policies/protocols for transmission-based precautions and resident placement into grey zone. Interview with laundry/laundry housekeeping supervisor revealed no knowledge of policies/procedures for grey zone residents or related laundry or cleaning protocols. Laundry/housekeeping supervisor was re-educated on 7/8/20 on facilities policies/procedures for grey zone residents, routine cleaning and disinfectant policy, bathroom cleaning, cycle cleaning, care-cleaning-storage of housekeeping equipment, linen handling and handling soiled linen.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285108	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-O'NEILL LLC	PO BOX 756, 1102 NORTH HARRISON O' NEILL, NE 68763

(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 20	F 880	Staff member NA-A was re-educated on 7 -9-2020 on identification of residents in the grey zone and associated infection control measures needed to care for these residents. Infection Preventionist confirmed resident #4 should have been placed in grey zone with transmission- based precautions. Resident #4 has been on transmission-based precautions d/t dialysis; on 7/9/20 care plan revised to include transmission based precautions in place. Staff to acknowledge/view recommended CDC videos: Sparkling Surfaces, Clean hands, Lessons, Closely Monitor Residents, Keep COVID-19 Out! By 7/24/20. SYSTEM CHANGES: Visitors are screened for signs/symptoms of COVID-19, this screening includes visitor temperatures. The DON and/or her designee will oversee this process throughout the day to assure the screening form is properly filled out, staff understand a visitor answering yes to any symptom or a temperature over 100 degrees will not be allowed to enter the facility and staff understand who they can refer to if there are any questions on the screening process. DNS provided re-education to facility staff on 7-8-20 to ensure visitors are screened for signs/symptoms of COVID-19, staff are	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285108	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-O'NEILL LLC	PO BOX 756, 1102 NORTH HARRISON O' NEILL, NE 68763

(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 21	F 880	aware of transmission-based precautions are they are implemented for any residents in the grey zone, and masks are worn in a manner to prevent cross contamination. Residents that are to be monitored in the grey zone were identified and appropriate documentation can be found in the resident□s individual record. DNS has made a resident roster available at the nurses station designating those residents that are to be in the grey zone. Appropriate signage is in place to identify the necessary infection control steps that need to be taken to care for these residents. DNS and/or designee will review daily to assess any changes in resident status and/or discuss any residents changes that may require grey zone criteria. Staff will be re-educated how to properly wear masks. Masks will be properly applied when entering the building and checked throughout the day by the staff members supervisor. Re-education done 7/8/20. Residents infection control status will be discussed at each resident□s care plan meeting. It will be the responsibility of the DNS and/or designee to ensure that residents requiring transmission-based precautions have been appropriately clinically assessed and have the appropriate documentation their medical records along with appropriate care plan interventions. Education/in-service with	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285108	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR CARE CENTERS-O'NEILL LLC	**PO BOX 756, 1102 NORTH HARRISON O' NEILL, NE 68763**

(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 22	F 880	care plan team provided on 7/8/20 as to this process. MONITORING PROCESS FOR THE SYSTEM CHANGE: An audit will be conducted by the DNS and/or designee to ensure that visitors are screened for signs/symptoms according to facility policy, transmission based precautions are implemented for any resident requiring the grey zone, and masks are worn by staff in a manner to prevent potential cross contamination. Audits will be completed weekly for two months. The results of the audits will be reported to the monthly QAPI meeting to ensure compliance. QAPI will determine frequency of audits if needed past two months. DNS/Designee are accountable to the process.	

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

Pete Ricketts, Governor

July 22, 2020

Heather Geis, Administrator
Arbor Care Centers-Tekamah Llc
823 M Street
Tekamah, NE 68061

CMS CERTIFICATION NUMBER: 285118

Dear Ms. Geis:

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

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

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

Sincerely,

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

CV/kd

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

Pete Ricketts, Governor

June 29, 2020

Joseph Kezar, Administrator
Arbor Care Centers-Valhaven, Llc
300 West Meigs Street
Valley, NE 68064

CMS CERTIFICATION NUMBER: 285117

Dear Mr. Kezar:

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

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

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

Sincerely,

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

CV/kd

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

Pete Ricketts, Governor

August 5, 2020

Todd Consbruck, Administrator
Avera Creighton Care Centre
P O Box 289, 1603 Main Street
Creighton, NE 68729-0186

CMS CERTIFICATION NUMBER: 285284

Dear Mr. Consbruck:

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

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

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

Sincerely,

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

CV/kd

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

Pete Ricketts, Governor

July 10, 2020

Michael Early, Administrator
Azria Health Ashland
1700 Furnas Street
Ashland, NE 68003

CMS CERTIFICATION NUMBER: 285140

Dear Mr. Early:

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

CV/kd

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

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 22, 2020

Nicholas Mann, Administrator
Azria Health Broadwell
800 Stoeger Drive
Grand Island, NE 68803 **CMS Certification No. 285221**

Subject: Survey Results
Cycle Start Date: July 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 July 16, 2020, a survey was completed at Azria Health Broadwell 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 August 1, 2020**, to the State Survey Agency Contact. **Failure to submit an acceptable PoC by August 1, 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.

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

  Payment will be denied for all NEW Medicare and Medicaid admissions, August 21, 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 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

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285221	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH BROADWELL	800 STOEGER DRIVE GRAND ISLAND, NE 68803

(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 the survey report as they apply to deficient practices identified.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		8/14/20

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

Electronically Signed | 07/31/2020

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
	285221	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH BROADWELL	800 STOEGER DRIVE GRAND ISLAND, NE 68803

(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 12-006.17B	F 880	- Whirlpool Tub & Shower How corrective action will be	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285221	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH BROADWELL	800 STOEGER DRIVE GRAND ISLAND, NE 68803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 LICENSURE REFERENCE NUMBER 175 NAC 12-006.17D Based on observation, interview, and record review; the facility failed to follow CMS (Centers for Medicare and Medicaid) and CDC (Centers for Disease Control) infection control guidelines to prevent potential cross contamination and prevent the potential spread of Covid-19 by: failing to clean and disinfect the whirlpool and the whirlpool lift scale chair which had the potential to affect 1 resident (Resident 21); failing to clean and disinfect the shower which had the potential to affect all 40 residents who used the shower (Residents 3, 19, 20, 22, 1, 23, 18, 24, 25, 26, 27, 28, 29, 30, 10, 31, 32, 33, 17, 34, 35, 36, 4, 37, 38, 14, 39, 40, 41, 42, 43, 2, 16, 44, 45, 46, 47, 48, 49, and 50); failing to perform 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 donning gloves and when hands were soiled before handling care and hygiene products in the bath house which had the potential to affect the 41 residents who were bathed in the bath house (Residents 21, 3, 19, 20, 22, 1, 23, 18, 24, 25, 26, 27, 28, 29, 30, 10, 31, 32, 33, 17, 34, 35, 36, 4, 37, 38, 14, 39, 40, 41, 42, 43, 2, 16, 44, 45, 46, 47, 48, 49, and 50); failing to perform hand hygiene between residents and after hands were soiled during meal service in resident rooms for 9 residents (Residents 14, 15, 16, 17, 18, 40, 5, 6, and 7) and failing to ensure that staff wore the required Personal Protective Equipment (PPE) (protective clothing such as disposable gloves, gowns, face masks, and face shields worn to help prevent the spread of germs) including N95 respirator masks	F 880	accomplished for those residents found to have been affected by the deficient practice: Staff identified in the 2567 were re-educated on 7/15/20 by DON on how to clean the Whirlpool Tub to assure sanitation of the whirlpool tub will not spread infections to residents 3,19, 20, 22, 1, 23, 18, 24, 25, 26, 27, 28, 29, 30, 10, 31, 32, 33, 17, 34, 35, 36, 4, 37, 38, 14, 39, 40, 41, 42, 43, 2, 16, 44, 45, 46, 47, 48, 49, 50. Procedure for cleaning the Whirlpool tub and shower given to both bath aides on 7/15/2020 and education on procedure done by DON on 7/15/2020 . Address how the facility will identify other residents having the potential to be affected by the same deficient practice: DON or designee reviewed bathing schedule on 7/15/2020 to ensure staff were re-educated prior to providing bathing. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: Provided re-education to bath aides on sanitation of whirlpool and shower by DON or designee on or before 7/15/2020 including return demonstration. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285221	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH BROADWELL	800 STOEGER DRIVE GRAND ISLAND, NE 68803

(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 3 (a particulate-filtering face piece respirator that meets the U.S. National Institute for Occupational Safety and Health N95 classification of air filtration, meaning that it filters at least 95% of airborne particles) when in the rooms of residents under quarantine to prevent the potential for cross contamination and Covid-19. This had the potential to affect 25 residents (Residents 17, 15, 34, 43, 44, 39, 40, 14, 16, 48, 45, 46, 38, 41, 47, 56, 5, 6, 7, 8, 9, 10, 42, 52, and 53). The facility identified a census of 52 at the time of survey. Findings are: A. Review of the undated "Penner Spas Cascade" document received from the facility Administrator revealed the following: System Cleaning (After Every Bath): Clean and disinfect the tub after every bath with Penner Cleaner/Disinfectant as follows: 1. Close and lock the door. 2. Press the Tub Fill Button and turn the Temperature Control Knob all the way to the left to its warmest level to heat the disinfectant solution and maximize its effective ness. 3. Remove any visible tissue, residue, or fluids from the tub by pressing the Shower Button and rinsing the inside tub surfaces with the shower sprayer. 4. Press the Fill Button again to turn off the water. Allow the tub to drain, and place the drain plug over the drain. 5. On the Aqua-Aire Tubs, press and hold the Disinfect Button located on the left side of the tub. As the button is held down, the properly mixed cleaning solution is running through the air injection system and out all of the air jets. Release the button after you see solution coming out of all the air jets and you have 1 to 1 ½ gallons of disinfectant solution in the foot well of the tub. 6. Using the long-handled brush, available from your	F 880	This will be monitored 5 x weekly 8 weeks through visual audits of watching cleaning process of whirlpool tub & shower. This will be followed weekly through Standards of Care where we review all open Quality Improvement Plans. This will be reviewed monthly through our Quality Assurance Meeting for 3 months to assure continued compliance of proper cleaning of whirlpool tub & shower to assure no spread of infections through bathing. Monitored by Administrator, Director of Nursing, Infection Control Nurse, & RN/LPN Charge Nurses. - Whirlpool Lift Chair How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Staff identified in the 2567 were re-educated on how to clean the whirlpool bath chair to assure sanitation of the bath chair will not spread infections to residents 3,19, 20, 22, 1, 23, 18, 24, 25, 26, 27, 28, 29, 30, 10, 31, 32, 33, 17, 34, 35, 36, 4, 37, 38, 14, 39, 40, 41, 42, 43, 2, 16, 44, 45, 46, 47, 48, 49, 50 by DON on or before 7/21/2020. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Admin or designee completed an audit of facility Whirlpool bath chair to ensure sanitation instructions were placed on	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285221	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH BROADWELL	800 STOEGER DRIVE GRAND ISLAND, NE 68803

(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 Penner distributor, thoroughly scrub all interior surfaces of the tub with the solution that remains in the foot well of the tub. Let disinfectant stay on surface for 10 minutes (Or, as recommended by the instructions on the disinfectant concentrate container.) 7. Remove the plug from the drain. 8. Rinse the tub's interior surfaces thoroughly with the shower sprayer. 9. Press and hold the Rinse button located on the left side of the control panel until clear water runs from all the air jets. Then release the Rinse button. 10. Finish rinsing the interior surfaces of the tub with the shower sprayer. 11. Start the air blower by pushing the Aqua-Aire Button. Allow it to run for 30 seconds. This pushes the rinse water out of the air injection system. If this was the last bath of the day, allow the blower to run for 2 minutes to dry out the system. 12. Stop the Aqua-Air blower by again pushing the Aqua-Aire button. 13. Visibly check that the tub and the reservoir (if applicable) was effectively cleaned during the disinfecting procedure. If not, repeat the procedure. Review of the undated facility procedure "Whirpool (sic) Cleaning" received from the facility Administrator revealed the following: 1. Wash hands before starting task following Hand Hygiene Procedure. 2. Ensure bath spa door is in locked potion (sic). 3. Press the Tub Fill Button and turn the Temperature Control Knob all the way to the left to its warmest level to heat the disinfectant solution and maximize its effectiveness. 4. Remove any visible tissue, residue, or fluids from the spa by pressing the Shower Button and rinsing the inside spa surfaces with the shower sprayer. 5. Press the Tub Fill Button again to turn off the water. Allow the spa to drain, and place the drain	F 880	bath chair. Education on the posting of the procedure on bath chair completed. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: Nursing staff were re-educated on cleaning of whirlpool bath chair by DON on 7/21/2020. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. This will be monitored 5 x weekly 8 weeks through visual audits of watching cleaning process whirlpool chair. This will be followed weekly through Standards of Care where we review all open Quality Improvement Plans. This will be reviewed monthly through our Quality Assurance Meeting for 3 months to assure continued compliance of proper cleaning of whirlpool chair to assure no spread of infections through bathing. Monitored by Administrator, Director of Nursing, Infection Control Nurse, & RN/LPN Charge Nurses. - Meal Tray Delivery How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Education provided to staff identified in	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285221	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH BROADWELL	800 STOEGER DRIVE GRAND ISLAND, NE 68803

(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 plug over the drain. 6. Press and hold the Disinfect Button located on the control panel on the side. As the button is held down, the properly mixed cleaning solution is running through the air injection system and out all the air jests (sic). Release the button after you see solution coming out of all the air jets and you have 1 to 1 ½ gallons of disinfectant solution in the foot well of the spa. 7. Using scrub brush: was all interior surfaces of the spa. Let disinfectant say on surface for 10 minutes to properly disinfect. Tub MUST stay wet with disinfectant for a full 10 minutes so you may need to spray more disinfectant on the tub with the spray bottle during the 10 minutes. 8. After 10 minutes remove the plug from the drain. 9. Rinse the spa's interior surfaces thoroughly with the shower sprayer. 10. Press and hold the Rinse button located on the control panel on the side until clear water runs from all the air jets. Then release the Rinse button. 11. Finish rinsing the interior surfaces of the spa with the shower sprayer. 12. Start the air blower by pushing the Aqua-Aire button. Allow it to run for 30 seconds. This pushes the rinse water out of the air injection system. If this was the last bath of the day, allow the blower to run for 2 minutes to dry out the system. 13. Stop the Aqua-Aire blower by again pushing the Aqua-Aire button. 14. Visibly check that the spa was effectively cleaned during the disinfecting procedure. If not, repeat the procedure. 15. If there is a delay of one or more hours before the next bath, we recommend using a towel to wipe off all excess water. This will keep	F 880	2567 regarding hand hygiene during delivery of meal tray to residents 14, 15, 16, 17, 18, 40, 5, 6, and 7. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All nursing staff educated on hygiene during delivery of meal tray to residents. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: Nursing staff were re-educated on safe handling of meal trays and hand hygiene on7/24/2020 by DON. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. This will be monitored 5 x weekly 8 weeks through visual audits of watching delivery of meal service. This will be followed weekly through Standards of Care where we review all open Quality Improvement Plans. This will be reviewed monthly through our Quality Assurance Meeting for 3 months to assure continued compliance of proper meal tray delivery to assure no spread of infections. Monitored by Administrator, Director of Nursing, Infection Control Nurse, & RN/LPN Charge Nurses. - PPE in Zones	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285221	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH BROADWELL	800 STOEGER DRIVE GRAND ISLAND, NE 68803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6 your spa looking great for years to come. To change out disinfectant, use small key next to the wall, put pressure under the key whole (sic) while turning to open and close panel. Get a new bottle from the bottom cabinet and unscrew the hose from the top of the old bottle and put the hose in the new bottle, put back in place and throw away the old bottle. On spray bottles follow directions to fill the bottle it is ½ to 1 ounce of disinfectant to 32 ounces of water. Observation on 7/14/2020 at 10:17 AM of NA-B (Nurse Aide) cleaning the facility Penner Spa whirlpool tub revealed the following: NA-B put the plug into the tub and pushed the "Tub Fill" button. Water flowed into the tub through the tub fill spout. NA-B filled the foot well of the tub with water, then NA-B pushed the tub fill button and the water stopped. NA-B then pushed the disinfect jets button for a few seconds. While NA-B was holding the disinfect jets button, they turned the tub fill button back on and water continued to flow into the tub through the tub fill spout. With the water still running into the tub through the tub fill spout, NA-B picked up a brush from the top of the tub and started scrubbing the tub. The water continued to run into the tub as NA-B scrubbed the sides of the tub with the brush. Interview with NA-B at this time revealed they did not know what the concentration of the whirlpool tub disinfectant was supposed to be. NA-B then turned the aqua air jets on then scrubbed the inside of the tub with the brush. The inside of the tub was wet and the jets were started at 10:20 AM. Observation at this time revealed the whirlpool lift chair was sitting in the hall. NA-B did not put it in the tub or clean it. Interview with NA-B at this time revealed all of the	F 880	How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Staff identified in 2567 were re-educated regarding the proper PPE to be worn including N95 mask when in rooms of residents under quarantine to prevent the potential for cross contamination. Residents including 17, 15, 34, 43, 44, 39, 40, 14, 16, 48, 45, 46, 38, 41, 47, 56, 5, 6, 7, 8, 9, 10, 42, 52, and 53. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All staff were re-educated regarding the proper PPE to wear in the different zones including grey zone where an N95 is preferred on 7/24/2020 by DON. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: All staff will be re-educated on correct grey zone PPE including N95 as preferred by DON or designee on 7/24/2020. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. This will be monitored 5 x weekly 8 weeks through visual audits of watching proper PPE including N95 in grey zone. This will	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285221	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH BROADWELL	800 STOEGER DRIVE GRAND ISLAND, NE 68803

(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 residents used the tub except the residents who were on quarantine. They were receiving bed baths. NA-B shut off the "aqua aire" button then NA-B rinsed the tub at 10:26 AM with the sprayer attachment after NA-B pulled the plug and let the water drain. NA-B then rinsed the jets with the rinse jets button until the water ran clear. NA-B then said they were done cleaning the tub. NA-B did not run the air jets when they were done cleaning the tub. NA-B did not leave the disinfectant on for 10 minutes per the Penner directions and facility directions to clean and disinfect the whirlpool. NA-B did not clean the outside of the tub or the control panels or the shower sprayer. NA-B did not put the concentration of disinfectant on the tub per the manufacturer's directions or through the jets as NA-B had diluted the disinfectant with water by filling the foot well of the tub with water and allowing the water to continue to run into the tub while NA-B dispensed the disinfectant into the tub. Interview with NA-B on 7/14/2020 at 10:27 AM revealed the residents sat on whirlpool chair while being bathed in the tub. NA-B pointed to the chair with a lift that was on wheels sitting in the hallway and confirmed it was the whirlpool bath chair. NA-B confirmed they should have had the chair in the tub to clean it when NA-B cleaned the whirlpool but it was being used on the hall for a scale to weigh the residents. NA-B revealed they were to disinfect the chair before and after they were taking it out of each resident's room when they weighed the residents. At 10:31 AM Surveyor requested NA-B demonstrate how they cleaned the whirlpool chair if they were using it for a scale. At 10:32 AM NA-B took wipes from a tub of MicroKill Bleach Wipes and NA-B wiped the	F 880	be followed weekly through Standards of Care where we review all open Quality Improvement Plans. This will be reviewed monthly through our Quality Assurance Meeting for 3 months to assure continued compliance of proper PEE in zones to assure no spread of infections. Monitored by Administrator, Director of Nursing, Infection Control Nurse, & RN/LPN Charge Nurses. - Hand Hygiene in bath house How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Staff identified in the 2567 were re-educated on proper hand hygiene to assure sanitation and to not spread infections to related to hand hygiene in bathhouse by DON 7/15/2020. Residents including 21, 3, 19, 20, 22, 1, 23, 18, 24, 25, 26, 27, 28, 29, 30, 10, 31, 32, 33, 17, 34, 35, 36, 4, 37, 38, 14, 39, 40, 41, 42, 43, 2, 16, 44, 45, 46, 47, 48, 49, and 50. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All staff were re-educated on proper hand hygiene to assure sanitation and to not spread infections to all residents on 7/15/2020 by DON. Address what measures will be put into	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285221	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH BROADWELL	800 STOEGER DRIVE GRAND ISLAND, NE 68803

(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 8 top of the whirlpool chair seat after wiping the handles then NA-B wiped the legs of the chair. NA-B was done wiping the chair at 10:33 AM. NA-B did not wipe the underside of the seat or the inside of the seat opening. Interview with NA-B at this time confirmed the whirlpool lift chair did go into the tub to be submerged in the water and was used for the residents who received whirlpool baths. Interview with the DON (Director of Nursing) on 7/14/2020 at 10:32 AM confirmed the whirlpool bath chair was being used on the halls/units to weigh the facility residents. Interview with RN-A (Registered Nurse) on 7/14/2020 at 10:53 AM revealed 1 resident used the whirlpool tub for bathing. Surveyor requested RN-A provide all of the documentation of every resident in the facility for the last 60 days specifically what they received for a bath as documented in the EHR (Electronic Health Record). Interview with NA-B on 7/14/2020 at 11:39 AM revealed they were using the scale to weigh residents on Cedar Cove and Birch Boulevard. Interview on 7/14/2020 at 11:41 AM with RN-A confirmed the whirlpool chair was being used to weigh the facility residents including the Aspen unit. RN-A revealed the whirlpool chair was supposed to be cleaned after it was used for weighing the residents before being used for the whirlpool bath. On 7/16/2020 at 11:11 AM the facility administrator provided the following response to the question: When the staff person is dispensing	F 880	place or what systemic changes you will make to ensure that the deficient practice does not recur: Bath Aides will be re-educated on hand hygiene in bath house including competency by DON or designee on 7/15/2020. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. This will be monitored 5 x weekly 8 weeks through visual audits of watching hand hygiene as it relates to the bathhouse. This will be followed weekly through Standards of Care where we review all open Quality Improvement Plans. This will be reviewed monthly through our Quality Assurance Meeting for 3 months to assure continued compliance of proper hand hygiene in bathhouse to assure no spread of infections. Monitored by Administrator, Director of Nursing, Infection Control Nurse, & RN/LPN Charge Nurses. Directed Plan of Correction All staff will complete videos and post test for each video. Sparkling Surfaces - https://youtu.be/t7OH8ORr5Ig Clean Hands - https://youtu.be/xmYMUly7qiE Closely Monitor Residents - https://youtu.be/1ZbT1Njv6xA	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285221	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH BROADWELL	800 STOEGER DRIVE GRAND ISLAND, NE 68803

(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 9 the disinfectant into the tub, is there supposed to be water in the tub and are they to continue to run water into the tub while they are dispensing the disinfectant, or does the "disinfect jets" button release the required concentration of disinfectant to disinfect the tub? (The) "disinfect jets" button release(s) the required concentration of disinfectant to disinfect the tub. On 7/16/2020 at 10:45 AM the facility Administrator provided the response to the following request for information: (What are) the specific directions on how to apply (the whirlpool disinfectant) and how long it has to remain on the surface for disinfection to occur? "We follow the process that is on the sheets previously sent. The tub dispenses the correct amount of disinfectant". Interview with RN-A on 7/14/2020 at 12:05 PM revealed the facility did not keep their bath logs more than a week and they would provide the bathing reports from the EHR. Interview with RN-A on 7/15/2020 at 12:11 AM revealed the facility staff did not document what type of bath the residents received and was unable to provide the documentation from the EHR (Electronic Health Record). RN-A revealed they would send the bath schedule the nursing staff followed when giving baths. Review of the facility "Bath List" received from RN-A revealed Resident 21 was listed as receiving a W/P (whirlpool tub bath). B. Observation on 7/14/2020 at 11:45 AM revealed NA-B had gloves on. NA-B and NA-E assisted Resident 47 to stand up out of their wheelchair by	F 880	Keep COVID-19 Out! - https://youtu.be/7srwrF9MGdw Lessons - https://youtu.be/YYTATw9yav4 Before 8-14-2020	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285221	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH BROADWELL	800 STOEGER DRIVE GRAND ISLAND, NE 68803

(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 10 touching Resident 47's arms, clothing, and fabric gait belt (a belt placed around the waist of a resident for the staff to use to support a resident during transfers) then sit on the whirlpool chair that was sitting out in the hall. The resident was dressed. Resident 47 was sitting on the seat of the whirlpool chair and touching the seat, the back, and the handles on the whirlpool chair. NA-B and NA-E performed a weight then NA-B and NA-E assisted Resident 47 into their wheelchair by touching Resident 47's arms and fabric gait belt, assisting Resident 47 to stand then sit in the wheelchair. NA-B then removed Resident 47's gait belt and draped the gait belt over the back of Resident 47's wheelchair. NA-B then entered the bath house wearing the same pair of gloves NA-B had touched Resident 47's arms, clothing and the gait belt with. The whirlpool chair was then left in the hall without being cleaned. Observation on 7/14/2020 at 11:48 AM revealed NA-B went into the bath house and with the same gloved hands they had used to assist Resident 47 with transferring, picked up a bottle of spray and NA-B sprayed the shower chair and the walls of the shower with the disinfectant. Using the same gloved hands, NA-B picked up 2 washcloths and then rinsed the walls of the shower and the shower chair at 11:50 AM with the shower attachment. NA-B then used the washcloths to dry the shower chair. NA-B did not spray the underside of the seat of the shower chair with the disinfectant. Interview with NA-B at 11:50 AM revealed NA-B followed this procedure between showering the facility residents. NA-B was done spraying, rinsing, and wiping the shower and the shower chair at 11:51 AM. Interview with NA-B at this time revealed they used Virex II 256	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
	285221	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH BROADWELL	800 STOEGER DRIVE GRAND ISLAND, NE 68803

(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 11	F 880		

disinfectant to spray the shower. At 11:52 AM, NA-B removed the gloves and discarded them, picked up a bag of trash with their bare hands and took the trash into the shower room next door by grasping the door handle to open the door. NA-B then donned new gloves without performing hand hygiene. NA-B then got some MicroKill bleach wipes out of a tub and went out to the hall and wiped the whirlpool chair they had used to weigh Resident 47. NA-B did not wipe the inside of the seat, the underside of the seat or the inner rim of the seat opening. NA-B removed the gloves with the wipes and discarded them into the trash in the bath house. NA-B then picked up a towel with their bare hands and put it in the hamper in the bath house. NA-B then picked up a pen and wrote on a piece of paper that was on a 3 tiered stand next to the whirlpool. NA-B then picked up a bottle of shave cream, body spray, deodorant, lotion, and body wash from the top of the cart next to the whirlpool and put them into a bag sitting on a chair in the bath house. NA-B did not perform hand hygiene before handling the items after they had removed their gloves and used their bare hands to handle soiled linen. Interview with NA-B at this time revealed NA-B used the items for the residents. NA-B then took the trash out of the can in the bath house by pulling up the liner and tying a knot in the bag using their bare hands. NA-B then adjusted 2 boxes of gloves on the stand by the whirlpool. NA-B then put the trash bag on top of the hamper and put a new liner in the trash can with their bare hands. NA-B then got a pair of gloves out of the box and put them on without performing hand hygiene. NA-B then put items away in a cupboard in the bath house then tied the bag of laundry in the hamper. NA-B then went next door and put the trash in the shower room by handling the door

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285221	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH BROADWELL	800 STOEGER DRIVE GRAND ISLAND, NE 68803

(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 12 knob then NA-B went down the hall with the hamper. Review of the undated facility procedure "Shower Cleaning" received from the facility Administrator revealed the following: 1. Wash hands before starting task following Hand Hygiene Procedure. 2. Remove any visible tissue, residue, or fluids form the shower by turning on the shower and rinsing the walls, floor, and shower chair surfaces with the shower sprayer. 3. Spray the walls, floors, and shower chair with disinfectant from the spray bottle. 4. Using scrub brush: wash all surfaces of the shower and chair top and bottom. Let disinfectant stay on surface for 10 minutes to properly disinfect. Shower and chair MUST stay wet with the disinfectant for a full 10 minutes so you may need to spray more disinfectant on the surfaces with the spray bottle during the 10 minutes. 5. After 10 minutes rinse the shower wall, floor, and chair surfaces thoroughly with the shower sprayer to remove all disinfectant. 6. Visibly check that the shower and chair was effectively cleaned during the disinfecting procedure. If not, repeat the procedure. Review of the "Virex II 256 Reference Sheet" revealed the following: For disinfection, all surfaces must remain wet for 10 minutes. Interview with RN-A on 7/14/2020 at 12:05 PM revealed the facility did not keep their bath logs more than a week and they would provide the bathing reports from the EHR. Interview with RN-A on 7/15/2020 at 12:11 AM	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
	285221	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH BROADWELL	800 STOEGER DRIVE GRAND ISLAND, NE 68803

(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 13	F 880		

revealed the facility staff did not document what type of bath the residents received and was unable to provide the documentation from the EHR (Electronic Health Record). RN-A revealed they would send the bath schedule the nursing staff followed when giving baths.

Review of the facility "Bath List" received from RN-A after a list of residents who used the shower was requested revealed the following residents were listed for using the facility shower: Residents 3, 19, 20, 22, 1, 23, 18, 24, 25, 26, 27, 28, 29, 30, 10, 31, 32, 33, 17, 34, 35, 36, 4, 37, 38, 14, 39, 40, 41, 42, 43, 2, 16, 44, 45, 46, 47, 48, 49, and 50. Resident 21 was listed as receiving a W/P (whirlpool tub bath).

C.
Observation of NA-B on 7/14/2020 at 12:13 PM revealed NA-B wheeled a 3 tiered cart of meal trays down the hall. NA-B stopped in the middle of the hall with the cart and touched their face mask with their bare right hand. NA-B then took the bathhouse key down that was hanging on the outside of the door frame and went into the bath house. NA-B came out of the bath house with gloves in their hand. NA-B put one glove on the left hand then proceeded to push the cart by touching the handle with their right hand. NA-B did not put a glove on their right hand. NA-B then picked up a tray with food, drinks, and silverware and took the tray to into Resident 40 who was sitting in their room. NA-B set up the tray after they put it down on the table next to Resident 40. NA-B touched the items on the tray and handled the silverware. NA-B did not perform hand hygiene after touching their face mask, handling the bath house key, or touching the door knob on the bath house. NA-B then took a tray of food to

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285221	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH BROADWELL	800 STOEGER DRIVE GRAND ISLAND, NE 68803

(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 14 Resident 14 who resided in a different room. NA-B put the tray of food down in front of Resident 14 who was sitting in their room and touched Resident 14's wheelchair with their bare hand. NA-B then picked up a coffee mug that was sitting on Resident 14's table, brought out the coffee mug, handled it, and then put it on top of the cart that had the food trays on it. NA-B then picked up a tray of food and took food it to Resident 15 who resided in a different room. NA-B did not perform hand hygiene after they had handled Resident 14's wheelchair and the coffee mug that had been in Resident 14's room before taking a tray of food to Resident 15. NA-B still had the glove on the left hand and a bare right hand. NA-B put the food on the table in Resident 15's room, came out, and then NA-B took a tray of food off the cart in the hall to Resident 17 who resided in a different room. NA-B did not perform hand hygiene before taking a tray of food to Resident 17. Observation on 7/14/2020 at 12:10 PM revealed the DON was in the hall and observed NA-B when NA-B came out of Resident 14's room then went into Resident 15's room. The DON left the hall then at 12:17 PM the DON returned with a bottle of ABHR (Alcohol Based Hand Rub-product used to sanitize the hands in place of hand washing) and told NA-B they were supposed to use it and the DON placed the ABHR on the top tier of the tray cart. NA-B picked up the bottle of ABHR and applied a small amount onto their hands and rubbed their hands for 3 seconds then picked up a tray of food off the cart and took it into Resident 16 who was sitting in their room. NA-B did not cover all surfaces of their hands with the ABHR or scrub the hands until they were dry. NA-B then came out of Resident 16's room	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
	285221	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH BROADWELL	800 STOEGER DRIVE GRAND ISLAND, NE 68803

(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 15	F 880		

and took the food tray cart down the hall. NA-B applied a small amount of ABHR to their hands and performed a 3 second hand rub. NA-B did not cover all surfaces of their hands with the ABHR or scrub the hands until they were dry. NA-B then picked up a tray of food, drinks, and silverware and took food in to Resident 18 who was sitting in their room. NA-B handled the items on the tray. NA-B took the trays with food, drinks, and silverware into each resident's room and handled the items on each tray before leaving the trays with all of the items on them in the residents' rooms. The residents were then all observed feeding themselves and handling the items that NA-B had handled without performing hand hygiene.

Interview with the DON on 7/14/2020 at 12:19 PM confirmed their expectation was for staff to perform hand hygiene between each resident while passing trays. The DON confirmed NA-B had contaminated their hands in Resident 14's room then took food to Resident 15 without performing hand hygiene. The hand hygiene and glove changing policy, policy for distributing meal trays, and the instructions for use for the ABHR the staff were using was requested from the DON.

Interview with the DON on 7/14/2020 at 12:25 PM confirmed there were "issues" with NA-B's hand hygiene while NA-B was serving meals to the residents.

Interview with RN-A on 7/14/2020 at 12:25 PM revealed NA-B had been trained and was expected to perform hand hygiene.

Review of the facility policy Handwashing/Hand

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285221	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH BROADWELL	**800 STOEGER DRIVE GRAND ISLAND, NE 68803**

(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 16 Hygiene revised August 2015 revealed the following: This facility considers hand hygiene the primary means to prevent the spread of infections. Wash hands with soap and water for the following situations: a. When hands are visibly soiled; and b. After contact with a resident with infectious diarrhea including, but not limited to infections caused by norovirus, salmonella, shigella, and C. Difficile. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: b. before and after direct contact with residents; f. before donning sterile gloves; h. Before moving from a contaminated body site to a clean body site during resident care; i. after contact with a resident's intact skin; l. after contact with objects (e.g. medical equipment) in the immediate vicinity of the resident; m. after removing gloves; o. before and after eating or handling food; p. before and after assisting a resident with meals. 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. Washing Hands: 1. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for	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
	285221	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH BROADWELL	800 STOEGER DRIVE GRAND ISLAND, NE 68803

(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 17 a minimum of 20 seconds (or longer) under a moderate stream of running water, at a comfortable temperature. 2. Rinse hands thoroughly under running water. Hold hands lower than wrists. Do not touch fingertips to inside of sink. 3. Dry hands thoroughly with paper towels and then turn off faucet with a clean, dry paper towel. 4. Discard towels into trash. Using Alcohol-Based Hand Rubs 1. Apply generous amount of product to palm of hand and rub hands together. 2. Cover all surfaces of hands and fingers until hands are dry. 3. Follow manufacturers' directions for volume of product to use. Applying and Removing Gloves 1. Perform hand hygiene before applying non-sterile gloves. 2. When applying, remove one glove from the dispensing box at a time, touching only to the top of the cuff. 3. When removing gloves, pinch the glove at the wrist and peel away from the hand, turning the glove inside out. 4. Hold the removed glove in the gloves hand and remove the other glove by rolling it down the hand and folding it into the first glove. 5. Perform hand hygiene. Review of the ABHR label with directions for use received from the facility Administrator revealed the following: Directions: wet hands thoroughly with product; rub hands together covering all surfaces until hands are dry. Review of the facility procedure "Covid-19 Personal Protective Equipment" revised	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
	285221	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH BROADWELL	800 STOEGER DRIVE GRAND ISLAND, NE 68803

(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 18 3/12/2020 revealed the following: Donning Step 1: Perform Hand Hygiene: Apply one pump of hand sanitizer to the cupped palm of one hand. Rub hands palm to palm. Rub the right palm over the back of the left hand with interlaced fingers and vice versa. Rub both palms together with fingers interlaced. With the left thumb clasped in the right palm, rub rotationally and switch. Cup the hands and place the back of fingers to opposing palms and rub side to side with fingers interlocked. Rotationally rubbing the clasped fingers of the right hand in a circular pattern on the palm of the left hand and vice versa. Continue to rub both hands together until the sanitizer is dry. Doffing Step 3: Gloves: Remove the gloves utilizing "glove in glove" technique. Doffing Step 4: Perform hand Hygiene: Perform hand hygiene for a minimum of 20 seconds or until the hand sanitizer is dry. Interview with the facility Administrator on 7/15/2020 at 3:47 PM revealed the facility did not have a policy for the delivery of meals specifically related to sanitation regarding staff hand hygiene between resident while passing trays. On 7/16/2020 at 10:01 AM the facility Administrator provided the responses to the following questions: Question: Are the facility staff expected to clean the whirlpool according to the facility procedure and the manufacturer's specifications? Administrator's response: The check list for whirl pool cleaning is taken from manufactures guidelines. Question: What is your expectation for the staff to clean the whirlpool chair? Administrator's response: Cleaning before and	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
	285221	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH BROADWELL	**800 STOEGER DRIVE GRAND ISLAND, NE 68803**

(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 19 after each use. Question: Are they (facility staff) expected to clean all of the surfaces in contact with the resident after it (the whirlpool chair) is used for weighing residents before it is used to bathe residents? Administrator's response: Yes Question: What is your expectation for the staff to clean the shower chair? Are they expected to follow the facility procedure for cleaning the shower chair? Administrator's response: Yes Question: Do all of the facility residents listed on the bath list for "shower" use the shower chair? Administrator's response: Yes all use shower chair Question: Do all of the facility residents listed on the bath list for "W/P" use the whirlpool? Administrator's response: Yes Question: Are the staff expected to follow the contact time for the disinfectant used to disinfect the shower chair and the whirlpool? Administrator's response: They are to follow the check list previously provided Question: What is your expectation for staff to perform hand hygiene prior to donning gloves and after doffing gloves? Administrator's response: Yes Question: What is your expectation for staff to perform hand hygiene after handling garbage and soiled linens? Administrator's response: Wash their hands. Question: What is your expectation for staff to perform hand hygiene while they are passing meal trays between residents and when the staff person's hands come in contact with resident personal items? Administrator's response: They are to use ABHR in between	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
	285221	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH BROADWELL	800 STOEGER DRIVE GRAND ISLAND, NE 68803

(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 20 Question: What is your expectation for staff to use the ABHR? (Do you feel a 2-3 second scrub is effective for hand hygiene?) Administrator's response: Follow directions on hand sanitizer to rub hand until dry. D. Record review of the facility document titled COVID-19 Guideline dated 6/11/20 revealed clarification for steps the facility will take to minimize exposures to respiratory pathogens (a bacteria, virus, or other microorganism that can cause disease) and promptly identify residents with clinical features. Prevention Measures: Step 2. Everyday standard precautions and preventive actions should be used and include: a. Appropriate hand hygiene. Observation on 7/14/20 at 11:59 AM revealed that the facility Dietary Manager (DM) pushed a cart of room meal trays to the room of Resident 5 and carried the meal tray into the room of Resident 5 (a resident under quarantine) with a Gray Zone (an area or room for asymptomatic admissions, readmissions, and residents that require out of facility appointments that are in 14 day quarantine) sign on the room door. The DM assisted the resident to open a drink container. The DM exited the resident's room carrying the plate cover and laid it on the cart. The DM did not perform hand hygiene. The DM carried a meal tray into the room of Resident 6 (a resident under quarantine with a Gray Zone sign on the room door). The DM pulled the privacy curtain inside the resident doorway aside to enter the resident's room. The DM exited the resident's room carrying a plate cover and laid the plate cover on the cart. The DM did not perform hand hygiene. The DM exited the hallway and walked	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
	285221	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH BROADWELL	800 STOEGER DRIVE GRAND ISLAND, NE 68803

(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 21 toward the facility dining room. Observation on 7/14/20 at 12:11 PM revealed that Medication Aide-D (MA-D) was wearing a surgical mask and put on a face shield and gloves and carried a meal tray into the room of Resident 9 (a resident under quarantine with a Gray Zone sign on the room door). MA-D removed the disposable gloves in the resident's room. MA-D exited the resident's room and did not perform hand hygiene. MA-D removed the face shield and wiped it with a Micro Kill Bleach wipe (a disinfectant wipe). MA-D performed hand hygiene with ABHR. MA-D put on the face shield and disposable gloves. MA-D carried a meal tray into the room of Resident 10 (a resident under quarantine with a Gray Zone sign on the room door). MA-D exited the resident's room and walked to the PPE cart. MA-D did not perform hand hygiene. MA-D removed the face shield and wiped it with a Micro Kill Bleach wipe and performed hand hygiene with ABHR. Record review of the facility policy titled Hand Hygiene dated August 2015 revealed that the facility considers hand hygiene the primary means to prevent the spread of infections. The section titled Policy Interpretation and Implementation revealed: Step 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, resident, and visitors. Step 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 direct contact with residents; l. After contact with objects in the immediate vicinity of the resident;	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
	285221	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH BROADWELL	800 STOEGER DRIVE GRAND ISLAND, NE 68803

(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 22 m. After removing gloves; n. Before and after entering isolation precaution settings; p. Before and after assisting a resident with meals. Step 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. Step 10. Single-use disposable gloves should be used: c. When in contact with a resident, or the equipment or environment of a resident, who is on contact precautions. The section titled Procedure Applying and Removing Gloves: 1. Perform hand hygiene before applying non-sterile gloves. 2. When applying, remove one glove from the dispensing box at a time, touching only the top of the cuff. 3. When removing gloves, pinch the glove at the wrist and peel away from the hand, turning the glove inside out. 4. Hold the removed glove in the gloved hand and remove the other glove by rolling it down the hand and folding it into the first glove. 5. Perform hand hygiene. Interview per email on 7/16/2020 at 10:01 AM with the Facility Administrator confirmed that the expectation is for staff to perform hand hygiene between residents when they are passing meal trays and when the staff person's hands come in contact with resident's personal items. Staff are to perform hand hygiene before putting on gloves and after removing gloves. E.	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
	285221	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH BROADWELL	800 STOEGER DRIVE GRAND ISLAND, NE 68803

(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 23	F 880		

Record review of the document titled Review of Zones and PPE received from the facility Registered Nurse Consultant (RN-A) on 7/16/20 at 4:38 PM revealed that a Gray Zone (Transitional Zone) is for residents who are transferred from the hospital/outside facilities and are usually kept in this zone for 14 days. If the resident remains asymptomatic at the end of 14 days they will be moved to a Green Zone (a COVID-19 free zone for asymptomatic residents without any exposure to COVID-19). PPE to be used for residents in a Gray Zone is a gown, gloves, eye protection and N95 mask (N95 preferred, if no N95, then surgical mask with face shield).

Record review of the facility document titled COVID-19 Guideline dated 6/11/20 revealed that Gray Zone: Area where asymptomatic admission/readmissions/residents that require out of facility appointments are in 14 day quarantine.

Record review of the Centers for Disease Control document titled Understanding the Difference between a surgical mask and an N95 respirator revealed that a surgical mask does not provide the wearer with a reliable level of protection from inhaling smaller airborne particles and is not considered respiratory protection. The N95 mask filters out at least 95% of airborne particles including large and small particles.

Observation on 7/14/20 at 11:59 AM revealed that the facility Dietary Manager (DM) pushed a cart of room meal trays to the room of Resident 5 and carried the meal tray into the room of Resident 5 (a resident under quarantine with a Gray Zone sign on the room door). The DM wore a surgical mask but did not put on eye protection. The DM

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285221	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH BROADWELL	800 STOEGER DRIVE GRAND ISLAND, NE 68803

(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 24	F 880		

assisted the resident to open a drink container. The DM exited the resident's room carrying the plate cover and laid it on the cart. The DM did not perform hand hygiene. The DM carried a meal tray into the room of Resident 6 (a resident under quarantine with a Gray Zone sign on the room door). The DM wore a surgical mask but did not put on eye protection. The DM pulled the privacy curtain inside the resident doorway aside to enter the resident's room. The DM exited the resident's room carrying a plate cover and laid the plate cover on the cart. The DM did not perform hand hygiene. Medication Aide-C (MA-C) arrived at the room tray cart. The DM exited the hallway and walked toward the facility dining room. MA-C put on gloves and carried a room tray into the room of Resident 7 (a resident under quarantine due to being a new admission to the facility on 7/10/20 with a Gray Zone sign on the room door). MA-C was wearing a surgical mask but did not put on eye protection. MA-C cut up the meat on the plate for the resident. MA-C exited the resident's room and removed the disposable gloves and performed hand hygiene with alcohol based hand rub (ABHR).

Observation on 7/14/20 at 12:11 PM revealed that Nursing Assistant-E (NA-E) was wearing a surgical mask. NA-E put on a gown, gloves, and a face shield and carried a meal tray into the room of Resident 8 and sat the meal tray on the over bed tray in front of Resident 8 (a resident under quarantine with a Gray Zone sign on the room door). NA-E placed a folding chair on the side of the over bed tray across from the resident and sat down and assisted the resident with the meal. Medication Aide-D (MA-D) was wearing a surgical mask and put on a face shield and gloves and carried a meal tray into the room of

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285221	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH BROADWELL	800 STOEGER DRIVE GRAND ISLAND, NE 68803

(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 25 Resident 9 (a resident under quarantine with a Gray Zone sign on the room door). MA-D removed the disposable gloves in the resident's room. MA-D exited the resident's room and did not perform hand hygiene. MA-D removed the face shield and wiped it with a Micro Kill Bleach wipe (a disinfectant wipe). MA-D performed hand hygiene with ABHR. MA-D was wearing a surgical mask and put on the face shield and disposable gloves. MA-D carried a meal tray into the room of Resident 10 (a resident under quarantine with a Gray Zone sign on the room door). MA-D exited the resident's room and walked to the PPE cart. MA-D did not perform hand hygiene. MA-D removed the face shield and wiped it with a Micro Kill Bleach wipe and performed hand hygiene with ABHR. Record review of the Centers for Disease Control (CDC) document titled Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the Coronavirus Disease 2019 (COVID-19) Pandemic Updated July 15, 2020 revealed the section Implement Universal Use of Personal Protective Equipment. For HCP working in areas with minimal to no community transmission, HCP should continue to adhere to Standard (infection control practices that apply to all patients and situations regardless of infection status) and Transmission-Based (additional precautions needed to prevent infection transmission in addition to standard precautions) Precautions, including use of eye protection and/or an N95 or equivalent or higher-level respirator based on anticipated exposures and suspected or confirmed diagnoses. Interview by email on 7/16/2020 at 1:30 PM with	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
	285221	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH BROADWELL	800 STOEGER DRIVE GRAND ISLAND, NE 68803

(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 26	F 880		

the Facility Administrator confirmed that the facility has an adequate supply of N95 masks in the facility and are able to obtain more as needed.

Interview by email on 7/16/20 at 8:45 AM from the Facility Administrator revealed that the facility orders the PPE supplies weekly and that the current inventory of PPE is: N95 masks 12 boxes 285+ , 4 boxes of disposable gowns, 5 boxes of full face shields plus a box of face shields from Ford that has 100+. The Facility Administrator revealed that as a company, they also have a reserve supply that could be sent out to the facility at any time. The facility also received on top of their regular orders supply donations from the local health department and Nebraska Health Care, etcetera. Also in the Facility Administrator's office the Facility Administrator had the Centers for Medicare and Medicaid Services (CMS)/Federal Emergency Management (FEMA) donation of PPE that is not counted in the above numbers which includes 28 Eye Protection, 347 Masks, 1600 Gloves, and 291 Gowns.

Observation of the sign on Gray Zone room doors revealed that the sign read: Gray Zone (Transitional zone) PPE for Non-Contact cares includes surgical mask and Eye protection. PPE for Contact cares includes gowns, surgical mask, eye protection, and gloves.

Interview by phone on 7/15/20 at 2:58 PM with the Regional Nurse Consultant (RN-A) confirmed that facility staff followed the gray zone door sign on the resident room door for PPE requirements for entering resident rooms.

Record review of the facility nursing staff

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285221	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH BROADWELL	800 STOEGER DRIVE GRAND ISLAND, NE 68803

(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 27 schedule for 7/14/20 revealed that staff MA-C and NA-E were scheduled to work in rooms 24-49 during the day shift on 7/14/20. Interview on 7/15/20 at 2:58 PM with the RN-A confirmed that staff member MA-D had been transferred to work on the day shift on the Master Schedule for 7/14/20. Record review of the facility list of residents by room number revealed that Rooms 24-49 (Unit C) had a census of 25 residents. The facility identified 16 residents on Unit C were in green rooms (Residents 17, 15, 34, 43, 44, 39, 40, 14, 16, 48, 45, 46, 38, 41, 47, and 56) and 9 Residents were in Gray Rooms (Residents 5, 6, 7, 8, 9, 10, 42, 52, and 53).	F 880		

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

MIDWEST DIVISION OF SURVEY AND CERTIFICATION

July 13, 2020

Nicholas Mann, Administrator
Azria Health Broadwell
800 Stoeger Drive
Grand Island, NE 68803

CMS Certification No: 285221

Dear Mr. Mann:

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

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

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

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

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

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

https://qioprogram.org/locate-your-qio.

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

Sincerely,

Lisa Hauptman

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

cc:
NE DHHS
Power/Grimes

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

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 24, 2020

Katherine Klingsporn, Administrator
Azria Health Central City
2720 South 17th Avenue
Central City, NE 68826-0259

CORRECTED LETTER

CMS Certification No. 285147

Subject: Survey Results
Cycle Start Date: June 25, 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 25, 2020, a survey was completed at Azria Health Central City 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 August 3, 2020**, to the State Survey Agency Contact. **Failure to submit an acceptable PoC by August 3, 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.

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

  Payment will be denied for all NEW Medicare and Medicaid admissions, September 7, 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 25, 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/ls

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
	285147	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH CENTRAL CITY	2720 SOUTH 17TH AVENUE CENTRAL CITY, NE 68826

(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 the survey report as they apply to deficient practices identified.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		8/7/20

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

Electronically Signed | 07/31/2020

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
	285147	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH CENTRAL CITY	2720 SOUTH 17TH AVENUE CENTRAL CITY, NE 68826

(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 12-006.17B	F 880	Whirlpool Tub & Shower How corrective action will be	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285147	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH CENTRAL CITY	2720 SOUTH 17TH AVENUE CENTRAL CITY, NE 68826

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 LICENSURE REFERENCE NUMBER 175 NAC 12-006.17D LICENSURE REFERENCE NUMBER 175 NAC 12-006.18C LICENSURE REFERENCE NUMBER 175 NAC 12-006.11E Based on observations, interviews, and record reviews; the facility failed to protect the facility residents from the potential spread of Covid-19 by the facility failure to 1) disinfect the shower and whirlpool bath tub to prevent cross contamination and had the potential to affect all of the facility residents; 2) facility failure to change the barrier between the soiled and clean glucometer which had the potential to affect 4 residents (Residents 22, 23, 24, and 35); 3) facility failure to prepare and deliver water pitchers and drinks to prevent potential cross contamination which affected 24 residents (Residents 9, 5, 11, 25, 26, 27, 28, 29, 30, 12, 6, 15, 19, 31, 10, 24, 21, 7, 20, 13, 18, 33, 34, and 4`) facility failure to perform hand hygiene after contamination which had the potential to affect all of the facility residents. 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) during the performance of blood sugar checks for diabetic residents, between contact with residents receiving blood sugar checks, before and after putting on disposable gloves, and that staff wore disposable gloves during cleaning of the glucometer (a medical device used to measure and display the amount of sugar in the blood for residents with diabetes) to prevent the potential for cross contamination for 3 residents (Residents	F 880	accomplished for those residents found to have been affected by the deficient practice: NA-A and NA-B were re-educated and had a competency completed, NA-a on 7-5-20 and NA-B on 7-2-20 by the Director of Nursing or designee on how to clean and disinfect the Whirlpool Tub to assure sanitation of the whirlpool tub will not spread infections to residents 19, 29, 16, 27, 2, 36, 37, 24, 5, 38, 39, and 40. Procedure for cleaning and disinfecting the Whirlpool tub and Shower was hung on the wall in the Bath House to give visual guidance on proper cleaning of the whirlpool tub & shower and chair on 6-25-20. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: DON or designee reviewed bathing schedule on 6-25-20 to ensure staff were re-educated prior to providing bathing. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: Nursing staff provided bathing were provided re-education and had a competency completed on sanitation of whirlpool and shower by Director of Nursing or designee on or before 7-31-20 including return demonstration. Procedure for cleaning and disinfecting the Whirlpool tub and Shower was hung	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285147	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH CENTRAL CITY	2720 SOUTH 17TH AVENUE CENTRAL CITY, NE 68826

(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 3 4, 5, and 6) of 3 residents observed. The facility failed to ensure that staff performed hand hygiene before putting on and after taking off gloves and failed to ensure that staff scrubbed the hands for 20 seconds during hand washing with soap and water during resident cares to prevent the potential for cross contamination for 1 resident (Resident 8) of 1 resident observed. The facility census was 61. Findings are: A. Observation of the facility bath house on 6/24/2020 at 9:22 AM revealed NA-A (Nursing Assistant) sprayed the shower chair with "Classic Disinfectant" from a spray bottle then scrubbed the shower chair with a brush while rinsing it with water from the shower sprayer at the same time. NA-A was done rinsing the shower chair and the brush at 9:24 AM. NA-A did not let the disinfectant sit on the surfaces of the shower chair before rinsing it off and did not clean or disinfect the underside of the shower chair or the shower area including the walls, the floor, and the shower sprayer. Observation of the facility bath house on 6/24/2020 at 10:02 AM revealed NA-A cleaned the whirlpool in the bath house. It was a "Penner Spa" tub. NA-A sprayed the tub with the sprayer attachment on the tub. Interview with NA-A at this time revealed they were spraying the soap out of the tub. NA-A then sprayed the inside of the tub with Classic Disinfectant from a spray bottle. NA-A wet all surfaces inside the tub with the disinfectant at 10:03 AM. At 10:04 AM, NA-A rinsed the surfaces of the inside of the tub NA-A had sprayed with the disinfectant. NA-A then filled the foot well of the tub with water. NA-A then	F 880	on the wall in the Bath House to give visual guidance on proper cleaning of the whirlpool tub & shower and chair on 6-25-20. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. This will be monitored 5 x weekly for 3 months through visual audits of watching cleaning and disinfecting process of whirlpool tub & shower. This will be followed weekly through Standards of Care where we review all open Quality Improvement Plans. Updates will be completed and communicated to staff through our communication board on PCC and through the competency audits to assure compliance. This will be reviewed monthly through our Quality Assurance Meeting for 3 months to assure continued compliance of proper cleaning and disinfecting of whirlpool tub & shower to assure no spread of infections through bathing. Monitored by Administrator, Director of Nursing, Infection Control Nurse, & RN/LPN Charge Nurses. [redacted] How corrective action will be accomplished for those residents found to have been affected by the deficient practice: RN-C on 7-24-20, LPN-G on 7-8-20, & MA-E on 7-27-20 were re-educated and a competency completed on how to clean/disinfect and proper hand hygiene on the [redacted] to assure	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285147	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH CENTRAL CITY	2720 SOUTH 17TH AVENUE CENTRAL CITY, NE 68826

(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 poured disinfectant into the water in the foot well of the tub from a jug of disinfectant that was sitting on top of the whirlpool and did not measure the amount of disinfectant. At 10:14 AM, NA-A drained the tub, rinsed the brush and the inside of the bottom foot well with the sprayer attachment. NA-A then said the tub was ready for the next resident. NA-A revealed 2 more residents were to receive whirlpool baths that day. NA-A did not disinfect and rinse the jets or run the air blower through the jets. NA-A also did not clean or disinfect the control panel or the sprayer attachment on the tub. Review of the facility Care Plan Item/Task Listing Report dated June 24, 2020 received from the facility administrator after a list of residents who used the facility shower and whirlpool tub was requested revealed 61 residents used the shower or whirlpool bath, which included every resident in the facility. Residents 19, 27, 5, and 39 used the shower. Residents 36, 37, 24, 38, and 16 used the whirlpool tub. Residents 29 and 40 used both the shower and the tub. Review of Resident 2's Care Plan dated 4/17/2020 revealed they took a tub bath with staff assistance. Review of the undated Instructions for Classic Whirlpool Disinfectant Cleaner revealed the following: For broad spectrum disinfection of gram negative and gram positive bacteria, including Pseudomonas aeruginosa and Staphylococcus aureus, add two ounces Classic Whirlpool Disinfectant Cleaner to one gallon of water. Remove heavy soil or gross filth from the surface to be disinfected, then apply properly diluted solution with a mop, cloth, sponge, or hand pump trigger sprayer so as to wet the	F 880	sanitation to assure we will not spread infections to residents 22, 23, 24, 4,5,6 and 35 Director of Nursing or designee. Each resident was given their own [redacted] on 6-26-20. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: DON or designee reviewed current residents with orders for [redacted] monitoring on 6-26-20and provided each resident identified with a [redacted] Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: All residents that have [redacted] testing we will follow the proper procedures of cleaning/disinfecting and proper hand hygiene on the [redacted] to assure no spread of infections and each resident will have their own [redacted]. All RN/LPN/QMA were re-educated and a competency completed on how to clean the [redacted] to assure sanitation of the [redacted] by Director of Nursing or designee on or before7-31-20. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. This will be monitored 5 x weekly for 3	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285147	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH CENTRAL CITY	2720 SOUTH 17TH AVENUE CENTRAL CITY, NE 68826

(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 surface thoroughly. Allow to remain wet for 10 minutes and then let air dry. If higher detergency is desired, increase dilution to 4 to 6 ounces per gallon of water. Prepare a fresh solution for each use or when solution becomes visibly dirty. To disinfect hard, non-porous, inanimate surfaces (such as fiberglass and stainless steel tubs and chair surfaces, chrome plated intakes and lefts, etc.), apply properly diluted Classic Whirlpool Disinfectant Cleaner so as to wet all surfaces thoroughly. For routine disinfection, proper dilution is 1:64 (2 ounces of product per gallon of water). Allow to remain wet for 10 minutes, then let air dry. For heavily soiled areas, a pre-cleaning step is required. Prepare a fresh solution of reach use as above. For cleaning bath and therapy equipment: after using the whirlpool unit, drain the water and refill with fresh water to just cover the intake valve. Add 2 ounces of Classic Whirlpool Disinfectant Cleaner for each gallon of water in the unit at this point. Briefly start the pump to circulate the solutions. Turn off pump. Wash down the unit sides, seat of the chairlift and any/all related equipment with a clean swab or sponge. After the unit has been thoroughly cleaned, drain solutions from the unit and rinse any/all clean surfaces with fresh water. Review of the undated facility policy Whirpool (sic) Cleaning Checklist Audit revealed the following: 1) ensure bath tub door is in locked position-close the drain-press disinfectant jet located on side of the tub-it should take about 20-30 seconds to fill the tub with the injector value (sic) on-ensure cleaning fluid is coming out of jets 2) using scrub brush: wash tub in all areas inside and out allowing tub to sit for 10 minutes to properly disinfect. 3) After 10 minutes open drain, rinse the tub with the spray outlet. 4) Allow the	F 880	months through visual audits of watching cleaning process of [redacted] This will be followed weekly through Standards of Care where we review all open Quality Improvement Plans. Updates will be completed and communicated to staff through our communication board on PCC and through the competency audits to assure compliance. This will be reviewed monthly through our Quality Assurance Meeting for 3 months to assure continued compliance of proper cleaning of glucose meter to assure no spread of infections. Monitored by Administrator, Director of Nursing, Infection Control Nurse, & RN/LPN Charge Nurses. Water Pitcher & Fluid Delivery How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Water pitchers and cups for residents 9, 5, 11, 25, 26, 27, 28, 29, 30, 12, 6, 15, 19, 31, 10, 24, 21, 7, 20, 13, 18, 33, 34, and 4 were replaced on 6-25-20 by Nursing Staff on duty. MA-D and DA-F were educated on policy/procedure on proper water pitchers and fluid delivery on 7-1-20 by Certified Dietary Manager. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All current residents with water pitchers and/or cups had pitchers and/or cups replaced with clean items on 6-25-20.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285147	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH CENTRAL CITY	**2720 SOUTH 17TH AVENUE CENTRAL CITY, NE 68826**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6 scrub brush and tub to air dry before the next resident. 5) Showers: use disinfect (sic) spray from cupboard (classic disinfectant cleaner) spray mat by rinse then spray with bottle in cabinet and rinse. Spray down the shower area floor and walls and scrub with brush for then allow spray to sit 10 minutes before rinsing down area. Don't forget shower chair if used. 6) Reminder that the first bath and shower and the last bath and shower temps need to be taken and recorded on the tracker on the cabinets, every day. To change out disinfectant, use small key and with the panel which is next to the wall, put pressure under the key whole (sic) while turning to open and close panel. Get a new bottle from the bottom cabinet and unscrew the hose from the top of the old bottle and put the hose in the new bottle, put back in place and throw away the old bottle. Review of the undated Penner Manual on System Cleaning revealed the following: System Cleaning (After Every Bath) Note. Penner Cleaner/Disinfectant is a special non-abrasive cleaning and disinfecting solution that will not harm the tub's fiberglass surface. Penner Cleaner/Disinfectant is the only cleaning solution designed and recommended for use with your Penner Spa. 1. Close and lock the door. 2. Press the Tub Fill Button and turn the Temperature Control Knob all the way to the left to its warmest level to heat the disinfectant solution and maximize its effectiveness. 3. Remove any visible tissue, residue, or fluids from the tub by pressing the Shower Button and rinsing the inside tube surfaces with the shower sprayer. 4. Press the Fill Button again to turn off the water. Allow the tub to drain, and place the drain plug over the drain. 5. Press and hold the	F 880	Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: MA-D, DA-F, and all staff were re-educated on safe handling of drinking utensils on or before 7-31-20 by Certified Dietary Manager or designee. Cups for meal service and water pitching passing will be kept in the dishwashing rack for delivery turned upside down to allow staff to only touch the bottom of the cup. Lids for the water pitchers will be placed in a bin so that they can be picked up by the outside edge of the lid without touching areas of the lid that could come in contact with someone□s mouth. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Meal deliver will be monitored 5 x weekly for 3 months and Water pitcher service will be monitored 3 x weekly for 3 months through visual audits of watching delivery process of water pitchers and fluids during meal service. This will be followed weekly through Standards of Care where we review all open Quality Improvement Plans. Updates will be completed and communicated to staff through our communication board on PCC and through the competency audits to assure compliance. This will be reviewed monthly through our Quality Assurance Meeting for 3 months to assure continued compliance of proper delivery of water	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285147	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH CENTRAL CITY	2720 SOUTH 17TH AVENUE CENTRAL CITY, NE 68826

(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 Disinfect Button located on the control panel. As the button is held down, the properly mixed cleaning solution is running through the air injection system and out all of the air jets. Release the button after you see solution coming out of all the air jets and you have 1 to 1 ½ gallons of disinfectant solution in the foot well of the tub. 6. Using the long-handled brush, available from your Penner distributor, thoroughly scrub all interior surfaces of the tub and Swivel Lift chair with the solution that remains in the foot well of the tub. Let disinfectant stay of surface for 10 minutes. (Or, as recommended by the instructions on the disinfectant concentrate container.) 7. Remove the plug from the drain. 8. Rinse the tub's interior surfaces thoroughly with the shower sprayer. 9. Press and hold the Rinse button located on the control panel until clear water runs from all the air jets. Then release the Rinse button. 10. Finish rinsing the interior surfaces of the tub with the shower sprayer. 11. Start the air blower by pushing the Aqua-Aire Button. Allow it to run for 30 seconds. This pushes the rinse water out of the air injection system. If this was the last bath of the day, allow the blower to run for 2 minutes to dry out the system. 12. Stop the Aqua-Aire blower by again pushing the Aqua-Aire button. 13. Visibly check that the tub and reservoir was effectively cleaned during the disinfecting procedure. If not, repeat the procedure. 14. If there is a delay of one or more hours before the next bath, we recommend using a towel to wipe off all excess water. B. Observation on 6/24/2020 at 9:26 RN-C doing a [redacted] check for Resident 23 revealed the following: The [redacted] (a machine used to check [redacted]) was sitting on a piece of aluminum foil on the top of	F 880	pitchers and fluids in cups to assure no spread of infections. Monitored by Administrator, Director of Nursing, Infection Control Nurse, Certified Dietary Manager, & RN/LPN Charge Nurses. Hand Hygiene How corrective action will be accomplished for those residents found to have been affected by the deficient practice: MA-D, DA-F, NA-A, NA-B, LPN-G, and Director of Nursing were re-educated and competency completed on proper hand hygiene to assure sanitation and to not spread infections to residents 9, 11, 25, 26, 27, 28, 29, 30, 12, 15, 19, 31, 10, 24, 21, 7, 20, 13, 18, 33, 34, 4, 5, 6, and 8 by Administrator or designee on or before 7-31-20. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All staff were re-educated on proper hand hygiene to assure sanitation and to not spread infections to all residents by 7-31-20. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: Cups for meal service and water pitching passing will be kept in the dishwashing rack for delivery turned upside down to	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285147	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH CENTRAL CITY	2720 SOUTH 17TH AVENUE CENTRAL CITY, NE 68826

(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 8 the medication/treatment cart. RN-C cleaned the [redacted] with a MicroKill Bleach wipe at 9:28 AM. It was dry in seconds. RN-C did hand hygiene then got a [redacted] and alcohol wipe out of the drawer. RN-C donned gloves and took the [redacted] into Resident 23's room. RN-C checked Resident 23's [redacted] by handling their hand an [redacted] RN-C then left the room and laid the [redacted] on the same piece of foil RN-C took it out of initially. At 9:36 AM RN-C cleaned the [redacted] with the MicroKill wipe and laid it on the same piece of foil that RN-C had laid it on before RN-C had cleaned it. It was dry in less than 30 seconds. At 9:38 AM RN-C wrapped the [redacted] in the same piece of foil and put it back in the drawer on the cart. Interview with RN-C on 6/24/2020 at 9:28 AM revealed the facility residents shared a [redacted] Observation on 6/24/2020 at 10:51 AM revealed MA-E doing [redacted] checks. MA-E laid out a clean piece of foil on the cart and got supplies out [redacted] and alcohol wipes). MA-E put the supplies and the [redacted] onto the foil and took them in to Resident 35's room. MA-E laid the supplies on the foil on Resident 35's bed. MA-E checked Resident 35's BS by [redacted] that was inserted into the [redacted]. MA-E touched Resident 35's hand and handled the [redacted] After MA-E checked Resident 35's [redacted] MA-E took the [redacted] on the piece of foil out to the medication/treatment cart, sat it on the cart, and cleaned the [redacted] with a MicroKill Bleach wipe at 10:57 AM; it stayed wet for less than 30 seconds. MA-E put the [redacted] back into the	F 880	allow staff to only touch the bottom of the cup. Lids for the water pitchers will be placed in a bin so that they can be picked up by the outside edge of the lid without touching areas of the lid that could come in contact with someone□s mouth. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. This will be monitored 5 x weekly for 3 months through visual audits of watching hand hygiene during meal service and resident cares. This will be followed weekly through Standards of Care where we review all open Quality Improvement Plans. Updates will be completed and communicated to staff through our communication board on PCC and through the competency audits to assure compliance. This will be reviewed monthly through our Quality Assurance Meeting for 3 months to assure continued compliance of proper hand hygiene to assure no spread of infections. Monitored by Administrator, Director of Nursing, Infection Control Nurse, Department Managers, & RN/LPN Charge Nurses. Directed Plan of Correction All staff will complete Clean Hands - https://youtu.be/xmYMUly7qiE Keep COVID-19 Out! - https://youtu.be/7srwrF9MGdw Before 8/7/20 Nursing staff will complete	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285147	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH CENTRAL CITY	2720 SOUTH 17TH AVENUE CENTRAL CITY, NE 68826

(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 9 drawer at 10:58 AM. Interview with MA-E on 6/24/2020 at 10:51 AM revealed the facility residents shared the glucometer. Review of the facility policy [redacted] dated 9/1/2018 revealed the following: If a [redacted] that has been used for one resident must be reused for another resident, the device is cleaned and disinfected with a bleach preparation of: 1 part bleach to 10 parts water or an approved designated cleaner. Interview with the facility Administrator on 6/25/2020 at 9:38 AM revealed Residents 22, 23, and 24 used the [redacted] on the same unit. C. Observation on 6/24/2020 at 9:12 AM revealed NA-A (Nursing Assistant) entered the bath house. Resident 17 was seated on the shower chair. NA-A reported Resident 17 had just finished being assisted with a shower. NA-A and NA-B used the full lift and transferred Resident 17 into their wheelchair. At 9:19 AM, NA-B wheeled Resident 17 out of the bath house. At 9:20 AM, NA-A cleaned the lift with a MicroKill Bleach wipe after taking the lid off the wipe container and putting it on the floor. The lift was dry in seconds. The DON (Director of Nursing) picked the lid up off the floor and put it on the tub of wipes and put it back in the storage bag on the lift at 9:21 AM. The DON did not clean the lid after it was laying on the floor and did not do hand hygiene after they touched the lid that was laying on the floor. The DON then left the bath house without doing any hand hygiene. Review of the label with directions for use for the	F 880	Lessons - https://youtu.be/YYTATw9yav4 Before 8/7/20	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285147	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH CENTRAL CITY	2720 SOUTH 17TH AVENUE CENTRAL CITY, NE 68826

(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 10 Micro-Kill Bleach disinfectant wipes received from the facility Administrator revealed the following: Directions for Use: 1. Always use personal protective equipment. 2. Open Micro-Kill Bleach Germicidal Bleach Wipes Canister. 3. Remove pre-moistened 5 in x 5 in wipe. 4. Apply pre-saturated towelette and wipe desired surface to be disinfected. 5. A 30 second contact time is required to kill all of the bacteria and viruses on the label except a 1 minute contact time is required to kill Candida albicans and Trichophyton mentagrophytes and a 3 minute contact time is required to kill Clostridium difficile spores. Reapply as necessary to ensure that the surface remains wet for the entire contact time. 6. Allow surface to air dry and discard used wipe and empty canister. Interview with the facility Administrator on 6/25/2020 at 9:50 AM revealed the facility residents shared the lifts. D. Observation on 6/24/2020 at 10:30 AM revealed MA-D (Medication Aide) was putting lids on water pitchers that were sitting on a cart in the dining area by the ice machine by handling the inside of the lids with their bare hands before snapping them onto the pitchers. MA-D then picked up a stack of red cups and handled them by the drinking rim with bare hands and placed each one of them on top of each of the pitchers. MA-D then took the cart down the hall with the pitchers and glasses on it and took them to the residents on the south unit. Observation of the south unit on 6/24/2020 at 10:48 AM revealed the water pitchers and glasses were in the resident rooms. Interview with	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
	285147	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH CENTRAL CITY	2720 SOUTH 17TH AVENUE CENTRAL CITY, NE 68826

(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 11	F 880		

Resident 15 at this time confirmed MA-D had brought them a water pitcher and glass from the cart.

Record review of the undated facility document Water Pitchers received from the facility Administrator revealed the following residents received a water pitcher from the cart: 9, 11, 5, 25, 26, 27, 28, 29, 30, 12, 6, 15, 19, 31, 10, 24, 21, 7, 20, and 4.

Observation on 6/24/2020 at 12:07 PM revealed DA-F (Dietary Assistant) picked up 2 glasses touching the inside of the glass with bare hands, sat them on the top of the cart that was sitting in the south hall and poured juice in them. The DS (Dietary Supervisor) then took the juice to Residents 13 and 18 at 12:09 PM. At 12:11 PM DA-F touched the inside of a glass with their bare hand and then poured milk in it. The DS then took the milk in to Resident 21. At 12:13 PM DA-F handled more glasses by the rims with their bare hands. DA-F poured coffee, milk and juice for Resident 20 and poured Resident 29 milk and Kool-Aid. The DS then took them in to them in their room. At 12:14 PM DA-F touched the mask on their face with their bare hands. DA-F then poured drinks for Resident 19 by handling the glasses then the DS took them to the room. DA-F then poured drinks for Resident 30 and Resident 25 after DA-F had handled the glasses with their bare hands. DA-F then touched their cloth face mask that was covering their face then poured more drinks by handling the glasses with their bare hands and not performing hand hygiene. At 12:17 PM the DS took drinks to Resident 5 after DA-F had touched their mask then poured the drinks by handling the glasses. At 12:18 PM, DA-F handled more glasses by the rims to pour

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285147	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH CENTRAL CITY	2720 SOUTH 17TH AVENUE CENTRAL CITY, NE 68826

(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 12	F 880		

drinks and the DS took the drinks to Resident 28 and Resident 27. At 12:19 PM, DA-F poured 2 glasses each of milk, juice, and coffee and was touching the rims of the glasses with their bare hands. The DS took the drinks in to Residents 33 and 34. DA-F did not perform hand hygiene between each residents' drink preparation or after touching their mask before preparing the drinks. All of the residents were observed handling the glasses and drinking from them after the drinks were taken to them.

Review of the undated facility policy Procedure for Pouring drinks during Covid Precaution Serving revealed the following: Dietary aide pre-pours special drinks i.e. thickened drinks, lactose free, fortified drinks, etc. and places in refrigerator until serving time. All other drinks will be poured at point of service outside resident's rooms. Dietary aide will take two carts for each meal service outside resident's rooms. Dietary aide will take two carts for each meal service with: Juice/KA, Skim Milk, Whole Milk, Special Drinks. ALL gallons placed in tub of ice for duration of service. Special drinks placed in freezer tubs until passed to resident. The carts will have wrapped silverware, coffee, lidded cups, 8 oz and 4 oz cups ready to be utilized during meal service. Dietary aide MUST wear blue cover/gown while passing items/drinks if they will be entering a resident room. Prior to meal service: wash hands, load ice tubs, don gown, wash hands. Exit kitchen and begin hallway meal service. Pour drinks one room at a time. After each residents, staff will use hand sanitizer before pouring the next set of drinks. If available, other staff may help take items into resident's room including CDM, office staff, CNAs, etc. Any dietary staff entering a resident's room must have

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285147	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH CENTRAL CITY	2720 SOUTH 17TH AVENUE CENTRAL CITY, NE 68826

(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 13 gown/blue cover on. Dietary staff will not go into quarantine/isolation rooms. Review of the undated Procedure for AM Water Pitcher/Pink Mug Pass revealed the following: By 10 am every day, the med aide will come to kitchen, don a hair net, wash hands, and place water pitchers on a clean cart. There is a list available to reference who receives a mug and who is on fluid restrictions. Pitchers are filled with ice/water, clean red cups are put with each mug. Med aide then passes the mugs and cups, picking up used red cups from noc to be wash for next day. Pre-thickened water available on med cart for residents needing thickened fluids with med pass. All mugs will be picked up on NOC shift and taken to kitchen for washing. The red cups stay in the room so that resident have a cup to use overnight. When dietary aide comes in for am shift, they wash all pink mugs and place on drying rack. Review of the facility policy Handwashing/Hand Hygiene revised August 2015 revealed the following: This facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations: when hands are visibly soiled; and after contact with a resident with infectious diarrhea including, but not limited to infections caused by norovirus, salmonella, shigella, and C.	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
	285147	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH CENTRAL CITY	2720 SOUTH 17TH AVENUE CENTRAL CITY, NE 68826

(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 14 difficile. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: a. before and after coming on duty; b. before and after direct contact with residents; c. before preparing or handling medications; d. before performing any non-surgical invasive procedures; e. before and after handing an invasive device; f. before donning sterile gloves; g. before handling clean or soiled dressing, gauze pads, etc.; h. before moving from a contaminated body site to a clean body site during resident care; i. after contact with a resident's intact skin; j. after contact with blood or bodily fluids; k. after handling used dressings, contaminated equipment, etc.; l. after contact with objects (e.g. medical equipment) in the immediate vicinity of the resident; m. after removing gloves; n. before and after entering isolation precaution settings; o. before and after eating or handling food; p. before and after assisting a resident with meals; and q. after personal use of the toilet or conducting your personal hygiene. Hand hygiene is the final step after removing and disposing of personal protective equipment. Interview with the facility Administrator on 6/24/2020 at 11:05 AM revealed the following: 1. Questions: What is the expectation for staff to pour drinks? Are they allowed to touch the rims and insides of the glasses with bare hands?	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
	285147	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH CENTRAL CITY	2720 SOUTH 17TH AVENUE CENTRAL CITY, NE 68826

(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 15 If they touch their face mask, are they expected to perform hand hygiene before pouring the drinks and handling the drink glasses? Administrator's response: Wash hands before meal service, if you touch something other than dishware you would sanitize your hands again with soap and water if available or hand sanitizer. Pre-poured drink are covered with tinfoil or Saran wrap can be lifted from cooler tub by rim only touching cover and then remove covering and use side or bottom of glass to deliver. 2. Questions: What is the expectation for filling water pitchers? Are they allowed to touch the inside of the lids and the rims of the water glasses with bare hands? Administrator's response: Medication Aide fills water pitchers washing hands prior to completing the task. Lids should only be touched on the outside rim and glasses touched from side or bottom not at rim. 3. Questions: What is the expectation for cleaning the shower chair? Are the staff supposed to let the disinfectant sit for the amount of time per manufacturer? Administrator's response: Same as whirlpool and it should sit for 10 minutes. 4. Questions: What is the expectation for cleaning the whirlpool bath tub? Is the disinfectant supposed to be allowed to sit on the entire bathtub for the amount of time per manufacturer before being rinsed off? Are the whirlpool jets supposed to be disinfected and rinsed between residents? Administrator's response: Follow policy that we sent - The disinfectant should sit in tub for 10 minutes and then rinsed off - You push the	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
	285147	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH CENTRAL CITY	2720 SOUTH 17TH AVENUE CENTRAL CITY, NE 68826

(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 16 disinfectant button and then the rinse button to clean the jets. 5. Questions: Are they supposed to follow the directions on the disinfectant wipes for contact time? Are they supposed to place the wipe container lid on the floor? When they handle the disinfectant tub, are they supposed to wash their hands afterwards? Administrator's response: MicroKill bleach wipes are used to clean the lift after use - yes - no if it is on the floor it needs to be cleaned before used again - hands hygiene should be performed if a staff member's hand becomes contaminated. 6. Questions: What is the expectation for handling of the [redacted] Are they supposed to wrap the clean [redacted] machine in a clean piece of foil after they have put the dirty machine on it? Administrator's response: [redacted] is clean when in the medication cart if the foil becomes contaminated then new foil should be replaced. 7. Questions: What is the expectation for staff performing hand washing with soap and water and how long they must scrub the hands? Administrator's response: 20 seconds 8. Questions: What is the expectation for hand hygiene before gloving and after removal of gloves? Administrator's response: Wash before and after 9 Questions: When obtaining blood glucose what is the expectation for staff for washing hands/hand hygiene and putting on gloves prior	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
	285147	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH CENTRAL CITY	2720 SOUTH 17TH AVENUE CENTRAL CITY, NE 68826

(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 17 to obtaining a blood sample and what is the expectation for removing gloves and performing hand hygiene after the blood sample is obtained? Administrator's response: Wash before and after 10. Questions: What is the expectation for PPE used when wiping the glucometer after use? Administrator's response: Gloves 11 Questions: What is the expectation for Hand hygiene between resident contacts when performing blood glucose tests between residents (is the expectation that staff can go from one room to another without performing hand hygiene), when going from room to room delivering meals, before and after assisting a resident with meals, before and after handling food, and after removing PPE? Administrator's response: Wash between resident contact E. Record review of the facility policy titled Handwashing/Hand Hygiene dated 8/2015 revealed the Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation Section Step 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Step 8. Hand hygiene is the final step after removing and disposing of personal protective equipment (gloves, gowns, masks, eye protection).	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
	285147	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH CENTRAL CITY	**2720 SOUTH 17TH AVENUE CENTRAL CITY, NE 68826**

(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 18	F 880		

Step 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.
Procedure section:
Applying and Removing Gloves:
1. Perform hand hygiene before applying non-sterile (disposable) gloves.
2. When applying, remove one glove from the dispensing box at a time, touching only the top of the cuff.
3. When removing gloves, pinch the glove at the wrist and peel away from the hand, turning the glove inside out.
4. Hold the removed glove in the gloved hand and remove the other glove by rolling it down the hand and folding it into the first glove.
5. Perform hand hygiene.

Observation on 6/24/20 at 11:03 AM beside the facility nurses station revealed that Licensed Practical Nurse-G (LPN-G) performed hand hygiene with alcohol based hand rub (ABHR). LPN-G removed the [redacted] from a drawer of the treatment cart and placed it on a disposable foil square on the top of the cart. LPN-G wiped the right index fingertip of Resident 4 with an alcohol prep pad. LPN-G pricked the resident's finger and wiped off a blood drop. LPN-G applied a new blood drop to the [redacted] and told the resident that the [redacted]. LPN-G asked Resident 4 if the [redacted] could be rechecked and the resident gave permission. LPN-G wiped the fingertip of the resident's 4th finger of the right hand with an alcohol prep pad and pricked the finger and obtained a blood drop. LPN-G wiped off the blood drop with a cotton ball and obtained a new

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285147	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH CENTRAL CITY	2720 SOUTH 17TH AVENUE CENTRAL CITY, NE 68826

(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 19	F 880		

blood drop and told the resident that the [redacted] LPN-G placed the [redacted] on the disposable foil on the top of the cart. LPN-G removed the disposable gloves and did not perform hand hygiene. LPN-G went toward the facility kitchen and got juice for Resident 4. LPN-G returned to the treatment cart and wiped the [redacted] with a disinfectant wipe without wearing gloves and laid the [redacted] on a new foil square. LPN-G did not perform hand hygiene. LPN-G went to the desk of the nurse's station and obtained the charge nurse sheet from the nurse's desk and returned to the treatment cart and wrote the resident [redacted] on the charge nurse sheet. LPN-G pushed the treatment cart down the South Hallway and parked the cart across the hallway from the room of Resident 5. LPN-G did not perform hand hygiene and put on disposable gloves. LPN-G took the [redacted] into the room of Resident 5 and obtained a [redacted] for the resident. LPN-G exited the room and returned to the treatment cart. LPN-G removed the disposable gloves and did not perform hand hygiene. LPN-G wiped the [redacted] with a disinfectant wipe without wearing disposable gloves and placed the [redacted] on a new foil square on the top of the cart. LPN-G wrote the [redacted] for Resident 5 on the charge nurse sheet. LPN-G did not perform hand hygiene and put on disposable gloves. LPN-G entered the room of Resident 6 with the [redacted] LPN-G told the resident that the [redacted] LPN-G exited the resident's room and returned to the treatment cart. LPN-G removed the disposable gloves and did not perform hand hygiene. LPN-G wiped the [redacted] with a disinfectant wipe without

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285147	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH CENTRAL CITY	2720 SOUTH 17TH AVENUE CENTRAL CITY, NE 68826

(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 20 wearing gloves and placed the [redacted] on a new foil square on the top of the cart. LPN-G performed hand hygiene with ABHR. Record review of the facility procedure titled [redacted] dated 9/1/18 revealed the Section titled Procedures: Step 3. If a [redacted] that has been used for one resident must be reused for another resident, the device is cleaned and disinfected with a bleach preparation or an approved designated cleaner. Step 6. Wash hands and put on gloves. Step 10. Wipe away the first drop of blood. Step 13. Discard lancet (a pricking needle used to obtain drops of blood for testing). Step 14. Remove gloves and wash hands. Interview on 6/24/20 at 12:28 PM with LPN-G confirmed that the [redacted] is shared between residents. Record review of the facility document titled Clinical Competency Assessment: [redacted] dated 12/01 revealed: Step 6. Properly washes hands and puts on gloves. Step 12. (After [redacted] obtained) Properly disposes of lancet and [redacted] Step 13. Discards gloves and washes hands. Interview by email from the Facility Administrator on 6/25/20 at 11:05 AM revealed that staff are expected to perform hand hygiene before putting on gloves and after removal of the gloves. Staff are expected to remove the gloves and perform hand hygiene after a blood sample is obtained.	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
	285147	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH CENTRAL CITY	2720 SOUTH 17TH AVENUE CENTRAL CITY, NE 68826

(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 21	F 880		

Staff are to wear gloves when wiping the [redacted] after use. Staff are to perform hand hygiene between resident contacts when performing blood glucose tests.

F.
Observation on 6/24/20 at 11:37 AM in the room of Resident 8 revealed that Nursing Assistant-A (NA-A) entered the resident's bathroom and performed handwashing with soap and water. NA-A put on disposable gloves. Nursing Assistant-B (NA-B) entered the resident's bathroom and performed hand washing with soap and scrubbed the hands for 11 seconds. NA-B put on disposable gloves. Resident 8 was lying on the resident's back on the bed. NA-B unsecured the resident's brief (a disposable underwear for containing involuntary release of urine or bowel) and wiped the front private area of the resident with a disposable wipe. NA-A rolled Resident 8 onto the resident's left side and NA-B wiped stool from the resident's anal area. NA-B disposed of the resident brief with the resident stool into the trash can beside the resident's dresser. NA-B removed the disposable gloves and did not perform hand hygiene. NA-B positioned a new brief underneath the resident and NA-A rolled the resident onto the resident's back onto the brief. The facility MDS Coordinator (MDSC) laid a pair of disposable gloves on the foot of the bed near NA-B. NA-B told the MDSC thanks and put on the disposable gloves without performing hand hygiene. NA-B secured the brief on the resident. NA-B opened the top dresser drawer with the disposable gloves on and got clothing out of the dresser drawer. NA-B put socks on the resident's feet. NA-A and NA-B put pants on the resident and then put a shirt on the

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285147	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH CENTRAL CITY	2720 SOUTH 17TH AVENUE CENTRAL CITY, NE 68826

(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 22 resident. NA-B removed the disposable gloves and did not perform hand hygiene. NA-B positioned the mechanical total body lift (a mechanical assistive device used to transfer a resident with difficulty standing up on their own) over Resident 8. NA-B and NA-A hooked the lift sling (a fabric device with straps that is placed underneath a resident and connected to the mechanical total body lift to transfer a resident with difficulty or inability to stand up on their own from a seated or lying position) to the total body lift. NA-B operated the lift and lifted Resident 8 from the bed. NA-B and NA-A transferred Resident 8 from the bed into the wheelchair. NA-B and NA-A unhooked the sling from the total body lift. NA-B straightened the sheet, pad, and bedding on the resident's bed. NA-B handed the call light cord to Resident 8. NA-A entered the bathroom in the resident's room and wet the hands and applied soap. NA-A scrubbed the hands with soap for 6 seconds. NA-B entered the resident's bathroom and applied soap and scrubbed the hands for 18 seconds. NA-A put on disposable gloves. NA-A wiped the total body lift with a Clorox wipe. NA-B put on disposable gloves and wiped the controller area of the lift with Clorox wipes. NA-B removed the disposable gloves and washed the hands with soap for 8 seconds and exited the resident's room. NA-A removed the disposable gloves and did not perform hand hygiene. NA-A carried the plastic trash bag with the used resident brief out of the resident's room. NA-A carried the trash bag to the facility room labeled bath-2 and opened the room door and disposed of the trash bag. NA-A exited the room and performed hand hygiene with ABHR. Record review of the facility policy titled	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
	285147	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH CENTRAL CITY	2720 SOUTH 17TH AVENUE CENTRAL CITY, NE 68826

(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 23 Handwashing/Hand Hygiene dated 8/2015 revealed the Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation Section Step 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, resident, and visitors. Step 7. h. before moving from a contaminated body site to a clean body site during resident care. I. After contact with objects in the immediate vicinity of the resident. m. After removing gloves. Procedure section: Washing Hands: 1. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) under a moderate stream of running water, at a comfortable temperature. Applying and Removing Gloves: 1. Perform hand hygiene before applying non-sterile gloves. 2. When applying, remove one glove from the dispensing box at a time, touching only the top of the cuff. 3. When removing gloves, pinch the glove at the wrist and peel away from the hand, turning the glove inside out. 4. Hold the removed glove in the gloved hand and remove the other glove by rolling it down the hand and folding it into the first glove. 5. Perform hand hygiene. Interview by email from the Facility Administrator on 6/25/20 at 11:05 AM revealed that the expectation is that staff perform hand hygiene	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
	285147	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH CENTRAL CITY	2720 SOUTH 17TH AVENUE CENTRAL CITY, NE 68826

(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 24 before putting on gloves and after removing gloves. The expectation for staff during hand hygiene with soap and water is that staff scrub the hands for 20 seconds.	F 880		

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

Pete Ricketts, Governor

July 2, 2020

Michael Early, Administrator
Azria Health Gretna
700 Highway 6
Gretna, NE 68028

CMS CERTIFICATION NUMBER: 285146

Dear Mr. Early:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 23, 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
	285218	A. BUILDING _____ B. WING _____	06/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH MIDTOWN	910 SOUTH 40TH STREET OMAHA, NE 68105

(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		8/7/20

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

Electronically Signed | 07/09/2020

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
	285218	A. BUILDING _____ B. WING _____	06/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH MIDTOWN	910 SOUTH 40TH STREET OMAHA, NE 68105

(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: 175 NAC 12-006.17	F 880	Correction to Resident:	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285218	A. BUILDING _____ B. WING _____	06/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH MIDTOWN	910 SOUTH 40TH STREET OMAHA, NE 68105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observation, interview, and record review the facility failed to implement contact precautions for 3 [Residents 1, 3 and 4] of 4 sampled residents and failed to identify a gray zone in accordance with facility policy for COVID 19. The facility had a total census of 52 residents. Findings are: A. Observations on 6/10/20 at 1 PM revealed Nurse Aide A donning gown and gloves for entrance to Resident 1's room. Nurse Aide B had donned gown and gloves before entrance to room. Nurse Aide A wore a cloth mask and Nurse Aide B wore a hospital mask when entering Resident 1's room. Nurse Aide A and Nurse Aide B were not wearing goggles or a face mask. Nurse Aide A reported personal care was to be provided. Observations inside of Resident 1's room revealed a red barrel containing used gowns and a red barrel for linen. In an interview on 6/10/20 at 1 PM, Nurse Aide A reported that gowns and gloves would be discarded in red barrel before exiting Resident 1's room. Observations on 6/10/29 at 1:30 PM revealed Nurse Aide A wearing a cloth mask. In an interview on 6/10/20 at 1:30 PM, Nurse Aide A confirmed that masks were not be changed after coming out of an isolation room. In an interview on 6/10/29 at 2:30 PM, Registered Nurse C confirmed cloth masks are not to be worn into rooms of residents in contact isolation. Registered Nurse C reported hospital masks	F 880	Resident 1 no longer resides in the facility. Cloth masks were immediately removed from use and C.N.A was re-educated and provided the appropriate PPE. Resident 3 has appropriate signage on the door indicating PPE required. PPE is available outside of resident room. Care plan update to indicate isolation and PPE needs. Resident 4 no longer resides in the facility. Resident rooms have signage regarding isolation needs including PPE needed. PPE is available outside resident rooms. Review of other residents at risk for deficient practice: All other resident rooms reviewed for isolation needs and signage place to indicate PPE requirements on 6/25/20. All residents reviewed for isolation needs and appropriate transitional zones in place 6/25/20. Policy Change/Re-Education Staff re-education on Green, Gray, Yellow and Red zones will be provided on or before 8/3/20. Nursing staff re-educated on requirements for Gray Zone including residents that leave for regular outside appointments like dialysis on or before 8/3/20. PPE donning station established at employee screening station that is stocked with approved PPE 6/25/20. Directed Plan of Correction:	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285218	A. BUILDING _____ B. WING _____	06/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH MIDTOWN	910 SOUTH 40TH STREET OMAHA, NE 68105

(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 3 needed to be discarded when exiting a room of resident in isolation and a new mask put on. Registered Nurse C confirmed that there had been no masks available for staff outside of the rooms of residents in contact isolation. A review of undated policy titled Universal Use of Ear Loop Masks revealed the following: -The use of a universal mask does not apply for residents in transmission based precautions/isolation that requires the use of a mask. --If you have a resident in isolation you will removed the universal mask; place it in a secure area, sanitize or wash your hands and don a clean mask before entering the room that has isolation precautions in place. --Doffing of the mask and other PPE per normal procedures and hygiene apply when leaving the isolation room. --Then the universal mask may be retrieved and placed back in use. B. Review of Resident 3's care plan on 06/10/2020 revealed, Resident 3 attends an outside [redacted] appointment 2 times per week. Observation on 6/10/2020 at 10:30 AM of Resident 3's room revealed no signage indicating isolation precautions in place. Interview with Nurse Aide (NA) A on 6/10/2020 at 11:40 AM, it was revealed that Resident 3 was not indicated as being in isolation. Interview on 6/10/2020 at 10:45 am with Licensed Practical Nurse (LPN) D it was revealed that Resident 3 was not indicated as being in isolation. Record review on 06/10/2020 of Facilities; Midtown_COVID-19-LTCF-Slides-with-QA	F 880	Housekeeping staff will complete CDC video sparkling surfaces on or before 8/3/20 Sparkling Surfaces - https://youtu.be/t7OH8ORr5Ig Current employees will complete CDC video Keeping COVID out on or before 8/3/20 Keep COVID-19 Out! - https://youtu.be/7srwrF9MGdw Audits DON or designee will complete observational audits for room signage indicating the isolation needs 5 times a week for 2 weeks; 3 times a week for 2 weeks then weekly for 2 weeks with results taken to QAPI. Admin or designee will complete observational audits for PPE availability in resident care areas 5 times a week for 2 weeks, 3 times a week for 2 weeks; weekly for 2 weeks with results taken to QAPI. DON or designee will complete observational audits of PPE use 5 times a week for 2 weeks, 3 times a week for 2 weeks then weekly for 2 weeks with results taken to QAPI.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285218	A. BUILDING _____ B. WING _____	06/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH MIDTOWN	910 SOUTH 40TH STREET OMAHA, NE 68105

(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 revealed, All nursing homes should consider establishing a transitional zone for new admissions, returning residents from the hospital or those who are travelling in and out of the nursing home (such as the residents who are [redacted]). Interview with the Director of Nursing (DON) on 06/10/2020 at 3:35 PM revealed; Resident 3 was not in an isolation room. Interview also revealed Resident 3 should have been in a Gray Zone isolation room. C. Review of Resident 4's care plan on 06/10/2020 revealed, Resident 4 receives [redacted] at an outside infusion clinic and Resident 4 should be on [redacted]. Observation on 6/10/2020 at 10:20 AM of Resident 4's room revealed no signage indicating isolation precautions in place. Interview with NA A on 6/10/2020 at 11:40 AM, it was revealed that Resident 4 was not indicated as being in isolation. Interview on 6/10/2020 at 10:45 am with LPN D it was revealed that Resident 4 was not indicated as being in isolation. Record review on 06/10/2020 of Facilities; Midtown_COVID-19-LTCF-Slides-with-QA revealed, All nursing homes should consider establishing a transitional zone for new admissions, returning residents from the hospital or those who are travelling in and out of the nursing home (such as the residents who are [redacted]	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
	285218	A. BUILDING _____ B. WING _____	06/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH MIDTOWN	**910 SOUTH 40TH STREET OMAHA, NE 68105**

(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 Interview with DON on 06/10/2020 at 3:35 PM revealed; Resident 4 was not in isolation. Interview also revealed Resident 4 should have been in a Gray Zone isolation room. D. Observations on 6/10/2020from 10:15am to 3:00pm the first floor of the facility had 2 of 17 residents in isolation. Interview with NA A on 6/10/2020 at 11:40 AM, NA A report only 2 of 17 residents were in isolation. Interview on 6/10/2020 at 10:45 am with LPN D, LPN D reported only 2 of 17 residents were in isolation. Record review on 06/10/2020 of Facilities; Midtown_COVID-19-LTCF-Slides-with-QA revealed, All nursing homes should consider establishing a transitional zone for new admissions, returning residents from the hospital or those who are travelling in and out of the nursing home (such as the residents who are on dialysis). Interview with DON on 06/10/2020 at 3:35 PM revealed; a Gray Zone of isolation has not been established in the facility.	F 880		

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

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 1, 2020

Anthony Brewer, Administrator
Azria Health Midtown
910 South 40th Street
Omaha, NE 68105 **CMS Certification No. 285218**

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 Azria Health Midtown 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
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 29, 2020

Anthony Brewer, Administrator
Azria Health Midtown
910 South 40th Street
Omaha, NE 68105

CMS CERTIFICATION NUMBER: 285218

Dear Mr. Brewer:

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

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

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

Sincerely,

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

CV/kd

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

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 8, 2020

Hayley Adams, Administrator
Azria Health Montclair
2525 South 135th Avenue
Omaha, NE 68144-2499 **CMS Certification No. 285054**

Subject: Survey Results
Cycle Start Date: June 18, 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 18, 2020, a survey was completed at Azria Health Montclair 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 8, 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 18, 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

NEBRASKA
Good Life. Great Mission.
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

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

Pete Ricketts, Governor

July 23, 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 July 15, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

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

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

Sincerely,

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

CV/kd

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

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 14, 2020

Michael Lange, Administrator
Azria Health Waverly
11041 North 137th St
Waverly, NE 68462 **CMS Certification No. 285143**

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

PLAN OF CORRECTION

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

The PoC must contain the following:

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

ENFORCEMENT REMEDIES

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

- **Directed Plan of Correction:**

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

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

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

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

Connie Vogt, RN, BSN

dhhs.healthcarefacilities@Nebraska.gov

In the Subject Line please put: DPOC

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

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

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

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

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

WITHDRAWAL OF APPROVAL FOR NURSE AIDE TRAINING PROGRAM

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

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

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

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

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

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

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

APPEAL RIGHTS

If you disagree with the determination to impose remedies made on the basis of noncompliance identified at the 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 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
	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
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		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.

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
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: It is the intent of the facility to implement infection	

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
F 880	Continued From page 2 Based on observations, record reviews and interviews the facility failed to implement Infection Control Practices and CMS (Center for Medicare and Medicaid services) guidelines to prevent the potential for cross contamination including the spread of Covid-19 related to staff wearing universal masks into isolation rooms for 7 residents (Residents 1,2,3,4,5,6, and 7) and, touching inside of contaminated gown with removing, touching clean brief with soiled gloves, touching biohazard containers with bare hands for 1 resident (Residents 1). The facility failed to ensure The Infection Preventionist had completed specialized training in infection and control prevention and Screening Logs for staff were completed and reviewed by trained staff. This had the potential to affect all resident in the building. The facility census was 44. Cross Contamination/ PPE (Personal Protective Equipment)/ hand hygiene after Direct resident contact An observation on 6/24/20 at 10:40 AM revealed that outside of Resident 1's door on the door frame was a piece of gray tape. Record review of facility policy no date revealed pieces of red, yellow, gray and green tape were used to identify the zones according to each residents Covid -19 status. A gray zone indicated that residents in room are considered in isolation or a transition zone for 14 days post arriving to facility as new admission or returning from a medical appointment. Record review of Resident 1's Electronic Health Record revealed Resident 1 had left the facility to	F 880	control practices and CMS guidelines to prevent the potential for cross contamination including the spread of Covid-19. Correction to Resident(s) affected: Resident 1 has signage regarding appropriate zone which includes PPE needed. CNA□s were re-educated regarding Donning and Doffing PPE, handling biohazards materials, hand hygiene, appropriate PPE in each zone, and perineal care. Resident 2-7 have appropriate signage on the door indicating PPE required. CNA□s were re-educated regarding appropriate PPE use. The newly designated Infection Control Nurse was provided the link to the CDC Infection Prevention Training Modules. Nurses were educated on staff screening tool and the follow-up necessary when staff answers Yes to any questions. Policy Changes/ Re-education: All direct care staff will be re-educated, and competencies completed for donning and doffing PPE, handling biohazards materials, hand hygiene, appropriate PPE in each zone, and perineal care on or before 08/05/20. All non-nursing staff will be re-educated, and competencies completed on hand hygiene on or before 08/05/20. All other residents reviewed for appropriate signage and PPE needs and signage placed to indicate appropriate PPE on or before 08/05/20.	

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
F 880	Continued From page 3 got to a medical appointment on 6/16/20 and was place in Gray zone until 6/28/20. An observation on 6/24/20 at 10:49 AM revealed NA-A and NA-B leave Gray Zoned room with surgical mask on and had not discarded or applied a new mask. An observation on 6/24/20 at 11:35 AM revealed NA -C enter Resident 1's room(a Gray Zoned Room) with only surgical mask. An observation on 6/24/20 at 10:45 AM revealed NA-B provided Resident 1 with Perineal Care (Cleaning of private area) after using the toilet. NA-B pulled up residents brief with the same gloves that were used to perform perineal care. An observation on 6/24/20 at 10:47 AM revealed NA-B lift red biohazard trash bin with (gender) bare hands. An observation on 6/24/20 at 10:49 AM revealed NA-A removing PPE by touching inside of gown with dirty gloves on. An observation on 6/24/20 at 11:38 AM revealed MA-D applied goggles and entered Resident 1's room to administer medications. An observation on 6/24/20 at 11:42 AM revealed MA-D removed goggles cleaned goggles with sanitizing wipe (no gloves) placed goggles back into PPE (Personal Protective Equipment) Caddy, hand hygiene was not preformed. An interview on 6/24/20 at 10:50 AM revealed NA-B was screening at the beginning of shift and provided a surgical (blue) mask to use for her	F 880	The designated Infection Prevention Nurse and DON were provided the link to the Infection Prevention training and the modules and training will be completed by 08/05/20. All employees will be educated that the charge nurse or designee will be responsible for screening all employees and visitors, filling out the screener tool, the charge nurse or designee will assess the employee or visitor for any answers resulting in Yes and follow-up documentation will be provided on the form or additional paper if necessary on or before 08/05/20. Directed Plan of Correction: Current employees will complete CDC video Keeping COVID out on or before 08/05/20 Keep COVID-19 Out! - https://youtu.be/7srwrF9MGdw Current employees will complete CDC video Clean Hands on or before 08/05/20 Clean Hands - https://youtu.be/xmYMUly7qiE Nursing employees will complete CDC video Lessons on or before 08/05/20 Lessons - https://youtu.be/YYTATw9yav4 Monitoring Process/Audits: Director of Nursing or designee will complete observation audits of hand washing 5 times a week for 2 weeks; 3 times a week for 2 weeks then weekly for 2 weeks with results taken to QAPI. Director of Nursing or designee will complete observational audits of PPE use 5 times a week for 2 weeks, 3 times a	

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
F 880	Continued From page 4 shift. NA-B noted that when entering Gray zone only gown, googles and gloves need to be added to surgical mask, no other mask is needed. An interview on 6/24/20 at 3:30 PM with DON confirmed when staff enter a Gray Zoned room they must be changing masks. DON confirmed red biohazard trash cans should not be touched with bare hands for any reason .DON confirmed after perineal care is preformed gloves should be discarded, hands washed before touching clean brief/ clothing. An interview on 6/24/20 at 4:30 PM with Administrator confirmed staff are to be applying a new mask (if using surgical masks) and applying PPE before entering Gray Zoned Rooms. Record review of policy titled Transmission Precautions: Droplet not dated revealed the following information that Staff need to perform hand washing, wear gloves when contact with anybody substance is anticipated, gowns must be worn when working within three feet of the resident. A mask must be worn when working within three feet of the resident. Record review of ICAP information dated 4/2/20 title Universal Use of Ear Loop Masks revealed - If you have a resident in isolation you will remove the universal mask; place it in a secure area, sanitize or wash your hands and don a clean mask before entering the room that has isolation precautions in place. Record review of document titled LTC (Long-Term Care) COVID Response Planning dated 6/19/20 revealed under section handles new admissions and handle returning residents -	F 880	week for 2 weeks then weekly for 2 weeks with results taken to QAPI. Director of Nursing or designee will complete observational audits of perineal care 5 times a week for 2 weeks, 3 times a week for 2 weeks then weekly for 2 weeks with results taken to monthly QAPI for reveiw and revision as needed. Director of Nursing or designee will complete observational audits for room signage indicating the isolation needs 5 times a week for 2 weeks; 3 times a week for 2 weeks then weekly for 2 weeks with results taken to Monthly QAPI meeting for review and revision as neede The Administrator or designee will audit completion of with a completion date of 8/05/20. The results of these audits to be presented at onthly QAPI meeting for review and revisions as needed. The Administrator, Social Worker or designee will audit the screener tools for accuracy and completeness for employees and visitors 2x a day for 1 month then 1 x day for 2 months. Results of audits will be brought to monthly QAPI meeting for review and revision as needed.	

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
F 880	Continued From page 5 facility policy/ process- follow COVID 19 guideline. Record review of policy dated 3/4/20 Titled Routine Female Perineal Care revealed that after performing perineal care staff should remove gloves, wash hands, apply new gloves and adjust resident clothing. Record review of COVID-19 PPE Donning and Doffing dated 2/14/20 revealed that when removing PPE (Eye protection, mask, gown and gloves) the following steps should be taken and are illustrated in step by step picture form. To remove PPE grasp gown on the outside(part of gown not touching body) , pull away from body only touching outside - never inside fold gown into its self and dispose, reform hand hygiene, remove eye protection, perform hand hygiene, remove mask, perform hand hygiene. All PPE should be removed before exiting resident's room. Upon exiting resident's room perform hand hygiene, apply gloves, clean eye protection, place eye protection in secured area, remove gloves, and perform hand hygiene. Infection Preventionist- Training F882 An interview on 6/24/20 at 9:30 AM with DON revealed that current Infection Preventionist RN-E was working on completing infection control and prevention training. Record review of RN-E education completion of specialized infection control and prevention was not available. An interview on 6/24/20 at 3:30 PM with DON confirmed Infection Preventionist RN-E has not	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
	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
F 880	Continued From page 6 completed her infection prevention training. Covid- 19 Screening and Logs Record review of Documentation title Covid Screener Acknowledgement Form (not dated) revealed staff were trained on how to use thermometer and if any abnormal results of Covid screening staff can ask the person to leave. Staff was also provided education and understanding that PPE(Personal Protective Equipment) is required depending on the Zone (Red' Gray/ Yellow/ Green) . Record review of Covid-19 Staff Screening logs revealed on 6/19 /20 and 6/22/20, NA (Nursing Assistant) -J and NA-G answered "Yes" to cough on screening questions. An interview on 6/24/20 at 3:30 PM with DON confirmed no additional documentation of NA-J and NA - G screening was available. DON agreed staff should have been questioned by a trained screener why questions were answered "yes". Record review of Covid-19 Staff Screening log dated 6/20/20 revealed LPN (Licensed Practical Nurse) I signed name but left all Screening Questions Blank. An interview on 6/24/20 at 3:30 PM with DON confirmed all staff are to complete screening questions and have temperature taken and recorded.	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
	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.

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 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
Good Life. Great Mission.
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**

(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		7/20/20

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.

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**

(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	F880 A. Immediate Change:	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on 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	

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**

(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 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.	

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**

(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 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		

NEBRASKA
Good Life. Great Mission.
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	

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 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	

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 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.	

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 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		

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

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

CV/kd

Enclosures: CMS 2567

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

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

Pete Ricketts, Governor

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

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

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

POC NOT FINAL

(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.

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

POC NOT FINAL

(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 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		

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

POC NOT FINAL

(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=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		

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

POC NOT FINAL

(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 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		

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

POC NOT FINAL

(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 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		

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

POC NOT FINAL

(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		

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.

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

POC NOT FINAL

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6 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		

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

POC NOT FINAL

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 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		

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

POC NOT FINAL

(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 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		

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

POC NOT FINAL

(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 9	F 880		

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

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

POC NOT FINAL

(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 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		

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

POC NOT FINAL

(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 11	F 880		

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

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

POC NOT FINAL

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 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		

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

POC NOT FINAL

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 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		

Nebraska DHHS Licensure Unit

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

POC NOT FINAL

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	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

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

POC NOT FINAL

(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 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

POC NOT FINAL

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		

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

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

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

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

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

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.

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 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.	

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 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.	

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 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	

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 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	

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 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**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6 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 F Vogt RN,BSN

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

CV/kd

Enclosures: CMS 2567

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

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

Pete Ricketts, Governor

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

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 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.

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 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.	

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 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		

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 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		

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 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		

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 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		

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

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

CV/kd

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

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 E Vogt RN,BSN

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

CV/kd

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

Pete Ricketts, Governor

June 24, 2020

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

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

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

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

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

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

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

POC NOT FINAL

(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
	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

POC NOT FINAL

(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 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
	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

POC NOT FINAL

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 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	

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

POC NOT FINAL

(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 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
	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

POC NOT FINAL

(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

POC NOT FINAL

(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

POC NOT FINAL

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6	F 880	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.	

NEBRASKA
Good Life. Great Mission.
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

NEBRASKA
Good Life. Great Mission.
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 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
	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.

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	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	

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	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	

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	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	

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	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.	

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	Continued From page 5 residents coming or returning from the hospital. This can serve as a step-down unit where they remain for 14 days with no symptoms (instead of integrating as usual on short-term rehab floor, or returning to long-stay original room)". Administrator reported that separate rooms were not available at this time of admission. Administrator also verified Resident #1 was tested for [redacted]. Administrator verified that both Resident #1 and #2 passed away with a [redacted] On 6-10-2020 at 3:28 p.m. Program Manager reviewed Potential IJ concerns with the team and instructed team to wait for follow up directives. On 6-10-2020 at 4:58 p.m. Program Manager Confirmed this deficiency rose to the level of Immediate Jeopardy. First non-compliance resulted when the facility failed to follow CMS guidance to isolate residents for 14 days following discharged from the hospital and admitted to a nursing home. Second as a result the facility had a total of 12 residents [redacted] four of which passed away including Resident #1 and Resident #2. Third there was a need for immediate action to prevent further spread of [redacted] through out the facility. On 6-10-2020 at 5:30 p.m. the Administrator was provided with an Immediate Jeopardy Template. The Administrator identified they had abated these concerns on 6-5-2020 when all residents and staff were [redacted] and isolation was being implemented on all residents pending test results. Further more the Administrator confirmed having discharged all [redacted]	F 880	6-10-2020 New admission placed in room by self to observe and monitor for 14 days. 6-12-2020 Plan of Action for moving residents from COVID-19 Wing to original rooms. 7-2-2020 New admission placed in room by self to observe and monitor for 14 days. 7-7-2020 Readmission from Hospital placed in room by self for 14 days following ICAP/CDC guidelines. Negative COVID test received prior to readmission. 7-13-2020 New admission placed in room by self to observe and monitor for 14 days. 7-14-2020 New admission placed in room by self in purple zone to observe and monitor for 14 days. 7-20-2020 Action Plan in place for education on DPOC training. This is our system change: All new admissions will have a [redacted] prior to admission and will be admitted to a room by themselves for 14 days where they can be observed and monitored for s/s of respiratory or other contagious illnesses. They will be assessed 3 times daily by a licensed nurse for change in condition and all s/s of COVID-19. We will follow the latest CDC Guidance on admissions. Any resident that returns from the hospital or an appointment out of the facility will be placed in a room by themselves for 14 days where they can be observed and monitored for s/s of	

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	Continued From page 6 [redacted] in order for those residents to receive the recommended treatment required and the Unit where all the [redacted] residents resided was closed and terminally cleaned. Facility red, green, yellow and gray zones were created. Including a dedicated red zone for positive COVID-19 residents to return too. On 4-5-2020 the facility abated the immediacy of the deficiency, lowering the scope and severity to a D after the immediate jeopardy.	F 880	respiratory or other contagious illnesses. They will be assessed 3 times daily by a licensed nurse for change in condition and all s/s of COVID-19. We will follow the latest CDC Guidance. Any resident exhibiting s/s of [redacted] will be put into a yellow zone following ICAP/CDC guidelines until negative test returned and 24 hours since last symptom without intervention. We will follow the latest CDC Guidance. Any Resident with a known exposure to [redacted] will be placed in a yellow zone room with all precautions in accordance with the ICAP and CDC guidelines for 14 days and then be tested at the end of 14 days for [redacted] We will follow the latest CDC Guidance.. Education and Guidance to staff: A [redacted] Book has been kept at the nurses station and updated with the latest guidance from CMC/CDC/ICAP for staff education. A bulletin board in the central area used to communicate emergent communication to staff. Staff Huddles held as new emergent information arises. 3-16-2020: March 13, 2020 CMS memo QSO-20-14-NH-Revised posted for staff to read in [redacted] educational notebook kept at nursing station. 3-16-2020: CMS Federal Blanket Waiver posted for staff concerning [redacted] residents.	

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	Continued From page 7	F 880	4-2-2020 CMS recommendations for designating space and staffing for positive, negative and unknown- status residents posted for staff. 4-13-2020 QSO-20-25-NH posted for staff education concerning cohorting 4-28-2020 QSO-20-28-NH concerning new admissions with unknown [redacted] status posted for staff education. 7-23-2020 Education available for DPOC for staff to complete on 5 videos to be completed by 7-30-2020: 1. Sparkling Surfaces 2. Clean Hands 3. Closely Monitor Residents 4. Keep COVID-19 Out! 5. Lessons MONITORING FOR THE SYSTEM CHANGE INCLUDING FREQUENCY AND TITLE: Audits will be completed on all admissions and readmissions by the Director of Nursing or designee on compliance for separation from other residents for 14 days. This audit will be completed for 12 months unless changes recommended in this process by the CDC/CMS. Audits will be completed by the Director of Nursing or Designee on monitoring vital signs and S/S of [redacted] or other respiratory or contagious illnesses on all new admissions and readmissions for 12	

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	Continued From page 8	F 880	months . This audit will be completed 1 x weekly during 14 day isolation stay. Audits will be completed on all residents that have been out of the facility by the Directory of Nursing or designee on compliance for separation from other residents for 14 days. This audit will be completed for 12 months unless changes recommended in this process by the CDC/CMS. Audits will be completed by the Director of Nursing or Designee on monitoring vital signs and S/S of [redacted] or other respiratory or contagious illnesses on all residents that have been out of the facility for 12 months . This audit will be completed 1 x weekly during 14 day isolation stay. Audits will be completed on all residents with suspected exposure to [redacted] by the Director of Nursing or designee on compliance for separation from other residents for 14 days. This audit will be completed for 12 months unless changes recommended in this process by the CDC/CMS. Audits will be completed by the Director of Nursing or Designee on monitoring vital signs and S/S of [redacted] or other respiratory or contagious illnesses on all residents with suspected exposure to COVID-19 for 12 months. This audit will be completed 1 x weekly during 14 day isolation stay.	

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	Continued From page 9	F 880	Audits will be completed to assure that education was completed by all staff with the DPOC of the 5 videos. This audit will be completed on July 30, 2020 by the Director of Nursing or Designee. All audits and education will be presented by the Director of Nursing or Designee to the QA committee monthly or upon request for review and recommendations and further audits and/or system changes will be determined by identifying trends and findings. PIP teams and Action Plans will be developed as necessary to ensure compliance.	

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

Pete Ricketts, Governor

July 22, 2020

Miriam Wall, Administrator
Carl T Curtis Health Education Center Nursing Home
Po Box 250, 100 Indian Hills Drive
Macy, NE 68039-0250

CMS CERTIFICATION NUMBER: 28A065

Dear Ms. Wall:

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

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

Pete Ricketts, Governor

July 24, 2020

Julie Skala, Administrator
Centennial Park Retirement Village
510 Centennial Circle
North Platte, NE 69101

CMS CERTIFICATION NUMBER: 285094

Dear Ms. Skala:

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

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

Pete Ricketts, Governor

August 7, 2020

Ed Hannon, Administrator
Chi Health St Francis
2116 West Faidley Avenue
Grand Island, NE 68803

Dear Mr. Hannon:

An unannounced visit was conducted to investigate a complaint at Chi Health St Francis on August 4, 2020-August 5, 2020, by representatives of the Department of Health and Human Services Division of Public Health. To complete this investigation, a representative sample of the residents who reside in the facility or had resided in the facility was selected. The investigative process included review of resident records; observation of the provision of care and services; and interviews with residents, family members and staff.

ALLEGATION:
1. The facility fails to follow infection control guidelines for illnesses.
2. The facility fails to change interventions after residents have been identified at risk for falls.

FINDINGS:
1. The facility followed infection control guidelines for illnesses. To make this determination; observations, interviews, and record reviews revealed staff followed Infection Control guidelines for illnesses. Observations of staff screening of visitors revealed temperatures were recorded and answers to the screening questions were completed. Observations of staff putting on and taking off PPE (personal protective equipment) revealed PPE was done according to the guidelines. Interviews with nursing staff revealed preventative measures were implemented to protect the residents. The facility was found to be compliance with the related regulatory requirements.

2. The facility changed interventions after residents have been identified at risk for falls. To make this determination; interviews, record reviews and observations reviewed interventions were implemented after falls. Record review of the facility resident incident / accident reports, resident care plans, and the facility's investigation of the incidents revealed new interventions were implemented after residents were identified as at risk for falls. Interviews with staff revealed knowledge of the residents individual plan of care and implemented fall interventions The facility was found to be in compliance with the related 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 Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

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

Pete Ricketts, Governor

August 7, 2020

Ed Hannon, Administrator
Chi Health St Francis
2116 West Faidley Avenue
Grand Island, NE 68803

CMS CERTIFICATION NUMBER: 285081

Dear Mr. Hannon:

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

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

Pete Ricketts, Governor

July 2, 2020

Kimberly Burry, Administrator
Chimney Rock Villa
P O Box A, 106 East 13th Street
Bayard, NE 69334

CMS CERTIFICATION NUMBER: 285260

Dear Ms. Burry:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 23, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

Pete Ricketts, Governor

July 7, 2020

Cherlyn Hunt, Administrator
Christian Homes Health Care Center
1923 West 4th Avenue
Holdrege, NE 68949-3130

CMS CERTIFICATION NUMBER: 285246

Dear Ms. Hunt:

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

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

Pete Ricketts, Governor

July 2, 2020

Heather Eagle, Administrator
Clarkson Community Care Center
212 Sunrise Drive
Clarkson, NE 68629-0280

CMS CERTIFICATION NUMBER:
285116

Dear Ms. Eagle:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 23, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

Pete Ricketts, Governor

July 10, 2020

Theresa Naber, Administrator
Cloverlodge Care Center
301 North 13th Street
St Edward, NE 68660

CMS CERTIFICATION NUMBER: 285201

Dear Ms. Naber:

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

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

Pete Ricketts, Governor

July 7, 2020

Margie Bromen, Administrator
Colonial Acres Nursing Home
1043 10th Street
Humboldt, NE 68376

CMS CERTIFICATION NUMBER: 285248

Dear Ms. Bromen:

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

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

Pete Ricketts, Governor

July 16, 2020

Lauren Lierman, Administrator
Colonial Haven
424 Harrison
Beemer, NE 68716-4201

CMS CERTIFICATION NUMBER: 285204

Dear Ms. Lierman:

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

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

Pete Ricketts, Governor

June 29, 2020

Rachael Hurley, Administrator
Colonial Manor Of Randolph
P O Box 67, 811 South Main Street
Randolph, NE 68771-1028

CMS CERTIFICATION NUMBER: 285183

Dear Ms. Hurley:

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

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

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 1, 2020

Kally Cloeter, Administrator
Community Memorial Health Center
P O Box 340, 1015 F Street
Burwell, NE 68823 **CMS Certification No. 285257**

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

Dear Administrator,

UNANNOUNCED COVID-19 SURVEY

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

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

SURVEY RESULTS

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

PLAN OF CORRECTION

A Plan of Correction (PoC) for the deficiencies must be submitted **by July 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

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

WITHDRAWAL OF APPROVAL FOR NURSE AIDE TRAINING PROGRAM

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

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

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

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

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

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

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

APPEAL RIGHTS

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

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

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

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

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

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

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

CONTACT INFORMATION

If you have any questions please contact this office.

Sincerely,

Connie F Vogt RN,BSN

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

CV/kd

Enclosures: CMS 2567

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

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285257	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HEALTH CENTER	P O BOX 340, 1015 F STREET BURWELL, NE 68823

(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 the survey report as they apply to deficient practices identified.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		8/3/20

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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285257	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HEALTH CENTER	**P O BOX 340, 1015 F STREET BURWELL, NE 68823**

(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: License Reference Number: 175 NAC 12-006.17B	F 880	1.Immediate action(s) taken for the resident(s) found to have been affected	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285257	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HEALTH CENTER	P O BOX 340, 1015 F STREET BURWELL, NE 68823

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observations, record reviews and interviews; the facility failed to implement infection control precautions to prevent the spread of COVID-19 as: 1) residents on the Special Care Unit (SCU- secured area used to protect and better meet dementia residents' needs and to address behaviors associated with dementias) did not maintain at least 6 feet distance between residents and/or wear masks (the facility reported 16 residents resided on the SCU); 2) staff failed to disinfect a pulse oximeter (small, clip-like device that attaches to a body part and measures the amount of oxygen in the blood) between resident uses; 3) staff failed to follow contact precautions for 1 (Resident 3) of 7 sampled residents; 4) staff failed to utilize appropriate hand hygiene and gloving when cleaning after the breakfast meal; 5) staff failed to ensure forms were completed for staff screening; and 6) the facility failed to ensure visitors were restricted based on the current guidance. This had the ability to affect all of the residents. The total sample size was 19 and the facility census was 57. Findings are: A. Review of the facility policy Cleaning and Disinfection of Portable Equipment with an implementation date of 5/20/20 revealed it was the policy of this facility to follow infection control principles to prevent the spread of infection through contact with portable equipment in the resident's care environment. The following guidelines were identified: -the manufacturer's guidelines for use, cleaning and disinfection were to be reviewed; -staff were to perform hand hygiene when using	F 880	include: A & B The certified Medication Aide (MA)-E was immediately in-serviced on Cleaning and Disinfection of Portable Equipment policy and procedure by the Director of Nursing. 6/26/2020 C & D The certified Nurse Aide (NA)-J was immediately in-serviced on the instructions regarding putting on Personal Protective Equipment (PPE) in isolation rooms by the charge nurse. 6/26/2020 E & F The interdisciplinary team immediately started to devise a plan to place more restrictions in our SCU dining room and activities which will include education and changes to dining and activities. 6/29/2020 G With the next meal (lunch), on 6/26/2020 staff were provided with gloves and multiple wash clothes in the bucket to be used for single use when cleaning off room trays. H Facility is now in phase three as of 7/2/2020 and the Phasing Guidance in Phase 3 states: All residents should have the ability to have limited visitation. I The Director of Nursing educated the Nurses who assess and fill out document to properly fill out document. Director of Nursing, or designee will also on a daily basis review the prior day/weekend to make sure all areas are complete. 7/3/2020	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285257	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HEALTH CENTER	P O BOX 340, 1015 F STREET BURWELL, NE 68823

(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 3 equipment, between resident contact and accessing the equipment; -cleaning to be performed daily and between residents; and -staff to use a clean barrier between the equipment and the surface on which the equipment was placed. B. On 6/26/20 at 9:30 AM the following was observed: -without performing hand hygiene, Medication Aide (MA)-E removed a [redacted] from the top of the medication cart and approached Resident 7, who was seated at the dining room table with the breakfast meal; -without using a clean barrier, MA-E placed the [redacted] directly on the dining table and next to the resident's drinks, silverware and food items; -MA-E proceeded to place the [redacted] on the resident's finger to obtain a reading; -after completion of task, MA-E returned to the medication cart and without placing a clean barrier positioned the [redacted] directing on the top of the cart; and -MA-E failed to clean the [redacted] after use for Resident 7 and to perform hand hygiene before continuing to pass medications. During an interview on 6/26/20 at 9:37 AM, MA-E indicated staff were to perform hand hygiene before and after any resident contact. In addition, MA-E indicated the [redacted] of all residents on the SCU, the equipment should have been placed on a clean barrier and it should have been cleaned with a disinfectant wipe after use. C. Review of the facility policy COVID-19	F 880	2.Actions taken/systems put into place to reduce the risk of future occurrence include: The DNS, or designee will re-educate All personnel on the facility s policy for Cleaning and Disinfection of Portable Equipment, proper Personal Protective Equipment (PPE) when resident is in isolation, SCU s new plan of Infection Prevention, proper cleaning of bedside tables in resident s room, and proper staff assessment completion prior to working. Re-Education includes auditing of personnel performing the procedures according to facility policies as stated above. Findings are reviewed with personnel. Corrective action is provided as needed. Completion Date (7/23/2020) 3.How the corrective action(s) will be monitored to ensure the practice will not recur: The Administrator, or designee will ensure that the Interdisciplinary Team (DNS, MDS, RN, Dietary Manager, Environmental Services Manager) will complete Validation Checklists of personnel and the timing and technique of the following: Cleaning and Disinfection of Portable Equipment, proper Personal Protective Equipment (PPE) when resident is in isolation, SCU s new plan of Infection Prevention, proper cleaning of bedside tables in resident s room, and proper staff assessment completion prior to working to ensure personnel are performing the procedures in accordance with our facility s practices and policies, auditing and monitoring bi-weekly for 2	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285257	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HEALTH CENTER	P O BOX 340, 1015 F STREET BURWELL, NE 68823

(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 Resident in Isolation [redacted] revealed the staff were to use a gown, gloves, N95 respirator mask and face shield/goggles before entering a resident's room who had been placed on isolation. The following instructions were identified regarding putting on Personal Protective Equipment (PPE): -perform hand hygiene using hand sanitizer; -put on isolation gown (tie all the ties on the gown); -put on N95 mask; -place on face shield or goggles: and -perform hand hygiene before putting on gloves. The following instructions were identified for removal of PPE: -remove gloves; -remove gown; -exit the resident's room; -perform hand hygiene; -remove the face shield/ goggles; and -perform hand hygiene. D. Observations of Nurse Aide (NA)-J on 6/26/20 from 9:42 AM to 9:55 AM revealed the following: -approached Resident 3's room wearing a surgical mask; -removed the surgical mask and placed it on top of a 3 drawer isolation cart outside of the resident's room; -without performing hand hygiene, NA-J removed an N95 mask form the isolation cart and placed on; -put on clean gloves followed by an isolation gown. NA-J failed to secure the ties of the gown and to put on a face shield or goggles before entering Resident 3's room and closing the door; -after completion of cares, NA-J opened the resident's room door and removed and discarded gloves and the isolation gown in a receptacle	F 880	weeks and weekly for 4 weeks. The Administrator will discuss findings in Morning Meetings with the interdisciplinary team on a weekly basis. The Administrator, or designee will report this plan of correction to the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Directed Plan of Care A&B- All staff will be educated by watching “Sparkling Surfaces” and “Clean Hands. C&D- All staff will be educated by watching “Keep COVID-19 Out!” and “Lessons”. E&F- All staff will be educated by watching “Closely Monitor Residents” and Keep COVID-19 Out!” G- All staff will be educated by watching “Sparkling Surfaces” and “Clean Hands” H- Administration and Director of Nursing re-educated on phasing guidance by reading phasing guidance. I- All staff will be educated by watching “Keep COVID-19 Out!” and “Lessons” All education and videos watched are will be done by 7/23/2020 The Infection Control Nurse, or designee set up stations for practicing; Donning and Doffing, Hand washing, Cleaning and Disinfecting of Portable Equipment, Washing tables after meals, and Proper Staff Assessment are starting on 7/22/2020 for staff to complete. DPOC/Education Completion date: 7/23/2020	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285257	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HEALTH CENTER	**P O BOX 340, 1015 F STREET BURWELL, NE 68823**

(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 inside the entrance of the room; -removed N95 mask and donned surgical mask which remained on top of the isolation cart; and -failed to complete hand hygiene before exiting the area. During an interview on 6/26/20 at 10:05 AM, NA-J confirmed the following: -Resident 3 was on isolation precautions as the resident was a new admission; -should have performed hand hygiene before putting on PPE and after removal of PPE; and -failed to secure the isolation gown and to wear a face shield before entering the resident's room per the facility policy. E. Review of the Infection Prevention and Control Assessment Tool (undated) revealed there was to be no communal dining or activities and if a resident was out of their room, they were to practice social distancing and/to wear a mask. F. Observations of the SCU dining room on 6/26/20 at 8:45 AM revealed the following: -8 residents were seated in the dining room; -8 additional place settings were placed at the dining tables; and -the residents were not positioned 6 feet away from each other. An observation on 6/26/20 at 10:30 AM revealed 4 residents were in the SCU activity room, 2 residents were seated in wheelchairs in the corridor and were positioned side by side outside of the activity room, and 3 additional residents were grouped in a sitting area in the middle of the corridor. Residents were not practicing social distancing and were not wearing masks. Staff were positioned throughout the corridor but failed	F 880	Date Certain: 8/3/2020	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285257	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HEALTH CENTER	**P O BOX 340, 1015 F STREET BURWELL, NE 68823**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6 to assist the residents with following infection control precautions During an interview on 6/26/20 at 10:35 AM, MA-E confirmed the residents were not wearing masks when out of their rooms or practicing social distancing. In addition, MA-E confirmed all 16 residents who resided on the SCU were served meals in the dining room and residents could not be kept 6 feet apart. G. On 6/26/20 at 8:30 AM, the following was observed regarding removal of resident breakfast room trays on the 200 corridor: -MA-L was wearing a pair of disposable gloves and a surgical mask. MA-L propelled a cleaning cart which held a large basin and 2 buckets with a liquid solution. A single dishcloth was identified in one of the buckets; -MA-L entered resident room 204 and exited the room with the resident's soiled silverware which were then placed in one of the buckets. MA-L returned to the room and brought out empty glasses, a plate and a small serving bowl then placed items in the basin. MA-L returned to the room a third time with the dishcloth from the second bucket. MA-L used the dishcloth to wipe down the bedside table which had been used for the meal service. MA-L returned to the cart and replaced the dishcloth into the bucket; -MA-L failed to remove gloves and to perform hand hygiene before entering room 205 and repeating this process; and MA-L followed this pattern for the remaining resident rooms. During an interview with the Director of Nursing (DON) on 6/26/20 at 11:20 AM, the DON verified MA-L should have removed gloves and	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
	285257	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HEALTH CENTER	P O BOX 340, 1015 F STREET BURWELL, NE 68823

(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 performed hand hygiene between entering each resident's room to prevent the potential for cross contamination. H. Review of the Long-Term Care COVID-19 Phasing Guidance dated 6/15/20 revealed in Phase 2 visitation was allowed for compassionate care situations, including end-of-life and residents with "significant" changes in condition including psycho-social or medical issues. Review of the Facility Visitor Screening Log revealed 21 visitors had visited from 6/22/20 to 6/25/20. This included visitors for Residents 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, and 19. Review of the form provided by the facility on 6/26/20 identified residents on hospice/end-of-life and residents with a significant change in condition (decline) revealed Resident 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, and 19 were not identified as having met that criteria. I. Review of the "Staff Assessment" log dated 6/2020 revealed: - On 28 occasions the staff member did not identify if the Health Questionnaire had been completed. - On 9 occasions the staff member marked "no" for completing the Health Questionnaire. - On 53 occasion the nurse completing the staff assessment was not identified. Review of the staff Professional Healthcare Providers Screening Questions forms revealed: - On 6/12/20 Environmental Services (ES)-O failed to actively screen for COVID-19 symptoms. - On 6/12/20 MA-R failed to actively screen for	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
	285257	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HEALTH CENTER	**P O BOX 340, 1015 F STREET BURWELL, NE 68823**

(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 8 COVID-19 symptoms. - On 6/17/20 Dietary Employee (DE)-Q failed to identify travel history and failed to actively screen for COVID-19 symptoms. - On 6/18/20 ES-O failed to identify travel history and identified a symptom that could be associated with COVID-19, no further screening was noted. - On 6/21/20 MA-P identified a symptom that could be associated with COVID-19, no further screening was noted. - On 6/22/20 ES-O failed to identify travel history and failed to actively screen for symptoms of COVID-19. - On 6/23/20 Staff Member-N failed to identify travel history and failed to actively screen for symptoms of COVID-19. Interview with the Administrator on 6/26/20 at 11:15 AM confirmed staff were to complete the "Professional Healthcare Providers Screening Questions" form, be assessed, have their temperature checked by the nurse, and document findings on the "Staff Assessment" log prior to working. Further interview confirmed the facility started allowing visitors for any resident with a scheduled appointment when the facility transitioned to Phase 2 on 6/22/20.	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
	285208	A. BUILDING _____ B. WING _____	07/13/2020

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY PRIDE CARE CENTER	901 SOUTH 4TH STREET BATTLE CREEK, NE 68715

(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		8/7/20

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

Electronically Signed | 08/07/2020

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
	285208	A. BUILDING _____ B. WING _____	07/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY PRIDE CARE CENTER	901 SOUTH 4TH STREET BATTLE CREEK, NE 68715

POC NOT FINAL

(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	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285208	A. BUILDING _____ B. WING _____	07/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY PRIDE CARE CENTER	901 SOUTH 4TH STREET BATTLE CREEK, NE 68715

POC NOT FINAL

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observation and interview the facility failed to 1) screen visitors by completing a covid question sheet and taking a temperature for COVID-19 (a mild to severe respiratory illness infection caused by a virus that can spread from person to person), upon entering the facility and 2) have/ develop a policy for residents with abnormal covid screening results 3) ensure dietary staff wore surgical mask to prevent the spread of Covid-19 4) Staff were performing self screening (including taking own temperatures and filling out covid screening questions 5) ensure Residents (Residents 1 and 2) were wearing face covering outside of their rooms. This had the potential to affect all staff and resident in the facility. The facility census was 43. Findings are: 1) A. Observation on 7/13/20 at 11:22 a.m. revealed signs on entrance door to ring door bell, no visitors allowed, and fill out COVID-19 screening sheet (a screening tool for COVID-19 symptoms and exposure), have temperature taken, and complete hand hygiene. Before entering facility. B. An observation upon entering the facility on 7/13/20 at 11:25 a.m. revealed the DON (Director of Nursing) opened facility door for three visitors to come in. DON asked to have hand hygiene completed and stated would complete COVID-19 screening sheets when the three visitors got into conference room. C. Interview with DON on 7/13/20 at 5:30 p.m. confirmed the COVID-19 screening sheets did not get completed on three visitors that entered	F 880	This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid Requirements. CORRECTION TO RESIDENT AFFECTED All residents have the potential to be affected due to the lack of proper infection control practices. SYSTEM CHANGES The facility recognizes that all residents are at risk for infection if a visitor, staff member or other resident is not feeling well. The Quality Assurance and Performance Improvement Committee met on 07/14/2020 to review all deficiencies and initiate corrections. The facility set up a table in the front entrance on 07/14/2020. This table is supplied with masks, sanitizing wipes and a thermometer. A seven question screening sheet is left at the table along with a temperature section, notes and the date of the screening. All visitors will be screened by either a nurse or certified medication aide. If there are any abnormal findings, a nurse will need to assess the visitor. If a visitor has a temperature of 100.0 degrees or above, they will be considered having a fever. The nurse will determine if the visitor needs to leave the facility or not. The Director of Nursing and/or designee will	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285208	A. BUILDING _____ B. WING _____	07/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY PRIDE CARE CENTER	901 SOUTH 4TH STREET BATTLE CREEK, NE 68715

POC NOT FINAL

(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 3 the facility on 7/13/20 at 11:22 a.m. D. Record view of facility policy titled COVID-19 Phasing Guidance dated June 22,2020 revealed, all visitors must be symptom free and screened according to current guidelines. Under screening heading 100% screening for all persons entering the building and all staff at the beginning of each shift. Temperature checks, and questionnaire about symptoms and potential exposure. 2) Interview on 7/13/20 at 2:10 p.m. with RN/IP (Registered Nurse and Infection Preventioist),revealed that residents get a daily temperature, and ask questions if they have a cough, sore throat, short of breath and record on a paper log and gets handed in to DON (Director of Nursing). RN/IP revealed a temperature of 99.0 or above facility would keep residents in their rooms and keep an eye on them. If they have a roommate the roommate would also stay in room and be monitored. RN/IP stated the facility has two shifts for dining. RN/IP stated that residents are allowed out of their rooms, and are not required to wear a masks at this time. RN/IP stated if a resident would have to go out of the building they would wear a mask or face covering. Interview on 7/13/20 at 2:45 p.m. with Resident 1 revealed that resident goes out of room without a face mask or face covering. Resident 1 stated we can go out of our rooms with out a face mask. Resident 1 stated we only wear a face mask if we go out of the facility. 2)	F 880	enter all visitor screens and verify that proper protocol is being done. This will be done on a daily basis. All residents will have temperature and symptom checks completed daily. If there are any abnormal finding, the nurse will fax the physician and will initiate isolation of the resident and roommate if applicable. If a residents is found to have a temperature of 100.0 degrees or higher, they will be considered having a fever. The Director of Nursing and/or designee will enter all resident screens and verify that proper protocol is being done. This will be done on a daily basis. The dietary staff member was directed to immediately wear the proper surgical mask supplied for by the facility. The Dietary Manager will verify that the staff member is wearing the proper surgical mask whenever she is on duty. If the Dietary Manager is not available, the Director of Nursing and/or designee will verify proper compliance. Every employee will need another employee to perform the temperature and seven symptom system check. The employee screening the employee coming on shift will then initial under the notes section of the screening form. If there are any abnormal finding, the employee will need to notify the nurse to be assessed. If the staff member has a temperature of 100.0 or higher they will be considered having a fever. The nurse will determine	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285208	A. BUILDING _____ B. WING _____	07/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY PRIDE CARE CENTER	901 SOUTH 4TH STREET BATTLE CREEK, NE 68715

POC NOT FINAL

(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 According to CDC (Center for Disease Control and Prevention) (An organization responsible for providing research and education on infections and prevention of illness Worldwide) Document titled Preparing for COVID-19 in Nursing Homes dated June 25, 2020 revealed the following ---Evaluate and Manage Residents with Symptoms of COVID-19. - Ask residents to report if they feel feverish or have symptoms consistent with COVID-19. -Actively monitor all residents upon admission and at least daily for fever (T?1) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement Transmission-Based Precautions as described below: Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures >9 might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for COVID-19. An interview on 7/13/20 at 3:15 PM with DON (Director of Nursing) revealed the facility has no policy or procedure for what to do if resident has an abnormal screening (this includes a temperature over 100.4, or answering "yes" to cough, fever, sore throat, difficulty breathing. DON stated in the event of an abnormal screening staff would contact residents physician and wait for directions. DON stated on one event they had resident with symptoms resident was placed in isolation with roommate, staff began	F 880	if the employee needs to be sent home or note if it is from a chronic condition. The Director of Nursing and/or designee will enter all staff screens and verify that proper protocol is being done. This will be done on a daily basis. All residents will be given a new surgical mask prior to awakening. Each mask will be individually packaged in a zip lock bag and placed in the residents room. Prior to any resident leaving their room a mask will be placed appropriately on the residents face. During meal times the masks will be removed and then reapplied before leaving the dining room. All staff will encourage residents to wear their masks when they are outside of their rooms. All staff will be required to watch the "Lessons", "Closely Monitor Residents" and "Keep COVID-19 out" educational videos by August 7th, 2020. MONITORING The Director of Nursing and/or designee will enter all visitor, staff and resident screens into a spreadsheet 5 days a week. The Director of Nursing and/or designee will monitor compliance that all screens are completed fully and done by other staff members and no one is self screening. The Dietary Manager, Director of Nursing and/or designee will verify that all employees are wearing the proper surgical mask when on duty. This will be done on a daily basis. All staff will monitor	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285208	A. BUILDING _____ B. WING _____	07/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY PRIDE CARE CENTER	901 SOUTH 4TH STREET BATTLE CREEK, NE 68715

POC NOT FINAL

(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 wearing full PPE and resident and roommate were tested for covid -19. Covid test returned negative. Record review of facility policies revealed no policy for facilities procedure regarding residents with abnormal screenings. 3) An observation on 7/13/20 at 11:50 AM revealed DA (Dietary Aide)- A was wearing a beard net over nose and mask. DA was not wearing a face mask or face shield. An interview on 7/13/20 at 11:50 AM with DA -A revealed (gender) had severe asthma and was unable to wear surgical mask or other types of masks because (gender) was not able to breathe; DA-A is wearing a beard net as an alternative to surgical mask. An interview on 7/13/20 at 11:55 AM with DS (Dietary Supervisor)- B revealed (gender) was aware of DA-A has a problem with not being able to breathe with surgical mask; DA- A has been wearing beard net as an alternative to surgical mask. DS-B states that one time DA-A was sent home due to having an asthma attack. Record review of document Titled COVID-19 Policy not dated revealed under section Universal Source Control and PPE -All facility staff and essential healthcare personnel, regardless of their position, who may interact with resident or enter resident rooms, should wear a surgical. procedural facemask. The facility staff, regardless of their position, who do not provide care to the residents and who have no interaction with resident should wear either a cloth face covering	F 880	that residents that leave their rooms will be wearing a surgical mask. These corrections listed above will be documented on a checklist and reviewed weekly at Significant Change Meetings. The Quality Assurance and Performance Improvement Committee and the Administrator will review these checklists on a monthly basis for compliance.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285208	A. BUILDING _____ B. WING _____	07/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY PRIDE CARE CENTER	901 SOUTH 4TH STREET BATTLE CREEK, NE 68715

POC NOT FINAL

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6 or facemask while in the facility. An interview on 7/13/20 at 3:00 PM with DON confirmed DA-A should be wearing a surgical mask per facility policy. 4) An interview on 7/13/20 at 12:00 PM with Activity Director revealed that when (gender) arrives at work though employee entrance, hand sanitizer is available, then must fill out from screening questions do you have any of the following symptoms of Covid-19? Fever, cough, sore throat, Difficulty Breathing (circle Yes or No for each). Then take temperature and document temperature. AD states if any screening questions answer "yes" or have a temperature you need to use walkie and call a nurse to see if you can come into work. An observation on 7/13/20 at 1:50 PM revealed the following NA (Nursing Assistants) -C,D,E preformed self-screening by taking their own temperatures documenting it on screening log and answering covid screening questions by circling "yes" or "no" for having cough, fever, sore throat, difficulty breathing. An interview on 7/13/20 at 3:00 PM with DON confirmed that staff are entering the facility performing screening by filling out Covid -screening sheet with the following questions do you have a Fever, cough, sore throat, Difficulty Breathing? (circle Yes or No for each). Document Temperature. DON stated facility is following CDC guidelines in regard to temperature and notes anything over 100.4. DON stated (gender)	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
	285208	A. BUILDING _____ B. WING _____	07/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY PRIDE CARE CENTER	901 SOUTH 4TH STREET BATTLE CREEK, NE 68715

POC NOT FINAL

(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 reviews logs daily. DON states staff are calling (gender) if they have symptoms or questions about coming to work. Per CMS QSO memo 20-30. All phases require 100% screening of every person entering the building. "Ensure all outside persons entering building have cloth face covering or facemask" and "observation of any signs or symptoms". 5) According to the CDC dated 7/9/20 Implement Universal Source Control Measures Source control refers to use of cloth face coverings or facemask's to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing. Because of the potential for asymptomatic and pre-symptomatic transmission, source control measures are recommended for everyone in a healthcare facility, even if they do not have symptoms of COVID-19. "Patients and visitors should, ideally, wear their own cloth face covering (if tolerated) upon arrival to and throughout their stay in the facility. If they do not have a face covering, they should be offered a facemask or cloth face covering, as supplies allow. Patients may remove their cloth face covering when in their rooms but should put it back on when around others (e.g., when visitors enter their room) or leaving their room. An interview on [redacted] at 11:40 AM with Resident 2 revealed (gender) had just moved in about 1 month ago due to having a [redacted] Resident 2 has been doing [redacted] and hopes to return home. Resident 2 states [redacted] only	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
	285208	A. BUILDING _____ B. WING _____	07/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY PRIDE CARE CENTER	901 SOUTH 4TH STREET BATTLE CREEK, NE 68715

POC NOT FINAL

(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 8 leaves his room for meals and therapy, Activities have all been held in hallways or individual. Visitors have been allowed thought the window only. Resident 2 states (gender) is receiving baths 2 times per week. Resident 2 was not wearing a mask during interview; Interview took place in communal area; Resident 2 states only wears mask when leaving the facility for appointments. Resident states he has left facility [redacted] in outside community. An interview on 7/13/20 at 3:00 PM with DON confirmed residents should be wearing masks when outside of their rooms and when leaving the facility.	F 880		

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

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 30, 2020

Steven Freese, Administrator
Community Pride Care Center
901 South 4th Street
Battle Creek, NE 68715 **CMS Certification No. 285208**

Subject: Survey Results
Cycle Start Date: July 13, 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 13, 2020, a survey was completed at Community Pride Care Center by the State Survey Agency to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the CMS 2567 and will be posted on the ePOC system.

PLAN OF CORRECTION

A Plan of Correction (PoC) for the deficiencies must be submitted **by August 9, 2020**, to the State Survey Agency Contact. **Failure to submit an acceptable PoC by August 9, 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.

- **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 13, 2020 survey, you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board (DAB). The appeal rights are set forth at 42 C.F.R. § 498.5 and the procedures for requesting a hearing are set forth at §498.40, et seq. You must file your hearing request electronically by using the DAB's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov/, unless you obtain a waiver from the DAB (*see* DAB Civil Remedies Division Procedures, § 6(a)(i)(1)). Your appeal must be filed no later than 60 days from the date of receipt of this letter.

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

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

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

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

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

CONTACT INFORMATION

If you have any questions please contact this office.

Sincerely,

Connie F Vogt RN,BSN

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

CV/kd

Enclosures: CMS 2567

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

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

Pete Ricketts, Governor

May 27, 2020

Jeffrey Harvey, Administrator
Continental Springs, Llc
3200 G Street
South Sioux City, NE 68776

Dear Mr. Harvey:

An unannounced visit was conducted to investigate a complaint at Continental Springs, Llc on May 12, 2020-May 19, 2020, by representatives of the Department of Health and Human Services Division of Public Health. To complete this investigation, a representative sample of the residents who reside in the facility or had resided in the facility was selected. The investigative process included review of resident records; observation of the provision of care and services; and interviews with residents, family members and staff.

ALLEGATION:
The facility fails to implement CMS directives related to COVID-19.
FINDINGS:
The facility failed to implement CMS directives related to COVID-19. To make this determination, a review was completed of residents throughout the facility. Observations revealed staff were not utilizing required personal protective equipment for residents on Transmission Based Precautions and breaks in infection control processes were identified. Interviews with staff revealed the staff were unaware of exactly who should be on Transmission Based Precautions as well as the required personal protective equipment required for residents on Transmission Based Precautions. Record review confirmed staff were not screened as required prior to working and providing care for the residents. It was determined the facility was in violation of F880 and Licensure Reference Number 175 NAC 12-006. 17.

Please see the enclosed letter for instructions on completion and submission of the plan of correction for the deficiency(ies) found during the complaint investigation.

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

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

Pete Ricketts, Governor

May 21, 2020

Jeffrey Harvey, Administrator
Continental Springs, LLC
3200 G Street
South Sioux City, NE 68776

Dear Mr. Harvey:

From May 12, 2020, through May 19, 2020, an abbreviated onsite Complaint Survey with a Targeted COVID-19 Infection Control survey was conducted at your facility by representatives of the Nebraska Department of Health and Human Services, Division of Public Health (State Survey Agency), to determine whether your facility was in compliance with requirements for nursing homes participating in the Medicare/Medicaid program and Skilled Nursing Facility licensure requirements. After careful review of the survey findings, it was determined that the conditions at Continental Springs, LLC constitute an immediate threat to the health, safety and welfare of residents. The survey findings are documented on the enclosed Immediate Jeopardy Summary. The Immediate Jeopardy was unremoved at the time of the survey exit.

F880 Infection Control

These conditions involved the facility's failure to follow acceptable infection control practices for COVID-19 by facility administration, nursing, and dietary staff not wearing personal protective equipment (PPE) appropriately while in resident care areas and while providing care to residents. Furthermore, the facility failed to protect all residents in the facility by not following acceptable infection control practices for COVID-19. Specifically, nursing, administrative, and dietary staff were allowed to work and provide care and services to residents without being properly screened for COVID-19, and starting as early as May 15, 2020, staff were allowed to work with and provide care to residents after reporting signs and symptoms of COVID-19 on facility screening sheets. Staff who reported symptoms of COVID-19 were allowed to return to work sooner than recommended per CDC Guidelines. During that time period, staff cared for residents who tested positive or identified as presumed positive COVID-19 and asymptomatic residents who tested negative for COVID-19. The lack of screening also included the facility's failure of not assessing the temperature of all staff prior to allowing staff to provide resident care. In addition, COVID-19 positive and presumed positive residents were not following recommended precautions/isolation.

F684 Quality of Care

On May 19, 2020, an onsite visit was conducted and identified additional concerns related to the assessment and ongoing monitoring of residents who were positive or presumed positive for COVID-19. The staff failed to address ongoing changes, provide monitoring, and to report changes to the residents' physicians. In addition, the facility failed to implement monitoring, interventions, and physician communication related to diabetic management and hemodialysis for two residents that had a change in condition. This led to a failure to assure the residents received the required care and treatment. Subsequently, these two residents were hospitalized and expired.

The following actions are being taken by the State Survey Agency under the federal and state regulatory processes.

FEDERAL PROCESS

Based on the survey findings, the State Survey Agency will recommend to CMS that your Medicare and Medicaid agreement be terminated effective **June 11, 2020.**

Should the Centers for Medicare and Medicaid Services determine that termination or any other remedy is warranted, you will be provided with a separate formal notification of that determination.

The facility is required to submit an allegation of removal of immediate jeopardy including evidence of steps taken to remove the immediate jeopardy. This allegation shall be sent to the Nebraska Department of Health and Human Services, Division of Public Health, Licensure Unit, 301 Centennial Mall South, Lincoln, NE 68509-4986. Failure to submit an allegation of removal will result in termination of your provider agreement. If a revisit substantiates the facility has corrected the conditions posing the immediate jeopardy to the residents by June 11, 2020, the State Survey Agency will recommend to CMS that the termination be rescinded. If a revisit establishes that the immediate jeopardy has been removed but the facility has not yet achieved substantial compliance with all requirements, the denial of payment for new admissions will continue until the facility achieves substantial compliance.

A statement of deficiencies will be sent outlining in writing the findings of the surveyors.

Please note that Federal law, as specified in the Social Security Act at sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs (NATCEP) and competency evaluation programs (CEP) offered by or in a facility which within the last two years has operated under a section 1819(b)(4)(C)(ii)(II) or section 1919(b)(4)(C)(ii)(II) waiver; has been subject to an extended or partial extended survey; has been assessed a CMP of not less than $5,000.00; or, has been subject to a denial of payment; the appointment of a temporary manager; termination; or, in the case of an emergency, been closed and/or had its residents transferred to other facilities. If any of these situations occur, NATCEP will be denied, and you will be advised under separate notification.

STATE PROCESS

The State Survey Agency has notified the operator in an exit conference and in writing that a state violation exists which poses imminent danger to the health, safety and welfare of residents. The State Survey Agency will issue a written report of its findings and issue an official notice in the Form CMS 2567 of noncompliance to the facility.

The State Survey Agency will conduct a reinspection of the facility within 20 calendar days of May 19, 2020. If the operator fails to correct the imminent danger, the State Survey Agency may seek the imposition of any of the sanctions and remedies provided by law.

If you have any questions, please contact this office for assistance.

Sincerely,

Connie Vogt RN BSN

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

CV/kd

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

Pete Ricketts, Governor

IMMEDIATE JEOPARDY SUMMARY

May 21, 2020

Mr. Jeffery Harvey, Administrator
Continental Springs, LLC
3200 G Street
South Sioux City, Nebraska 68776

CMS Certification Number: 285082

F880 (L): Infection Prevention & Control

An abbreviated onsite Complaint Survey with a Targeted COVID-19 Infection Control survey was conducted representatives of the Nebraska Department of Health and Human Services, Division of Public Health (State Survey Agency) from May 12, 2020 to May 19, 2020 which identified widespread immediate jeopardy (IJ) noncompliance related to COVID-19 infection control practices and staff screenings for COVID-19 symptoms in accordance with CMS and the Centers for Disease Control and Prevention (CDC) guidelines.

These conditions involved the facility's failure to follow acceptable infection control practices for COVID-19 by facility administration, nursing, and dietary staff not wearing personal protective equipment (PPE) appropriately while in resident care areas and while providing care to residents. Furthermore, the facility failed to protect all residents in the facility by not following acceptable infection control practices for COVID-19. Specifically, nursing, administrative, and dietary staff were allowed to work and provide care and services to residents without being properly screened for COVID-19, and starting as early as May 15, 2020, staff were allowed to work with and provide care to residents after reporting signs and symptoms of COVID-19 on facility screening sheets. Staff who reported symptoms of COVID-19 were allowed to return to work sooner than recommended per CDC Guidelines. During that time period, staff cared for residents who tested positive or identified as presumed positive COVID-19 and asymptomatic residents who tested negative for COVID-19. The lack of screening also included the facility's failure of not assessing the temperature of all staff prior to allowing staff to provide resident care. In addition, COVID-19 positive and presumed positive residents were not following recommended precautions/isolation.

F684 (K) Quality of Care

On May 19, 2020 an onsite visit was conducted and identified concerns related to the assessment and ongoing monitoring of residents who were positive or presumed positive for COVID-19. The staff failed to address ongoing changes, provide monitoring, and to report changes to the resident's physician. In addition, the facility failed to implement monitoring, interventions, and physician communication related to diabetic management and hemodialysis for two residents that had a change in condition. This led to a failure to assure the residents received the required care and treatment. Subsequently, two residents were hospitalized and expired.

A determination was made that the facility's noncompliance placed all residents in immediate jeopardy. On 5/19/20, the IJ cited on 5/13/20 remained ongoing.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	**3200 G STREET SOUTH SIOUX CITY, NE 68776**

(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 the survey report as they apply to deficient practices identified.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-	F 580		6/10/20

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

Electronically Signed | 06/10/2020

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
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	**3200 G STREET SOUTH SIOUX CITY, NE 68776**

(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 580	Continued From page 1 (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Licensure Reference Number 175 NAC 12-006.04C3a Based on record review and interviews, the facility failed to: 1) notify Resident 25's physician regarding non-compliance with fluid restrictions and the resident's refusal and staff failure to complete blood glucose monitoring and insulin administration; and 2) verify Resident 21's physician orders for diabetic management. The total sample size was 28 and the facility census was 52. Findings are: A. Review of the facility policy "Change in a Resident's Condition or Status" with revision date 2/14 revealed the following:	F 580	This plan of correction is submitted as required under State and Federal law. The submission of the plan does not constitute an admission on the part of Continental Springs, to the accuracy of the surveyor's findings or the conclusions drawn therefrom. Residents 21 and 25 have expired All residents who reside in the facility have the potential to be affected. All staff in-service was held on 6/09/2020 regarding notifying residents' personal physicians on a change in condition, following up on a resident's change in condition, documentation related to	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 580	Continued From page 2 -the Charge Nurse was to notify the resident's physician when there was a significant change in the resident's physical/emotional/mental condition which included an accident, discovery of an injury of unknown origin, reaction to a medication, need to transfer to the hospital or treatment center and refusal of medication and/or treatment; -except in an emergency situation, notifications were to be made to the physician within 24 hours of the change of the resident's status; and -the Charge Nurse was to document in the resident's medical record, information relative to the change in status. B. Review of Resident 25's 22's Minimum Data Set (MDS- a federally mandated comprehensive assessment tool used for care planning) dated 2/17/20 revealed the resident was admitted on 2/11/20 with diagnoses of [redacted] Review of the resident's admission orders dated 2/11/20 revealed an order for the facility to check the resident's [redacted] efore meals and at bedtime. Review of the resident's Medication Administration Record (MAR) dated 4/2020 revealed the resident was to receive [redacted] efore each meal. The MAR also indicated the resident was to have [redacted] was administered. Further review of the MAR revealed the following from 4/1/20 through 4/30/20; -at 7:30 AM the resident did not receive the	F 580	change in conditions, with physician's orders. All staff that have not been educated at in-services will be educated as well before their next shift. Progress notes will be reviewed by the DON/Designee starting 6/10/20, by reviewing the 24-hour report and t he 72-hour report (for weekends) to ensure physician notifications, documentation, and nursing follow up on any changes in condition, including physician's orders. Any staff found to be noncompliant will be immediately re-educated. The facility Registered Nurse Consultant will be used for consultation as needed. By reviewing progress notes, DON/Designee will complete audits daily to ensure notification, follow up, and education is done in a time manner for three (3) months, then three (3) times a week for three (3) months, and then randomly thereafter. Changes in condition, physician notification, and nursing follow up will be discussed at stand-up meetings, beginning 6/9/20. The DON/Designee will update care plans to reflect interventions identified by the leadership team. Any new changes in condition will be reported by the DON/Designee to the MDS Coordinator so that care plans can be updated for new changes in condition. Residents with a change of condition will be added t o the Change of Condition log until condition is resolved to ensure follow	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 580	Continued From page 3 ordered [redacted] (11 out of 30 days); -at 11:30 AM the resident did not receive the ordered [redacted] (8 out of 30 day). In addition, the resident had [redacted] checked but did not receive [redacted] and -at 5:30 PM the resident did not receive the ordered [redacted] In addition, the resident had blood glucose level checked but did not receive [redacted] Review of the resident's Treatment Administration Record (TAR) dated 4/2020 revealed the resident had an order for a daily [redacted]. The resident was to receive [redacted] with meals and [redacted] Documentation revealed staff were charting each shift whether the resident was compliant or non-compliant with the designated [redacted]. Further review revealed the following: -6AM to 2PM the resident was not compliant with [redacted] There was no documentation regarding the resident's compliance on [redacted] -2PM to 10PM the resident was not compliant with [redacted] There was missing documentation of the resident's compliance on 4/8/20; and -10PM to 6AM the resident was not compliant regarding [redacted]	F 580	up evaluation and documentation continues. All nurse aides were educated on 5-28-2020 to immediately report any change in resident's usual condition. The nurse will assess the resident after being informed of change/s. Nurses were educated on assessment requirements and use of Change of Condition log May 28, 2020. The DON/Designee will discuss changes in condition, including hospitalizations at the Quality Assurance Performance Improvement (QAPI) meetings monthly for 6 months. Administrator will design an action plan if needed.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 580	Continued From page 4	F 580		

[redacted]

Review of the resident's medical record from 4/1/20-4/30/20 revealed no evidence the facility had monitored the resident's [redacted]

Review of the resident's MAR for 5/2020 revealed the following regarding the resident's ordered [redacted]
-at 7:30 AM the resident' [redacted] and the resident's [redacted]
-at 11:30 AM the resident's [redacted] and the resident's order [redacted] and
-at 5:30 PM the resident's [redacted] but the resident's [redacted]

Review of the resident's TAR from 5/1/20-5/16/20 revealed the following regarding the resident's non-compliance with [redacted]:
-6AM to 2PM the resident was non-compliant on [redacted]. The facility failed to document compliance or non-compliance on [redacted];
-2PM to 10PM the resident was non-compliant with [redacted] The facility failed to document compliance or non-compliance on 5/6, 5/14 and on 5/15/20; and
-10PM to 6AM the resident was non-compliant

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 580	Continued From page 5 with [redacted] The facility failed to document the resident's compliance or non-compliance on [redacted]. Review of the resident's medical record from [redacted] revealed no evidence the facility had monitored the resident's [redacted] Review of the resident's medical record from [redacted] revealed no evidence Resident 25's physician was notified regarding the resident's [redacted] During an interview on 5/19/20 at 1:30 PM, Licensed Practical Nurse (LPN)-A confirmed the following regarding Resident 25: -on a [redacted] and staff were to document compliance or non-compliance each shift; -the resident had [redacted]; -staff failed to always document the resident's compliance or non-compliance with [redacted] each shift; -the resident's physician was not notified regarding the resident's [redacted]; -the resident was a [redacted] and staff were to administer [redacted] before meals and to obtain a [redacted] -the resident would refuse to eat or would refuse [redacted]. The facility did not send [redacted] with the	F 580		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 580	Continued From page 6 resident when [redacted]; -the facility was not checking the resident's [redacted] at bedtime; and -the resident's physician was never notified regarding the resident's [redacted]. C. Review of Resident 21's MDS dated 3/22/2020 revealed the resident received supervision for transfers, toileting, bed mobility and dressing, and received [redacted] Review of Resident 21's Care Plan dated 3/30/20 revealed no indication that the resident received [redacted] Review of Resident 21's Progress Notes revealed: [redacted] the resident was admitted to the facility. [redacted] the facility sent a facsimile (fax) to the PCP (primary care physician) requesting [redacted] the facility received a reply to the fax generated on [redacted] with orders for [redacted] -5/6/20 at 11:30 AM the resident was found [redacted] Resident 5 was determined to have a [redacted]	F 580		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 580	Continued From page 7	F 580		

[redacted]
-[redacted] the resident returned to the facility with no new orders;
-5/8/20 at 2:21 PM the resident's family was notified of a [redacted]
-5/8/20 at 9:33 PM the resident was placed in [redacted]. The family and physician were notified.
-5/9/20 at 8:50 PM the resident was tested for [redacted]
-5/13/20 at 12:53 AM the resident's [redacted]
-5/15/20 at 3:00 PM the resident had a [redacted] by lunch time, had not eaten breakfast or lunch and the staff administered [redacted] The physician was faxed a request to change or hold the resident's night dose of [redacted]
-5/18/20 at 5:27 AM the resident was found [redacted] Further review of the Progress Notes revealed:
- no evidence that the facility made additional attempts to obtain a response from the resident's physician on 5/16/20 or 5/17/20 regarding changing or holding the resident's [redacted]

Interview with LPN-N on 5/19/20 at 11:30 AM revealed the nurse was unaware of any specific facility policies on notifying a physician, but would notify the physician of an emergent change in a resident's condition immediately, and would

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 580	Continued From page 8 continue to attempt notifications at least every 10 minutes until a response was obtained. For non-emergent notifications attempts to gain a physician response would be done at least every 24 hours. Interview with the Director of Nursing (DON) on 5/19/20 at 2:30 AM confirmed that nurses should continue to attempt getting a response from physicians as soon as possible by repeated attempts for emergencies, by the completion of the nurse's shift for non-emergencies, and/or at least daily for non-emergencies. In addition the DON confirmed that all attempts to contact a physician should be documented.	F 580		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		6/10/20

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	**3200 G STREET SOUTH SIOUX CITY, NE 68776**

(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 609	Continued From page 9 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Licensure Reference Number 175 NAC 12-006.02(8) Based on record review and interview the facility failed to report potential abuse and/or neglect allegations to the State Agency for 3 (Residents 21, 25, and 18) of 3 sampled residents. The facility census was 54. Findings are: A. Review of the facility policy Abuse and Neglect Reporting Policy and Procedure with a revision date of 4/21/20 indicated the following: -The Administrator and Director of Nursing (DON) were responsible for supervising the Abuse Prevention Program, -all staff received training on abuse and reporting when hired and then yearly, -all staff were considered to be mandatory reporters, -any reasonable suspicion of abuse of any form would be reported to staff supervisors and an investigation would be conducted, -the Administrator or Director of Nursing would report within 2 hours to the Abuse Hotline, and -a complete investigation would be submitted to the Department of Health and Human Services (DHHS) Investigation Unit within 5 working days	F 609	Resident #18 has expired. All residents who reside in the facility have the potential to be affected. All Staff In-service was held on 6/09/2020 regarding Abuse & Neglect, Resident Rights, Reportable events and Reporting process. All staff that has not been re-educated at in-services will be educated as well. The Reporting Abuse to State Agencies and other Entities/Individuals policy was reviewed on 6/05/2020. A new investigation form will be implemented for all allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property. All staff will be educated on procedures for submitting the initial report to DHHS Office of Licensure and Certification utilizing the Adult Protective Services (APS) hotline 1-800-652-1999 reporting instructions on 06/09/2020 and those not at the in-services will be educated on the same material before their next shift. The	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 609	Continued From page 10 of the incident. B. Review of Resident 21's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool use for care plan development) dated 3/22/2020 revealed the resident received supervision for [redacted] Review of Resident 21's Progress Notes revealed: -5/6/20 at 11:30 AM the resident was found [redacted] -5/6/20 at 5:12 PM the resident returned to the facility with no new orders. -5/8/20 at 2:21 PM the resident's family was notified of a potential exposure to a [redacted] -5/8/20 at 9:33 PM the resident was placed in [redacted]. The family and physician were notified. -5/9/20 at 8:50 PM the resident was tested for [redacted]. -5/13/20 at 12:53 PM the resident's [redacted] -5/15/20 at 3:00 PM the resident had [redacted]	F 609	Administrator, DON/designee will be responsible for submitting the Final Report to the DHHS. A weekly administrator report will be submitted to the owner of Continental Springs. Reportables will be one thing included on the Administrator Report. An incident report generated from PCC will be used to assure reportables are reported. DON/Designee will also be reviewing progress notes through 24-hour report and 72-hour report. While reviewing the progress notes and documentation any reportable information will be reported to the administrator. The Administrator will keep a log/audit of all reportables made, date report made to State/APS and 5-day follow-up. This information will also be discussed in Morning Meeting. Results will be submitted by DON and/or Designee through the QA/QAPI process monthly for review/recommendations. Any patterns will be identified. If necessary, an Action Plan will be written by the IDT and monitored by the Administrator weekly until resolved.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 609	Continued From page 11 [redacted]. The physician was faxed a request to change or hold the resident's [redacted] -5/18/20 at 5:27 AM the resident was found [redacted] Notes revealed: - no evidence Resident 21's unexpected death was investigated by the facility or reported to the State Agency as required. Interview with the DON on 5/19/20 at 2:15 PM on confirmed the facility did not investigate and/or report the Resident 21's unexpected death to the State Agency as required. C. Review of Resident 25's MDS dated 2/17/20 revealed the resident was admitted on [redacted] with diagnoses of [redacted] Review of a facsimile (fax) from the [redacted] had attempted to call the facility "9 times to multiple extensions' with "no answer" and a "voicemail left". The fax identified an order for the resident to be started on [redacted] with a request for the facility to call [redacted] back. Review of the resident's medical record revealed no evidence the facility noted and/or initiated the order for the medication. In addition, there was no documentation in the resident's medical record to indicate the reason [redacted] or that the facility was monitoring the resident for a potential [redacted].	F 609		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 609	Continued From page 12 Review of the resident's Nursing Progress Notes dated [redacted] revealed the following: -8:20 AM the resident was found unresponsive with no pulse present. Cardiopulmonary Resuscitation (CPR) was initiated and the resident was transferred to the hospital; and -11:50 AM the facility was notified the resident had expired at 8:51 AM. During an interview on 5/19/20 at 11:00 AM, the DON confirmed the following: -staff had not reported Resident 25's death to the DON; and -the State Agency was not notified of the resident's unexpected death on 5/17/20. D. Review of Resident 18's Progress Note dated [redacted] revealed the facility received a phone call from the police department. The police stated they had received a call from Resident 18's family member with complaints that the resident was not being properly cared for with examples being the resident getting changed, fed, and out of bed. The nurse called Resident 18's family member and apologized and offered assurance that the resident had been changed and stated the resident was getting out of bed, however, the resident's wheelchair was broken (no indication on how long the wheelchair had been broken). Observation of Resident 18's room door on [redacted] revealed a hand written note posted on the outside of the residents door, the note read "Needs Help Eating and More, Please Help"	F 609		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 609	Continued From page 13 During an interview with Resident 18 on [redacted] he resident voiced concerns related to care at the facility including long call light times and assistance with meals, the resident voiced feeling weaker. Review of Resident 18's Bath documentation dated [redacted] revealed the resident had been given one bath in the past 30 days. The resident's last bath was on [redacted] (24 days prior). Interview with the DON on 5/19/20 at 10:23 AM revealed the DON had received a call on [redacted] from Resident 18's family member with concerns related to lack of bathing. The DON confirmed the concern was not investigated to see when the resident last had a bath. The DON revealed the facility didn't have a bath aide scheduled. The DON stated they "don't have the staff" and the agencies "don't have the staff". The DON revealed the phone call from the police department on 5/16/20 had not been reported to the DON and the DON had been off Saturday, Sunday, and Monday. The DON confirmed the concerns reported by the police department had not been reported to Adult Protective Service or the State Agency as an allegation of potential neglect. Interview with the Administrator on 5/19/20 at 11:00 AM, revealed the concerns reported by the police department were looked at as a grievance as the resident had history of saying things like this (no evidence of this in the progress notes).	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		6/10/20

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 610	Continued From page 14 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Licensure Reference Number 175 NAC 12-006.02(8) Based on record review and interview the facility failed to complete then submit investigations of potential abuse and/or neglect allegations for 3 (Resident's 21, 25, and 18) of 3 sampled residents. The facility census was 54. Findings are: A. Review of the facility policy Abuse and Neglect Reporting Policy and Procedure with a revision date of 4/21/20 indicated the following: -The Administrator and Director of Nursing (DON) were responsible for supervising the Abuse Prevention Program, -all staff received training on abuse and reporting	F 610	Residents 21 and 25 have expired. All residents who reside in the facility have the potential to be affected. All staff in-service was held on 6/9/20 regarding Abuse and Neglect and the investigative process. All staff that has not been re-educated at in-services will be educated as well before working their next shift. The investigative process for allegations of abuse, neglect, and unexplained deaths and the submission of the investigation, including the result of the investigation to State Agencies and other Entities/Individuals policy was reviewed on	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 610	Continued From page 15 when hired and yearly, -all staff were considered to be mandatory reporters, -any reasonable suspicion of abuse of any form would be reported to staff supervisors and an investigation would be conducted, -the Administrator or Director of Nursing would report within 2 hours to the Abuse Hotline, and -a complete investigation would be submitted to the Department of Health and Human Services (DHHS) Investigation Unit within 5 working days of the incident. B. Review of Resident 21's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool use for care plan development) dated [redacted] revealed the resident received supervision for [redacted] Review of Resident 21's Progress Notes revealed: -5/6/20 at 11:30 AM the resident was found lying on the bed, unresponsive, diaphoretic (sweating profusely), and having [redacted] Resident 5 was determined to have a [redacted]. -5/6/20 at 5:12 PM the resident returned to the facility with no new orders. -5/8/20 at 2:21 PM the resident's family was notified of a potential exposure to a [redacted] -5/8/20 at 9:33 PM the resident was placed in isolation due to possible exposure, [redacted]	F 610	6/5/20. A new investigation form will be implemented for all investigations of abuse, neglect, exploitation, mistreatment, or unexplained death, including injuries of unknown origin and misappropriation of resident property. The Administrator, Director of Nursing (DON)/designee will be responsible for submitting the Final Report of the investigation to the Nebraska Department of Health and Human Services, Office of Licensure and Certification. A weekly administrator report will be sent to the owner of Continental Springs. Reportables will be one thing included on the Administrator Report. Administrator will audit alleged incidents utilizing the alleged incident audit tool. This audit tool will be updated for each incident that is reported. Reportables will also be discussed in morning meeting. Results will be submitted by Administrator or DON/designee through the Quality Assurance Performance Improvement (QAPI) process monthly for review/recommendations. Any patterns will be identified. If necessary, An action Plan will be written by the IDT and monitored by the Administrator weekly until resolved.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 610	Continued From page 16	F 610		

[redacted]. The family and physician were notified.
-5/9/20 at 8:50 PM the resident was tested [redacted]
-5/13/20 12:53 AM the resident's [redacted]
-5/15/20 at 3:00 PM the resident had [redacted] The physician was faxed a request to change or hold the resident's [redacted]
-5/18/20 at 5:27 AM the resident was found [redacted] Further review of the Progress Notes revealed:
-no evidence Resident 21's unexpected death was investigated by the facility or reported to the State Agency as required.

Interview with the DON (Director of Nursing) on 5/19/20 at 2:15 PM identified the facility did not investigate and/or submit a report regarding Resident 21's unexpected death to the State Agency as required.

C. Review of Resident 25's MDS dated 2/17/20 revealed the resident was admitted on [redacted]

Review of a facsimile (fax) from the [redacted] on 5/15/20 (no time) revealed [redacted] had attempted to call the facility "9 times to multiple extensions' with "no answer" and a

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 610	Continued From page 17 "voicemail left". The fax identified an order for the resident to be started on [redacted] with a request for the facility to call the center back. Review of the resident's medical record revealed no evidence the facility noted and/or initiated the [redacted] In addition, there was no documentation in the resident's medical record to indicate the reason [redacted] or that the facility was monitoring the resident for [redacted]. Review of the resident's Nursing Progress Notes [redacted] revealed the following: -8:20 AM the resident was found unresponsive with no pulse present. Cardiopulmonary Resuscitation (CPR) was initiated and the resident was transferred to the hospital; and -11:50 AM the facility was notified the resident had expired [redacted] During an interview on 5/19/20 at 11:00 AM, the DON indicated the following: -the facility had not identified the resident's unexpected death as a potential abuse and/or neglect allegation; -no investigation was completed; and -no investigation was sent to the State Agency within the required time frame.	F 610		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677		6/10/20

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	**3200 G STREET SOUTH SIOUX CITY, NE 68776**

(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 677	Continued From page 18 by: Licensure Reference Number 175 NAC 12-006.09D1c Based on interview and record review the facility failed to provide bathing assistance for Residents 18, 1, and 11. The sample size was 3 and the facility census was 54. Findings are: A. Review of Resident 18's Progress Note dated [redacted] revealed the facility received a phone call from the police department. The police stated they had received a call from Resident 18's family member with complaints that the resident was not being properly cared for with examples being the resident getting changed, fed, and out of bed. The nurse called Resident 18's family member and apologized and offered assurance that the resident had been changed and stated the resident was getting out of bed, however, the resident's wheelchair was broken. Observation of Resident 18's room door on 5/19/20 at 1:30 PM revealed a hand written note posted on the outside of the residents door, the note read "Needs Help Eating and More, Please Help" During an interview with Resident 18 on 5/19/20 at 1:45 PM, the resident voiced concerns related to care at the facility including long call light times and assistance with meals, the resident voiced feeling weaker. Review of Resident 18's Bathing documentation dated [redacted] revealed the resident had been given one bath in the past 30 days. The	F 677	Residents #18, 1 and 11 all had a review of their bathing documentation. An investigation completed on 6/5/20 revealed baths were not given as scheduled. There has been a bath aide designated to give baths. When the bath aide is not available to give all the baths it is the responsibility of the nursing staff to help give the residents baths. Additionally, a list of dependent residents was compiled. These residents were added to the audit tool to see that their ADLs were being provided and call light times were noted as well. All residents have the potential to be affected. The facility has been reaching out by using Facebook and temporary nursing agency to find more staff. The facility is also utilizing the temporary nurse aide training and checkoff competency. The facility currently has 3 Nurses and 3 Aides helping from various agencies. The bath schedule was viewed and revised on 6/7/2020 to indicate wit bath dates each resident will receive their baths. DON/Designee will audit ADLs 3 times weekly for 3 months to see that dependent resident are receiving appropriate care related to their ADLs and call light response time. Then 1 time weekly for 3 months and randomly after that.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 677	Continued From page 19 resident's last bath was on [redacted] (24 days prior). Interview with the Director of Nursing (DON) on 5/19/20 at 10:23 AM revealed the DON had received a call on [redacted] from Resident 18's family member with concerns related to lack of bathing. The DON confirmed the concern was not investigated to see when the resident last had a bath. The DON revealed the facility didn't have a bath aide scheduled. The DON stated they "don't have the staff" and the agencies "don't have the staff". The DON revealed the phone call from the police department on [redacted] had not been reported to the DON and the DON had been off Saturday, Sunday, and Monday. The DON confirmed the concerns reported by the police department had not been reported to Adult Protective Service or the State Agency. B. Review of Resident 1's Bathing documentation dated [redacted] revealed the resident had last received a bath on [redacted] (14 days prior). C. Review of Resident 11's Bathing documentation dated [redacted] revealed the resident had last received a bath on [redacted] (20 days prior).	F 677	A bathing completion audit tool was created. The DON/Designee will review the bath schedule with the bath sheets along with call light wait time being reviewed once weekly for 3 months, then every other month for 3 month. After that, audits to be completed randomly. Results will be submitted through the QA/QAPI process by the DON and/or Designee monthly for review/recommendations for 6 months. Any patterns will be identified. If necessary, and Action Plan will be written by t he IDT and monitored by the DON/Admin weekly until resolved.	
F 684 SS=K	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		6/10/20

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 684	Continued From page 20 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Licensure Reference Number 175 NAC 12-006.09D Based on record review and interviews, the facility failed to: 1) ensure assessments and ongoing monitoring were completed for Residents 9, 1, 20, 7 and 17 who were [redacted] 2) implement assessment and monitoring for Residents' 21 and 25 related to [redacted]; and 3) complete assessment and monitoring of Resident 25 related to [redacted] and the resident's multiple potential exposure to COVID-19 from transport and weekly visits to the [redacted]. The total sample size was 28 and the facility census was 54. Findings are: A. Review of the facility policy "Change in a Resident's Condition or Status" with revision date 2/14 revealed the Charge Nurse was to document in the resident's medical record information relative to a significant change in the resident's medical/mental condition or status. A significant change of condition was identified as a decline in the resident's status which would not normally resolve itself without intervention and/or impacted more than one area of the resident's health status. B. Review of the facility policy [redacted]	F 684	All residents will be assessed for any Covid 19 symptoms t.i.d. until notified by CMS COVID-19 is no longer a health emergency. If a change of condition is identified the PHCP will be notified for any required interventions. Resident's representative will be informed of the condition change and ordered treatment. Narrative documentation will occur along with car plan updating and continued monitoring until condition resolves and/or additional interventions are required. All residents with known diagnosis of diabetes will have the Covid 19 assessment along with diabetic monitoring to include glucose monitoring for additional signs of condition change and residents that don't currently have an order for glucose monitoring will be identified and their Primary Care Physician will be notified and recommendations for glucose monitoring will be requested. The facility will start to implement white board that will keep current information that is pertinent to residents in a secure location for privacy but will allow for better communication amongst employees. This white board will include resident with COVID-19, infections and other pertinent information. The white board will be covered by a curtain or some other	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 684	Continued From page 21 [redacted] with revision date 9/10 revealed the following regarding documentation in the resident's medical record: -location of access site; -condition of dressing to the site; -any report from [redacted]; and -observations post [redacted]. C. Review of the Centers for Medicare and Medicaid Services (CMS) Center for Clinical Standards and Quality, Safety and Oversight Group dated 4/24/20 revealed the following guidance for infection control and prevention of Coronavirus Disease 2019 (COVID-19): -implement active screening of residents for fever and respiratory symptoms. Actively take their temperatures and document the absence of shortness of breath, new or change in cough and sore throat; and -for a medically necessary appointment outside of the nursing home, such as dialysis, the facility should monitor the resident upon return for fever and signs and symptoms or respiratory infection (preferably in a space dedicated for observation of asymptomatic residents). D. Review of Resident 25's Minimum Data Set (MDS- a federally mandated comprehensive assessment tool used for care planning) dated 2/17/20 revealed the resident was admitted on [redacted] Review of the resident's admission orders dated [redacted] revealed an order for the facility to check the resident's [redacted]	F 684	material that will provide the privacy needed regarding this resident information. Don/Designee will check that the White Board is updated weekly for 3 months then monthly for 3 months then as needed. Maintenance Director fixed whirlpool in North hallway on 6/4/2020. Now there are 2 working whirlpools for baths and being able to provide baths will be less of an issue that it has in the past. Residents receiving hemodialysis shall be assessed for change of condition to include Covid 19 screening a minimum of t.i.d. Any adverse findings will be communicated immediately to the PHCP. Family will be notified of resident condition change and treatments. Residents receiving hemodialysis treatments will have their paperwork or communication notes received from dialysis by the facility nurse for possible change of condition. Residents with a change of condition will be added to the Change of Condition log until condition is resolved to ensure follow up evaluation and documentation continues. All nurse aides will be educated to immediately report any change in resident's usual condition. The nurse will assess the resident after being informed of change/s.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 684	Continued From page 22 [redacted] Review of Resident 25's Nursing Progress Note dated 3/13/20 at 3:44 PM revealed while the resident was at [redacted], the resident was transferred to the Emergency Room related to [redacted]. A chest x-ray and laboratory screening were completed before the resident returned to the facility. Review of the resident's medical record revealed no evidence the facility assessed and provided ongoing monitoring of Resident 25's [redacted] upon return to the facility. Review of [redacted] Further review revealed no documentation to indicate a [redacted] was completed on 4/8/20, 4/22/20, and on 4/29/20. Review of the resident's Medication Administration Record (MAR) for [redacted] revealed an order dated [redacted] for the staff to complete a [redacted] when the resident returned from [redacted]. Further review revealed no documentation to indicate the resident's vital signs were monitored upon return from [redacted] on 4/15/20, 4/17/20 and on 4/22/20. Review of the resident's MAR dated 4/2020	F 684	Nurses were educated on assessment requirements and use of Change of Condition log May 28, 2020. DON or designee will monitor the COC log daily to assure appropriate follow up is occurring. Reports will be submitted to QA weekly by DON for 12 months.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 684	Continued From page 23 revealed a physician order dated [redacted] for [redacted]. The MAR also indicated the resident was to have [redacted]. Further review of the MAR revealed the following from 4/1/20 through 4/30/20; -at 7:30 AM the resident did not receive the ordered [redacted] n 4/3, 4/6, 4/8, 4/9, 4/10, 4/15, 4/17, 4/22, 4/24, 4/27 and on 4/29/20 (11 out of 30 days); -at 11:30 AM the resident did not receive the [redacted] checked on 4/3, 4/8, 4/10, 4/15, 4/17, 4/21, 4/22 and on 4/29/20 (8 out of 30 day). In addition, the resident had [redacted] checked but did not receive [redacted] on 4/5, 4/6 and on 4/9/20; and -at 5:30 PM the resident did not receive the ordered [redacted] on 4/30/20. In addition, the resident had [redacted] but did not receive [redacted] on 4/1 and 4/13/20. Review of the resident's Treatment Administration Record (TAR) dated [redacted] revealed the resident had an order for a daily [redacted] The resident was to receive [redacted]. Documentation revealed staff were charting each shift whether the resident was compliant or non-compliant with the designated [redacted] Further review revealed the following: -6AM to 2PM the resident was [redacted] with [redacted] on 4/2, 4/6, 4/9, 4/13, 4/15, 4/16,	F 684		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 684	Continued From page 24 and on 4/30/20. There was no documentation regarding the resident's compliance on 4/3, 4/7, 4/10, 4/14, 4/21 and on 4/29/20; -2PM to 10PM the resident was [redacted] with [redacted] on 4/2, 4/3, 4/6, 4/7, 4/9, 4/10, 4/13, 4/14, 4/15, 4/16, 4/29 and on 4/30/20. There was missing documentation of the resident's compliance on 4/8/20; and -10PM to 6AM the resident was [redacted] regarding [redacted] on 4/2, 4/4 through 4/15, 4/23, 4/29 and on 4/30/20. Review of the resident's medical record from 4/1/20-4/30/20 revealed no evidence the facility had monitored the resident's [redacted] at bedtime or addressed the resident's [redacted]. In addition, no further assessment or monitoring was completed despite the facility failure at times to check the resident's [redacted] and to administer the [redacted] when ordered at 7:30AM, 11:30AM and at 5:30 PM. Review of the facility Resident Screening Log (form used to assess and document any potential signs and symptoms of COVID-19) from 5/1/20 to 5/16/20 revealed Resident 25 had no screening completed on 5/1, 5/4, 5/13, 5/15 and on 5/16/20. Further review of the resident's screening log revealed on 5/2, 5/3 and on 5/5/20 through 5/14/20, the resident had a temperature check but the facility failed to assess/document if the resident had any signs or symptoms and staff failed to document a signature to identify who had completed the resident screening. Review of the resident's MAR for 5/2020 revealed the following regarding the resident's ordered [redacted] administration and/or [redacted]	F 684		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 684	Continued From page 25 [redacted] monitoring from 5/1/20 through 5/16/20: -at 7:30 AM the resident's [redacted] was not checked and the resident's [redacted] was not administered on 5/1, 5/4, 5/6, 5/11, 5/12, 5/13, and on 5/15/20 (7 out of 16 days); -at 11:30 AM the resident's [redacted] was not checked and the resident's order for [redacted] was not administered on 5/1, 5/4, 5/5, 5/6, 5/8, 5/11, 5/13, and on 5/15/20 (8 out of 16 days); and -at 5:30 PM the resident's [redacted] was checked but the resident's [redacted] was not administered on 5/1, 5/9, 5/11, 5/13, 5/15 and on 5/16 (6 out of 16 days). Review of the resident's MAR for [redacted] revealed from 5/1/20 to 5/16/20, staff failed to monitor the [redacted] return from [redacted] on 5/4/20, 5/8/20, 5/11/20, 5/13/20 and on 5/15/20. Review of the resident's TAR from 5/1/20-5/16/20 revealed the following regarding the resident's [redacted]: -6AM to 2PM the resident was [redacted] on 5/2, 5/3, 5/5, 5/6, 5/7, 5/8, and on 5/16/20. The facility failed to document compliance on 5/4, 5/14 and on 5/15/20; -2PM to 10PM the resident was [redacted] with [redacted] on 5/1, 5/8, 5/9, 5/10, 5/11, 5/12, 5/13 and on 5/16/20. The facility failed to document compliance on 5/6, 5/14 and on 5/15/20; and -10PM to 6AM the resident was [redacted] with [redacted] on 5/1, 5/2, 5/8, 5/10, 5/11, 5/12, 5/15 and on 5/16/20. The facility failed to document the resident's compliance on 5/9, 5/13	F 684		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 684	Continued From page 26 and on 5/14/20. Review of the resident's medical record from 5/1/20-5/16/20 revealed no evidence the facility had monitored the resident's [redacted] at bedtime or addressed the resident's non-compliance with [redacted]. In addition, no further assessment or monitoring was completed despite the facility failure at times to check the resident's [redacted] and to administer the [redacted] when ordered at 7:30AM, 11:30AM and at 5:30 PM. Review of [redacted] dated 5/1/20-5/15/20 revealed no documentation to indicate a [redacted] record was completed on 5/11/20. Review of a facsimile (fax) from the [redacted] on 5/15/20 (no time) revealed the center had attempted to call the facility "9 times to multiple extensions' with "no answer" and a "voicemail left". The fax identified an order for the resident to be started on [redacted]) with a request for the facility to call [redacted] back. Review of the resident's medical record revealed no evidence the facility noted and/or initiated the order for the medication. In addition, there is no documentation in the resident's medical record to indicate the [redacted] or that the facility was monitoring the resident for a [redacted]. Review of the resident's Nursing Progress Notes dated 5/17/20 revealed the following: -8:20 AM the resident was found unresponsive with no pulse present. Cardiopulmonary	F 684		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 684	Continued From page 27 Resuscitation (CPR) was initiated and the resident was transferred to the hospital; and -11:50 AM the facility was notified the resident had expired at 8:51 AM. E. Review of Resident 7's MDS dated [redacted] revealed the resident was admitted on [redacted]. Review of Resident 7's Nursing Progress Notes revealed the following: -3/25/2020 at 7:59 PM the resident was observed to have [redacted] The resident was placed on [redacted] Review of the resident's medical record revealed no evidence further assessment was completed regarding the resident's [redacted]. Review of Resident 7's Nursing Progress Notes revealed the following: -5/9/20 at 8:48 PM the resident was identified as receiving the [redacted] -5/12/20 at 11:52 PM the facility was notified Resident 7 had tested [redacted]. Isolation precautions were put into place. The note further indicated staff were to complete vital signs every 4 hours as ordered by the resident's physician; -5/13/20 at 3:48 PM the resident's temperature was [redacted] and the resident's	F 684		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 684	Continued From page 28	F 684		

[redacted]
The resident's [redacted]
-5/13/20 at 4:34 PM a fax was sent to the resident's physician regarding [redacted]
-5/13/20 at 8:53 PM the resident's [redacted]. The resident had refused food and fluids. [redacted] The resident's physician was notified of the resident's condition;
-5/13/20 at 9:23 PM a new order was received for [redacted] The facility was to encourage the resident to stay up in a wheelchair as much as possible to prevent pneumonia. The resident refused the need for hospitalization at this time;
-5/14/20 at 5:30 PM the resident's temperature was [redacted];
-5/16/20 at 3:55 PM the resident's temperature was [redacted]. The resident requested to be transported to the hospital.

Review of the resident's medical record revealed no evidence the resident was assessed with vital signs completed every four hours as indicated by

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 684	Continued From page 29	F 684		

the resident's physician after the resident was diagnosed as [redacted] and prior to the resident's hospitalization.

F. Review of Resident 17's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 3/25/20 revealed the resident was admitted to the facility on [redacted]

Review of Resident 17's Nursing Progress Notes revealed the following:
-4/14/20 at 2:48 PM the resident was assessed as having a temperature of [redacted]
-4/17/20 8:42 AM the resident's temperature was [redacted]
-4/17/20 at 5:21 PM an order was received for the staff to check the resident's oxygen saturation level every shift and to report if the resident's saturation level was below 89%;
-4/20/20 at 4:56 PM the resident complained of [redacted]. A new order was received for [redacted]
-4/25/20 (5 days after the resident first indicated [redacted]) at 9:11 PM the resident had complaints of increased [redacted];
-4/28/20 at 10:52 AM the resident voiced complaint of not feeling well with [redacted]
-4/30/20 at 12:32 AM a facsimile (fax) was received from the resident's physician which identified new orders for [redacted]

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 684	Continued From page 30	F 684		

[redacted]

-5/5/20 at 1:02 PM the resident complained of still not feeling well at times with [redacted]. Further review of the resident's medical record revealed no evidence the resident had been assessed since the resident was started on an [redacted] 5 days earlier);
-5/7/20 at 11:06 AM the resident was admitted to the hospital with a diagnoses of [redacted];
and
-5/12/20 at 6:43 PM the resident was re-admitted from the hospital. [redacted]

-5/14/20 at 3:25 PM the resident's physician was notified the resident had complaints of [redacted]

-5/14/20 at 6:23 PM a facsimile (fax) was received from the resident's physician with an order to [redacted] Review of the resident's medical record revealed no evidence from 4/17/20 to 5/19/20 the staff were assessing the resident's [redacted] despite the physician order received 4/17/20 to check every shift;
-5/15/20 at 1:38 PM the resident left the facility for a [redacted] appointment;
-5/19/20 (5 days after the resident's physician instructed the facility to monitor the resident

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 684	Continued From page 31 closely) at 6:43 PM the resident was complaining of [redacted]. The resident's [redacted]. The resident's temperature was [redacted]. An order was received to transfer the resident to the hospital; and [redacted] the facility received a call from the hospital indicating the resident was now [redacted] G. During an interview on 5/19/20 at 1:30 PM, Licensed Practical Nurse (LPN)-A confirmed the following: -Resident 7 had an [redacted] Despite the resident portraying potential symptoms of [redacted], no further assessment of the resident was completed; -Resident 7 was tested for [redacted] on 5/9/20 and on 5/12/20, the test came back [redacted] -Resident 7's physician was notified the resident was [redacted] and ordered the resident's vital signs were to be assessed every 4 hours. The facility failed to complete vital signs every 4 hours; -Resident 17 was complaining of [redacted] on 4/17/20 with an order to have the resident's [redacted] assessed every shift and to report [redacted] to the resident's physician. Staff failed to complete [redacted] every shift as ordered by the resident's physician; -no further assessment of the resident until 4/20/20 when the resident was again displaying [redacted]; -no evidence the resident was assessed again until 4/25/20; -4/30/20 the resident was started on an [redacted]	F 684		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 684	Continued From page 32 [redacted] -no further assessment of the resident until 5/5/20 and on 5/7/20 the resident was admitted to the hospital for [redacted]; -5/14/20 the resident was complaining of [redacted] Staff were advised to monitor the resident closely. There were no further assessments documented for Resident 17 until 5/19/20 when the resident was again transferred to the hospital and tested [redacted]; -Resident 25 went to [redacted] and staff were to complete a full set of vital signs before going and after returning from [redacted] -missing documentation of assessments before and after returning from [redacted] -Resident 25 was on a [redacted] and staff were to document compliance or non-compliance each shift; -missing documentation as to the resident's compliance or non-compliance with [redacted] each shift; -Resident 25 was a [redacted] and staff were to administer [redacted] 3 times a day before meals and to obtain a [redacted] at the same time; -the resident would refuse to eat or would refuse [redacted] at times or the resident was at [redacted] The facility did not send [redacted] with the resident when at [redacted] -the facility was not checking the resident's [redacted]; -the resident's physician was unaware the resident's [redacted] was not being monitored or the [redacted] administered as ordered by the physician; -the order for [redacted] received from the [redacted] on 5/15/20 was not noted and/or initiated for the resident;	F 684		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 684	Continued From page 33 -there was no documentation in the resident's medical record to indicate why the [redacted] was ordered; and -no assessment of the resident's medical status from 5/15/20 until 5/17/20 when the resident was found unresponsive. H. Review of Resident 21's MDS dated 3/22/2020 revealed: -[redacted]; -the resident received supervision for dressing, toileting, bed mobility and dressing; and -the resident received [redacted] 6 out of 7 days, with 1 [redacted] order change. Review of Resident 21's Care Plan dated 3/30/20 revealed no indication that the resident received [redacted], or required monitoring related to the [redacted] Review of Resident 21's Progress Notes revealed: -[redacted] at 9:32 PM the resident was admitted to the facility. -[redacted] at 9:45 PM the facility faxed the PCP (primary care physician) requesting [redacted] monitoring and reporting parameters. -[redacted] at 4:40 PM (3 days later) the facility received a reply to the fax generated on [redacted] with orders for daily [redacted] monitoring, and an order to submit a [redacted] log to the PCP every 2 weeks. -5/6/20 at 11:30 AM the resident was found lying on the bed, unresponsive, diaphoretic (sweating profusely), and [redacted] Resident 21 was determined to [redacted], was treated with an injection of [redacted] and transported to the ER	F 684		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 684	Continued From page 34 (emergency room) for further treatment. -5/6/20 at 5:12 PM the resident returned to the facility with no new orders. The discharge Patient Education Material recommended [redacted] monitoring for patients at least 2 times daily. -5/8/20 at 2:21 PM the resident's family was notified of a potential exposure to a [redacted] -5/8/20 at 9:33 PM the resident was placed in isolation due to [redacted]. The family and physician were notified. -5/9/20 at 8:50 PM the resident was tested for [redacted] -5/13/20 at 12:53 AM the resident's [redacted] -5/15/20 at 3:00 PM the resident had a [redacted] by lunch time, had not eaten breakfast or lunch, and the staff administered [redacted] to raise the resident's [redacted]. The physician was faxed a request to change or hold the resident's night dose of [redacted] -5/18/20 at 5:27 AM the resident was found lying on the floor in the bathroom at 4:00 AM with no pulse or blood pressure. Further review of the resident's Nursing Progress Notes revealed: -no evidence the facility assessed the resident's change in status related to [redacted] following an ER visit on 5/6/20 until 5/15/20; -no evidence the facility completed assessments related to symptoms of [redacted] following the initial documented symptoms of [redacted] on 5/8/2020 at 9:33 PM;	F 684		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 684	Continued From page 35 -no evidence the facility made additional attempts to obtain a response from the resident's physician on 5/16/20 or 5/17/20 regarding changing or holding the resident's night dose of [redacted] and -no evidence the facility assessed the resident for signs and symptoms of [redacted] or documented on the resident's condition from [redacted] I. Review of Resident 9's MDS revealed: [redacted] -the resident received supervision for eating and extensive assistance provided for bed mobility, transfers, toileting, and dressing. -the resident had [redacted]. Review of Resident 9's Nursing Progress Notes revealed: -5/1/20 at 12:25 AM the resident complained [redacted] -5/8/20 at 3:09 PM the resident's emergency contact was informed of a potential exposure to [redacted] -5/9/20 at 9:25 PM the resident was tested for [redacted]. -5/11/20 at 2:00 AM the resident had a body temperature of [redacted] The physician was notified and recommended [redacted] -5/14/20 at 3:24 PM the facility was notified that resident's [redacted]. -5/16/20 at 5:09 PM the resident had increased	F 684		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	**3200 G STREET SOUTH SIOUX CITY, NE 68776**

(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 684	Continued From page 36 [redacted] and was transferred to the hospital and admitted. Further review of the resident's Nursing Progress Notes revealed: -no evidence the facility assessed the resident's change in status from 5/1/20 at 12:25 AM until 5/11/20 at 2:00 AM; and -no evidence the facility assessed the resident's change in status from 5/11/20 at 2:00 AM until 5/16/20 at 5:09 PM when the resident required admission to the hospital. J. Interview with DON on 5/19/20 at 2:00 PM confirmed that residents with a condition change should be assessed, and have documented condition assessments every shift until their condition stabilizes. K. Review of Resident 1's Nursing Progress Notes revealed: - On 5/13/20 the resident tested [redacted] with vital signs every 4 hours ordered. - No documentation in the Nursing Progress Notes on 5/15/20, 5/16/20, 5/17/20, 5/18/20, and 5/19/20. Review of Resident 1's [redacted] Flow Sheets dated 5/14/20 to 5/18/20 revealed: - On 5/14/20 the resident had vital signs taken at 3:20 PM and 3:40 PM; - On 5/15/20 the resident had vital signs taken at 8:00 AM and 3:00 PM; - On 5/16/20 the resident had vital signs taken once (time not indicated) and at 11:45 AM; - On 5/17/20 the resident had vital signs taken at 3:00 PM; and - On 5/18/20 the resident had vital signs taken at 11:40 PM.	F 684		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 684	Continued From page 37 Review of Resident 1's Nursing Progress Notes, Assessments, and Vital Signs section in the Electronic Health Record revealed no additional vital signs had been taken (with the order for vital signs every 4 hours) L. Review of Resident 20's Nursing Progress Notes: - On 5/14/20 at 3:16 PM, the resident was [redacted] - On 5/14/20 at 6:14 PM, the physician ordered a repeat [redacted]. - No documentation in the Nursing Progress Notes on 5/15/20 and 5/16/20. - On 5/17/20 at 11:15 PM, the physician was notified of the resident having an [redacted] The physician advised to start the resident on [redacted] - On 5/17/20 at 11:50 PM, the resident's [redacted] - On 5/18/20 at 4:09 PM (approximately 14 hours since the resident's last set of vital signs), the physician was contacted regarding the resident [redacted] - On 5/19/20 at 6:01 AM (approximately 14 hours since the resident's last set of vital signs), the resident had a [redacted] he resident was educated to wear the [redacted]. - There was no evidence to indicate the resident's [redacted] was repeated.	F 684		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis.	F 698		6/10/20

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 698	Continued From page 38 The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: LICENSURE REFERENCE NUMBER 175 NAC 12-006.09 Based on interview and record review, the facility failed to provide assessment and monitoring for Resident 25 who was receiving [redacted] The sample size was 1 and the facility census was 54. Findings are: A. Review of the facility policy [redacted] with revision date 9/10 revealed the following regarding documentation in the resident's medical record: -location of access site; -condition of dressing to the site; -any report from [redacted] nurse [redacted] being given; and -observations [redacted]. B. Review of Resident 25's Minimum Data Set (MDS- a federally mandated comprehensive assessment tool used for care planning) dated 2/17/20 revealed the resident was admitted on [redacted] with [redacted] Review of [redacted] Flow Sheets (form used to	F 698	Resident #25 has expired. 2 Residents, #3 and 12, that receive Hemodialysis have the potential to be affected. All nurses will be educated and competency checked by DON/Designee on care of residents receiving dialysis. In-service was held on 6/09/20 regarding the assessment and monitoring of residents that receive Hemodialysis, including assessment of the fistula side, vital signs, and residents' tolerance of the procedure, pre and post treatment assessment and documentation of these assessments. Licensed nurses that have not been educated at in-services, will be educated as well before their next shift. Fluid restrictions will be reviewed for each resident on a fluid restriction to ensure fluids are given according to resident's preference and not staff preference t o achieve compliance wit fluid restriction order. Nursing staff educated about electronic pocket care plan and fluid restrictions. Nursing and dietary will communicate to determine resident daily fluid intake. If resident is not following daily restriction, the physician will be notified and documented.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	**3200 G STREET SOUTH SIOUX CITY, NE 68776**

(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 698	Continued From page 39 document a resident's [redacted] vital signs which included a blood pressure, temperature, pulse, respirations and an oxygen saturation level) from 4/1/20 - 4/30/20 revealed the resident was receiving [redacted] Further review revealed no documentation to indicate a [redacted] Flow record was completed on 4/8/20, 4/22/20, and on 4/29/20. Review of the resident's Medication Administration Record (MAR) for 4/2020 revealed an order dated 4/13/20 for the staff to complete a full set of vital signs (temperature, pulse, respirations, blood pressure and oxygen saturation level) when the resident returned from [redacted] Further review revealed no documentation to indicate the resident's vital signs were monitored upon return from [redacted] on 4/15/20, 4/17/20 and on 4/22/20. Review of the resident's Treatment Administration Record (TAR) dated 4/2020 revealed the resident had an order for a daily [redacted] Documentation revealed staff were charting each shift whether the resident was compliant or non-compliant with the designated [redacted]. Further review revealed the following: -6AM to 2PM the resident was [redacted] with [redacted] on 4/2, 4/6, 4/9, 4/13, 4/15, 4/16, and on 4/30/20. There was no documentation regarding the resident's compliance on 4/3, 4/7, 4/10, 4/14, 4/21 and on 4/29/20; -2PM to 10PM the resident was [redacted]	F 698	Progress notes will be reviewed by the Director of Nursing (DON) or designee starting 6/10/20, Monday through Friday to ensure assessments and monitoring was completed for all residents receiving Hemodialysis. Any nurse found to be noncompliant will immediately be re-educated. Th facility Registered Nurse Consultant will be used for consultation as needed. By reviewing progress notes, DON/Designee will ensure audits are done for the assessments and monitoring of residents that received Hemodialysis was done 3 time weekly in a timely manner, any unusual findings from assessments and evidence the physician was notified for three (3) months and residents on fluid restrictions would be monitored daily for 3 months for their fluid intake, Then weekly for three (3) month, and then randomly thereafter. Additionally, the audit will include fluid intake was documented and if restriction orders refused for (2-3) days that physician was notified. The DON or the MDS Coordinator will update the care plans of residents receiving Hemodialysis to ensure assessments and monitoring are included in the plan of care. The DON/Designee will discuss the result of the assessments and monitoring of residents that received Hemodialysis at the Quality Assurance Performance	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 698	Continued From page 40 with [redacted] on 4/2, 4/3, 4/6, 4/7, 4/9, 4/10, 4/13, 4/14, 4/15, 4/16, 4/29 and on 4/30/20. There was missing documentation of the resident's compliance on 4/8/20; and -10PM to 6AM the resident was [redacted] regarding [redacted] on 4/2, 4/4 through 4/15, 4/23, 4/29 and on 4/30/20. Review of the resident's medical record from 4/1/20-4/30/20 revealed no evidence the facility had addressed the resident's [redacted] with [redacted]. Review of the resident's MAR for 5/2020 revealed from 5/1/20 to 5/16/20, staff failed to monitor the resident's pulse, blood pressure, temperature, respirations and oxygen saturation level upon return from [redacted] on 5/4/20, 5/8/20, 5/11/20, 5/13/20 and on 5/15/20. Review of the resident's TAR from 5/1/20-5/16/20 revealed the following regarding the resident's non-compliance with [redacted] -6AM to 2PM the resident was non-compliant on 5/2, 5/3, 5/5, 5/6, 5/7, 5/8, and on 5/16/20. The facility failed to document compliance on 5/4, 5/14 and on 5/15/20; -2PM to 10PM the resident was non-compliant with [redacted] on 5/1, 5/8, 5/9, 5/10, 5/11, 5/12, 5/13 and on 5/16/20. The facility failed to document compliance on 5/6, 5/14 and on 5/15/20; and -10PM to 6AM the resident [redacted] with [redacted] on 5/1, 5/2, 5/8, 5/10, 5/11, 5/12, 5/15 and on 5/16/20. The facility failed to document the resident's compliance on 5/9, 5/13 and on 5/14/20. Review of the resident's medical record from	F 698	Improvement (QAPI) meetings for 6 months.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 698	Continued From page 41 5/1/20-5/16/20 revealed no evidence the facility had addressed the resident's non-compliance with [redacted]. Review of [redacted] Flow Sheets dated 5/1/20-5/15/20 revealed no documentation to indicate a [redacted] Flow record was completed on 5/11/20. During an interview on 5/19/20 at 1:30 PM, Licensed Practical Nurse (LPN)-A confirmed the following: -Resident 25 went to [redacted] and staff were to complete a full set of vital signs before going and after returning from [redacted] -missing documentation of assessments before and after returning from [redacted] -Resident 25 was on a [redacted] and staff were to document compliance or non-compliance each shift; -missing documentation as to the resident's compliance or non-compliance with [redacted] each shift; and -the facility failed to address the resident's non-compliance with fluid restriction.	F 698		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in	F 725		6/10/20

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 725	Continued From page 42 accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Licensure Reference Number 175 NAC 12-006.04c Based on interview and record review the facility failed to ensure staffing levels met residents' needs including bathing assistance for Residents 18, 1, and 11. The sample size was 3 and the facility census was 54. Findings are: A. Review of Resident 18's Progress Note dated [redacted] at 5:46 PM revealed the facility received a phone call from the police department. The police stated they had received a call from Resident 18's family member with complaints that the resident was not being properly cared for with examples being the resident getting changed, fed, and out of bed. The nurse called Resident 18's family member and apologized and offered	F 725	All residents have t he potential to be affected by this alleged findings. It is the facilities goal t o maintain appropriate staffing at the facility on each unit for each shift. As resident numbers fluctuate so do staffing numbers and units. Travel staff have been at the facility to assist with staffing numbers. Temporary nursing aide program is being advertised as an option for additional staff. Resident #18 can receive assistance with meals, getting up out of bed and back into bed as desired, and receive changing as appropriate. DON/Designee will ensure residents have ability to have assistance with meals as appropriate and included in their MDS, to receive changing when appropriate, and	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 725	Continued From page 43 assurance that the resident had been changed and stated the resident was getting out of bed, however, the resident's wheelchair was broken. Observation of Resident 18's room door on 5/19/20 at 1:30 PM revealed a hand written note posted on the outside of the residents door, the note read "Needs Help Eating and More, Please Help" During an interview with Resident 18 on 5/19/20 at 1:45 PM, the resident voiced concerns related to care at the facility including long call light times and assistance with meals, the resident voiced feeling weaker. Review of Resident 18's Bathing documentation dated [redacted] revealed the resident had been given one bath in the past 30 days. The resident's last bath was on [redacted] (24 days prior). Interview with the Director of Nursing (DON) on 5/19/20 at 10:23 AM revealed the DON had received a call on 5/15/20 from Resident 18's family member with concerns related to lack of bathing. The DON confirmed the concern was not investigated to see when the resident last had a bath. The DON revealed the facility didn't have a bath aide scheduled. The DON stated they "don't have the staff" and the agencies "don't have the staff". The DON revealed the phone call from the police department on [redacted] had not been reported to the DON and the DON had been off Saturday, Sunday, and Monday. The DON confirmed the concerns reported by the police department had not been reported to Adult Protective Service or the State Agency.	F 725	get out of bed or get back into bed when desired. This practice shall continue to be followed for all residents at all meals. The DON/Designee will interview 10 interviewable residents weekly to see that they feel their needs are being met. Also, the DON/Designee will interview 10 staff members weekly to see that they feel they have adequate time to meet the needs of t he residents assigned to them and that they have time to properly place call lights for resident use. Also 10 family members will be interviewed weekly to see hat the fell that their loved ones needs are being met. This interviewing will continue until 4 consecutive weeks of zero negative findings is achieved. Afterwards, 3 interviewable residents, 3 family members and 3 staff members will be interviewed weekly for a period of not less that 6 month to ensure ongoing compliance. After that, random interviews will occur ongoing. Any concerns voiced will be addressed on an individual basis to the satisfaction of the interviewee. This will include reported the concerns to the Administrator who will work with the DON and the Staffing Coordinator to revise the schedule as needed to see that residents' needs are met. AT an all staff in-service held 6/09/2020 given by DON/Designee the following was reviewed: 1) Resident Rights 2) Dignity 3) Shower Policy Staff not at the in-service will be educated	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 725	Continued From page 44 B. Review of Resident 1's Bathing documentation dated [redacted] revealed the resident had last received a bath on [redacted] (14 days prior). C. Review of Resident 11's Bathing documentation dated [redacted] revealed the resident had last received a bath on [redacted] (20 days prior).	F 725	on the same material before working their next shift. At the monthly QA meeting, the results of the monitoring/review of DON/designee will be reviewed. Any patterns will be identified. if necessary an Action Plan will be written by the Interdisciplinary Team. Any Action Plan will be monitored by the Administrator weekly until resolved.	
F 726 SS=F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides.	F 726		6/10/20

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 726	Continued From page 45 The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Licensure Reference Number 175 NAC 12-006.04C1 Based on observations, record review and interview, the facility failed to ensure nursing personnel were knowledgeable and had demonstrated competency and skill sets for the provision of care related to Hemodialysis (a method used to treat kidney disease by clearing metabolic waste products, toxins, and excess fluid from the blood) and diabetic management. In addition, the facility failed to ensure education and/or competency testing related to COVID-19 and isolation procedures for Transmission Based Precautions. The total sample size was 28 and the census was 54. Findings are: A. During an observation of the 100 corridor on 5/13/20 from 7:50 AM to 8:10 AM, Dietary Aide (DA)-G distributed breakfast meals to the resident's room. DA-G had a cart in the corridor which contained several Styrofoam containers. DA-G was wearing a disposable mask, isolation gown, shoe coverings and gloves. DA-G was observed entering Rooms 111, 110 and 108. A bedside table was positioned in each of these resident rooms. The bedside tables contained various items which included television remote controls, Kleenex boxes, and pieces of loose paper, newspapers and magazines. Without	F 726	All residents who reside in the facility have the potential to be affected. An all staff education in-service by Mercy Hospital Infection Control Educational Nurses,Administrator, Maintenance and Housekeeping Supervisor,and Temporary Manager by video conference) occurred on 5/26/2020, to address the deficient COVID-19 infection control practices. The following is a list of topics discussed at the in-service. Staff that were not at this in0service will receive the same education. 1. COVID-19 Procedures (given to staff and reviewed with staff) 2. Proper donning and doffing wit hall staff (handouts for all staff and competencies given by MercyOne Hospital educational infection control trained nurses). 3. Review of Red Zones/Yellow Zones/Gray/and Green Zones (currently we only have Yellow but waiting on results from all residents that were tested by the National Guard at the facility on 5/21/2020. 4. Educated staff about new screening sheet implemented on 5/24/2020 to include O2 stats as well. 5. Educated staff of the importance of the nurse or designee that has been	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	**3200 G STREET SOUTH SIOUX CITY, NE 68776**

(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 726	Continued From page 46 cleansing the tables, DA-G moved aside items on the tables and placed Styrofoam containers onto the bedside tables. DA-G proceeded to open the containers and to provide set-up assistance which included placing straws into cups, opening silverware packets and assisting to cut up food items for the residents. After exiting the rooms, DA-G removed disposable gloves but failed to wash hands or to use hand sanitizer before putting on a clean pair of gloves, returning to the cart in the corridor and passing the next breakfast meal. During an interview on 5/13/20 at 8:10 AM, DA-G was unable to identify the residents who were currently on Transmission Based Precautions for positive and/or presumed positive COVID-19. In addition, DA-G confirmed no education had been provided to the dietary staff as to what personal protective equipment (PPE) should be worn when entering the rooms of residents on Transmission Based Precautions or the correct way to put on and to take off the required PPE. B. On 5/13/20 from 8:11 AM to 8:30 AM, an observation of medication administration for Resident 19 revealed the following: -the medication cart was positioned in the corridor outside of room 101. Licensed Practical Nurse (LPN)-A was wearing a disposable mask, isolation gown, shoe coverings and gloves. LPN-A while wearing gloves, opened a drawer of the medication cart and removed several bubble packs which were then placed on the top of the cart, next to a medication cup. LPN-A removed medications from the bubble packs by popping the medications into LPN-A's gloved hands and then placing into the medication cup; -LPN-A opened the top drawer of the cart and	F 726	trained to screen staff getting all the vital signs and additional screening information. 6. Educated all staff of the mandate that no staff self-screen. 7. Educated all staff on the importance of screening 2 times during their shift. 8. Hand washing 9. Location of the COVID-19 binder 10. Educated all staff about the information that is in the COVID-19 binder. 11. Explain the Colored Zones on the doors/walls (RED and YELLOW) it was decided there would be no Green Zone because with the number of positive residents and staff it was determined all staff and residents might have been exposed. 12. Explain proper donning/doffing posters are hanging by clean PPE drawers by hallway door entrances. 13. Educated all staff about hooks to hang your face mask (make sure your name is on it) clean N95 mask every break period and end of day with alcohol-wipe. 14. Educated all staff about bags with staff names on them located in the service hallway. Put N95 mask in you bag and your name should be on the N95 mask as well. Can be reused until soiled. All department heads (Maintenance-Transportation/Nursing/Dietary/Activities/Housekeeping-Laundry will hold monthly internal departmental meetings. Included as part of these meetings will be infection control practices	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 726	Continued From page 47 began rummaging through the drawer. LPN-A picked up each individual container in the drawer stating LPN-A was looking for eye drops. All containers were returned to the drawer and drawer was closed; -LPN-A opened another drawer of the cart and was able to locate 2 containers of [redacted] labeled for Resident 19. LPN-A placed the 3 items on the top of the medication cart; -LPN-A picked up the [redacted] 2 medication cups, a wrist blood pressure cuff, a thermometer, an oximetry machine and 2 individually packaged alcohol wipes from the top of the medication cart. LPN-A adjusted the items several times and finally balanced the items against the staff's isolation gown and took all the items at one time, into the resident's room; -while continuing to hold all of the items, LPN-A removed a paper towel from a dispenser next to the resident's hand-washing sink and placed the paper towel as a barrier on a bedside table in the resident's room. LPN-A failed to cleanse and/or disinfect the surface of the bedside table prior to placing the barrier. LPN-A positioned all of the items carried into the resident's room onto the paper towel barrier; -LPN-A removed gloves and washed hands at resident's sink; -without putting on a clean pair of gloves, LPN-A proceeded to administer the resident's [redacted]; -the resident identified complaints of an [redacted] and vocalized the inability to consume the breakfast meal. LPN-A indicated [redacted] would not be administered at this time and the LPN would contact the resident's physician; -the blood pressure cuff was placed on the resident's wrist and the cuff malfunctioned;	F 726	that affect that particular department. Notes from these department meetings will be kept along with a sign-in log. Additionally, there will be a monthly all-staff in-service. These all staff in-services will include aspects dealing with infection control (updates related to COVID-19). Furthermore, t here will be a Stand-up Center Chat and a Stand-down Center Chat each week. All nurses will be educated and competency checked by DON/Designee on care of residents receiving dialysis. In-services was held on 6/09/2020 regarding t he assessment and monitoring of residents that receive Hemodialysis, including assessment of the fistula site, vital signs, and resident' tolerance o the procedure, pre and post treatment, assessment and documentation of these assessments. Infection control practices related to medication administration and glucometer checks will also be covered this in-service. Any nurse that missed the in-service will receive the education before their next shift. New hire nurses will receive a competency assessment/check regarding infection control related to medication administration and glucometer checks during the hiring process or orientation. Then competency checks as needed. Administrator will implement a Manager on-duty Program on Saturday/Sunday for the next 3 months. The manager on-duty will assist staff, residents, and families.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	**3200 G STREET SOUTH SIOUX CITY, NE 68776**

(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 726	Continued From page 48 -without washing or sanitizing hands, LPN-A exited the resident's room, opened a drawer of the medication cart and removed another blood pressure wrist cuff from the cart; -still without washing or sanitizing hands, LPN-A placed the second cuff on the resident's wrist and obtained a blood pressure. LPN-A placed the wrist cuff on the paper towel barrier without cleaning; -LPN-A placed the oximetry machine on the resident's finger and obtained an oxygen level of [redacted]. LPN-A questioned the resident regarding a sore throat, cough or shortness of breath. The resident denied any respiratory complaints. LPN-A opened a pre-packaged alcohol wipe and used to cleanse the oximetry machine before returning the machine to the paper towel barrier; -LPN-A used the thermometer to obtain a temperature of [redacted] from the resident's forehead. LPN-A placed the thermometer back on the paper towel barrier without cleansing; -LPN-A reached under the staff's isolation gown and removed a pen from a uniform pocket. LPN-A then used the pen to document the resident's vital signs directly onto the paper towel barrier then returned the pen to the uniform pocket; -LPN-A without washing or sanitizing hands, removed the [redacted], the oximetry machine, the thermometer, the 2 blood pressure wrist cuffs and the paper towel barrier from the resident's room and placed all items on top of the medication cart; and -LPN-A returned the thermometer and 2 blood pressure wrist cuffs to a drawer of the medication cart without cleansing the reusable resident care equipment.	F 726	The manager on-duty will complete the Manager on-duty form and turn it into the administrator. A white board will be utilized in the conference room to assist staff with communication. The POC in PCC Kardex has a Care Plan that will be available for staff to utilize as a communication device and reference tool when caring for residents. Results will be submitted through the QA/QAPI process by the DON and/or Designee monthly for review/recommendations each month for 12 months. Any patterns will be identified. If necessary, an Action Plan will be written by the IDT and monitored by the DON/Admin weekly until resolved.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 726	Continued From page 49 During an interview on 5/13/20 at 9:00 AM, LPN-A confirmed the following: -LPN-A had not changed the disposable isolation gown, mask and shoe coverings the LPN was wearing despite going into and out of several resident's rooms including residents who were positive or presumed positive for [redacted]; -Resident 19's medications and the reusable resident care equipment used to obtain the resident's vital signs should have been cleansed before bringing into the resident's room and the items should not have been held against the LPN's isolation gown; -Resident 19's bedside table should have been cleansed and/or sanitized prior to placing paper towel barrier; -gloves should have been worn with administration of [redacted]; -hands should have been washed or sanitized before entering and exiting the resident's room; -all reusable resident care equipment should have been cleansed and/or sanitized after resident use and before returning the items to the medication cart; and -had not received any competency testing and/or training regarding isolation procedures for residents on Transmission Based Precautions. C. Review of Resident 25's Minimum Data Set (MDS- a federally mandated comprehensive assessment tool used for care planning) MDS dated 2/17/20 revealed the resident was admitted on [redacted] Review of the resident's admission orders dated [redacted] revealed an order for the facility to check the resident's [redacted]	F 726		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 726	Continued From page 50 [redacted] before meals and at bedtime. Review of [redacted] Flow Sheets (form used to document a resident's pre-dialysis vital signs which included a blood pressure, temperature, pulse, respirations and an oxygen saturation level) dated 4/1/20-4/30/20 revealed the resident was receiving [redacted] Further review revealed no documentation to indicate a [redacted] Flow record was completed on 4/8/20, 4/22/20, and on 4/29/20. Review of the resident's Medication Administration Record (MAR) for [redacted] revealed an order dated 4/13/20 for the staff to complete a full set of vital signs (temperature, pulse, respirations, blood pressure and oxygen saturation level) when the resident returned from [redacted]. Further review revealed no documentation to indicate the resident's vital signs were monitored upon return from [redacted] on 4/15/20, 4/17/20 and on 4/22/20. Review of the resident's MAR dated 4/2020 revealed a physician order dated 2/11/20 for [redacted] before each meal. The MAR also indicated the resident was to have [redacted] checked before [redacted] was administered. Further review of the MAR revealed the following from 4/1/20 through 4/30/20; -at 7:30 AM the resident did not receive the ordered [redacted] or have [redacted] checked on 4/3, 4/6, 4/8, 4/9, 4/10, 4/15, 4/17,	F 726		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 726	Continued From page 51 4/22, 4/24, 4/27 and on 4/29/20 (11 out of 30 days); -at 11:30 AM the resident did not receive the ordered [redacted] or have [redacted] checked on 4/3, 4/8, 4/10, 4/15, 4/17, 4/21, 4/22 and on 4/29/20 (8 out of 30 day). In addition, the resident had [redacted] checked but did not receive [redacted] on 4/5, 4/6 and on 4/9/20; and -at 5:30 PM the resident did not receive the ordered [redacted] or have [redacted] checked on 4/30/20. In addition, the resident had [redacted] checked but did not receive [redacted] on 4/1 and 4/13/20. Review of the resident's MAR for 5/2020 revealed the following regarding the resident's ordered [redacted] administration and/or [redacted] monitoring from 5/1/20 through 5/16/20: -at 7:30 AM the resident' [redacted] was not checked and the resident's [redacted] was not administered on 5/1, 5/4, 5/6, 5/11, 5/12, 5/13, and on 5/15/20 (7 out of 16 days); -at 11:30 AM the resident's [redacted] was not checked and the resident's order for [redacted] was not administered on 5/1, 5/4, 5/5, 5/6, 5/8, 5/11, 5/13, and on 5/15/20 (7 out of 16 days); and -at 5:30 PM the resident's [redacted] was checked but the resident's [redacted] was not administered on 5/1, 5/9, 5/11, 5/13, 5/15 and on 5/16 (6 out of 16 days). Review of the resident's MAR for 5/2020 revealed from 5/1/20 to 5/16/20, staff failed to monitor the resident's pulse, blood pressure, temperature respirations and oxygen saturation level upon return from [redacted] on 5/4/20, 5/8/20, 5/11/20, 5/13/20 and on 5/15/20	F 726		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 726	Continued From page 52	F 726		

Review of [redacted] Flow Sheets dated 5/1/20-5/15/20 revealed no documentation to indicate a [redacted] Flow record was completed on 5/11/20.

Review of the resident's medical record from 4/1/20-5/16/20 revealed no evidence the facility had monitored the resident's [redacted] at bedtime or addressed the resident's [redacted] with provision of [redacted] monitoring and [redacted] administration.

During an interview on 5/19/20 at 10:30 PM, the Director of Nursing (DON) confirmed Resident 25 was an [redacted] who required frequent monitoring of [redacted]. In addition, the resident received [redacted] and staff needed to assess the resident's vital signs as well as the resident's health status before and after the resident's return from [redacted]

During an interview on 5/19/20 at 1:30 PM, LPN-A identified no on-going training had been provided regarding [redacted] for Resident 25.

D. Review of the facility staff/visitor screening log dated 4/22/20 to 5/12/20 revealed all staff members did not have screening completed related to signs/symptoms of COVID-19. In those cases the staff members' temperature was listed but no indication as to whether the staff had symptoms of COVID-19 was recorded. Further review revealed Registered Nurse (RN)-H did not have documentation of screening for signs/symptoms of COVID-19 on the night of 5/7/20 when the RN worked the over-night shift into 5/8/20 (RN-H was identified as testing

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	**3200 G STREET SOUTH SIOUX CITY, NE 68776**

(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 726	Continued From page 53 COVID-19 positive on 5/9/20) Interview with the Administrator on 5/12/20 at 1:45 PM revealed the staff members had been screening themselves prior to working. E. Review of the facility form "Residents on Isolation Precautions" dated 5/12/20 identified Resident 8 as being on isolation related to a potential exposure. Observation on 5/13/20 at 10:20 AM revealed LPN-A in the resident's room with a mask on but no other PPE. LPN-A was helping move the resident's wheelchair with the resident's bedside tray table and then helped reposition the resident's feet on the base of the table. LPN-A then went and got gloves (didn't complete hand hygiene first) and assisted the residents roommate (Resident 28) to the bathroom. The curtain was not pulled and the residents passed within 6 feet of each other. F. Review of the facility form "Residents on Isolation Precautions" dated 5/12/20 identified Resident 4 as being on isolation due to an exposure to a [redacted]. Observation of breakfast meal delivery on 5/13/20 from 8:00 AM to 8:30 AM revealed DA-D delivered drinks to room [redacted] prior to going to room [redacted] DA-D changed gloves but failed to perform hand hygiene after removing gloves. DA-D continued down the hallway changing gloves between residents but not performing hand hygiene when changing gloves. DA-D then got to Resident 4's room. The table outside of the room had PPE (Personal Protective Equipment-can include items such as gowns, gloves, masks,	F 726		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 726	Continued From page 54	F 726		

goggles, face shields, and foot coverings) setting on top of it. DA-D commented "what is going on with" Resident 4. Housekeeper-E walked by at that time and said the resident was [redacted] and that "this" wasn't needed anymore (while moving the PPE off of the table). NA-D then entered Resident 4's room to deliver breakfast drinks, touched items in the resident's room including bedside table, came back out and took a packet of creamer from a plastic baggie with multiple packets in it and took a milk of out the ice bin with multiple individual milks without changing gloves/hand hygiene. After completing Resident 4's drinks NA-D changed gloves but didn't complete hand hygiene prior to moving on to the next resident. The gown NA-D was wearing while delivering all meals remained in place after Resident 4's room as well.

G. On 5/13/20 at 10:21 AM NA-B entered Resident 18's room with NA-B's face mask not covering the NA's nose (bilateral nares visible) and was within 6 feet of the resident.

H. Review of Resident 1's Progress Notes revealed:
- On 5/13/20 the resident tested [redacted] with vital signs every 4 hours ordered.
- No documentation in the Progress Notes on 5/15/20, 5/16/20, 5/17/20, 5/18/20, and 5/19/20.

Review of Resident 1's [redacted] Flow Sheets dated 5/14/20 to 5/18/20 revealed:
- On 5/14/20 the resident had vital signs taken at 3:20 PM and 3:40 PM;
- On 5/15/20 the resident had vital signs taken at 8:00 AM and 3:00 PM;
- On 5/16/20 the resident had vital signs taken once (time not indicated) and at 11:45 AM;

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 726	Continued From page 55 - On 5/17/20 the resident had vital signs taken at 3:00 PM; and - On 5/18/20 the resident had vital signs taken at 11:40 PM. Review of Resident 1's Progress Notes, Assessments, and Vital Signs section in the Electronic Health Record revealed no additional vital signs had been taken (with the order for vital signs every 4 hours) I. Review of an "In-Service Training Sign-In Sheet" dated 5/13/20 with the topic identified as "isolation identification, PPE, Handwashing" revealed 11 staff members had been educated. J. On 5/19/20 at 1:30 PM NA-M was observed to open Resident 18's room door (coming out of the room) and pushed the mechanical sit to stand lift out of Resident 18's room into the hallway. NA-M had on a face shield, mask, and gown and placed the sit/stand lift in the hallway. NA-M stood in Resident 18's doorway and proceeded to remove the gown, this took multiple tries with NA-M touching multiple surfaces on the outside of the gown with bare hands. NA-M then discarded all of the PPE in a trash bin in the hallway approximately 15 feet from the resident's room. NA-M then re-entered the resident's room with no PPE/no mask on and walked over by the sink in the room, mumbles a few words and exited without washing hands. NA-M then got some hand sanitizer out of the dispenser located outside of the resident's room, hand rubbed for approximately 3-5 seconds and proceeded down the hallway. The mechanical sit to stand lift was not observed to have been cleaned (no wipes present to clean with).	F 726		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 726	Continued From page 56	F 726		

Interview with NA-M on 5/19/20 at 1:30 PM confirmed the mechanical sit to stand lift was not cleaned after use. NA-M stated the night shift cleaned the lifts and would need to ask them.

K. Additional interviews revealed:
-Interview with RN-I (who was identified as the facility infection preventionist) on 5/12/20 at 2:10 PM revealed RN-I was unaware of who was on Transmission Based Precautions. When asked if the residents with yellow Isolation Door Caddies or signage on their doors meant the residents were on transmission-based precautions RN-I stated "I don't know I just got here today", when asked when RN-I worked last RN-I stated "last night". When RN-I was asked how the staff were cleaning the reusable blood pressure cuff RN-I was unsure and didn't know if it was actually being cleaned between uses.
- During an interview with RN-L on 5/12/20 at 2:11 PM (who had keys and was in the medication cart on the back hallway), RN-L stated they were "agency" and hadn't worked at the facility in "over a year" and was not sure who was on isolation.
-Interview with Housekeeper-E on 5/13/20 at 7:50 AM confirmed their department was not informed of which residents were on Transmission Based Precautions. Housekeeper-E stated there were "four of them" but wasn't sure which actual residents were involved. Housekeeper-E stated the only way they know if a resident was on Transmission Based Precautions was if they had a sign or a yellow Isolation Door Caddy, if they didn't have one of those items then they would assume they were not on isolation.
-Interview with DA-D on 5/13/20 at 8:10 AM revealed DA-D did not know what residents were currently on isolation. DA-D stated they looked for signage on the residents' doors to indicate this

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 726	Continued From page 57 or an Isolation Door Caddy. DA-D stated they were not supposed to go into any rooms with residents on isolation, they were to leave the meals on the table outside of the resident's door and then nursing would take it from there. - Interview with the Administrator on 5/13/20 at 12:43 PM revealed the residents that were admitted/re-admitted were put into a 14 day "quarantine" and therefore full PPE was not being required.	F 726		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Licensure Reference Number 175 NAC 12-006.02 Based on observation, interviews, and record review; the facility failed to utilize resources to ensure provision of care and services were provided in a manner to prevent potential cross-contamination and the spread of COVID-19 (A highly contagious virus primarily spread from person to person through respiratory droplets, which can lead to serious illness and even death). This had the ability to affect all residents. The sample size was 28 and the facility census was 54. Findings are:	F 835	All residents that reside at t he facility have the potential to be affected by this alleged finding. Temporary Manager arrived to the facility on 5/23/2020. A conference call was conducted on 5/23/2020 at 2 pm with NE ICAP, Dakota County Department of Health, Dr. Ashraf, Administrator of Continental Springs, Rural Health Development Nurse Consultant, and Facility Temporary Manager. There has been constant communication by Facility Temporary Manager and Ne ICAP, Dakota County Department of Health and Dr. Ashraf.	6/10/20

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 835	Continued From page 58 A. An Immediate Jeopardy (IJ) abatement plan was presented by the facility on 5/13/20 at 3:45 PM and 5:17 PM. The facility had identified a plan to ensure all residents that required transmission based precautions were clearly identified, to ensure all staff were screened for temperature and for signs/symptoms of COVID-19 prior to working, to ensure education was completed with staff, to ensure hand hygiene and gloving were used correctly, and to ensure staff were utilizing the correct personal protective equipment when in resident rooms with residents on Transmission Based Precautions. Additional survey was completed on 5/19/20 to ensure the abatement plan was in place with additional concerns identified. B. Review of the facility [redacted] Tracking Log sent 5/18/20 revealed a total of 8 staff members and 6 residents had now tested [redacted] C. Review of the facility COVID-19 Screening Tool dated 5/15/20 to 5/19/20 revealed: - Not all staff were identified as being screened before working. Transportation Aide-F was not identified as screened prior to working on 5/19/20 (The Administrator confirmed the staff member was working). - From 5/14/20 to 5/19/20 10 staff members didn't address if they did or didn't have symptoms of COVID-19. - From 5/14/20 to 5/19/20 staff members identified 14 times they presented with COVID-19 symptoms. There was no evidence the cause of the symptoms were investigated prior to the staff members being allowed to work and provide care for the residents.	F 835	8 Residents were sent to MercyOne Hospital in order to establish zones and clean rooms. Professional cleaning company that has been trained in COVID-19 cleaning was called on 5/23/2020 to clean 8 resident rooms on 5/24/2020 and 7 more rooms cleaned on 5/27/2020. Temporary Manager worked with Maintenance Director and Administrator on 5/23/2020 to identify an appropriate Red Zone. Staff were educated on 5/26/2020 by Temporary Manager, Administrator, Maintenance Director, and MercyOne Hospital Infection Control Education Nurses. Topics included: 1) The Red Zone and Yellow Zone 2) Hand washing with competency 3) New Screening Sheet 4) COVID Binder 5) Donning and Doffing of PPE 6) Cleaning equipment with MicoKill Bleach or Germicidal Bleach Wipe Temporary Manager re-educated Continental Springs Administrator on 6/5/2020 over the following topics: Dignity, Resident Rights, COVID-19 Policies, Abuse, Investigations, and Infection Control PPE. Department heads were in-serviced with all the same training material provided on 6/5/2020. The administrator will submit a bi-weekly report to the State starting 6/21/2020 regarding Infection Control and COVID-19 practices as outlined in the disciplinary notice as sent to the facility and a condition of the facility for being on	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	**3200 G STREET SOUTH SIOUX CITY, NE 68776**

(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 835	Continued From page 59 -The staff member completing the screening was not identified 48 out of 72 times. Interview with the Administrator and the Director of Nursing (DON) on 5/13/20 at 9:00 AM confirmed the staff were allowed to work with COVID-19 symptoms, the DON stated I currently have symptoms (cough and a sore throat) and don't know if I should be here right now. D. Review of Resident 18's Progress Note dated 5/14/20 at 3:17 PM revealed the resident had tested [redacted] On 5/19/20 at 1:30 PM Nursing Assistant (NA)-M was observed to open Resident 18's room door (coming out of the room) and pushed the mechanical sit to stand lift out of Resident 18's room into the hallway. NA-M had on a face shield, mask, and gown and placed the sit/stand lift in the hallway. NA-M stood in Resident 18's doorway and proceeded to remove the gown, this took multiple tries with NA-M touching multiple surfaces on the outside of the gown with bare hands. NA-M then discarded all of the PPE in a trash bin in the hallway approximately 15 feet from the resident's room. NA-M then re-entered the resident's room with no PPE/no mask on and walked over by the sink in the room, mumbles a few words and exited without washing hands. NA-M then got some hand sanitizer out of the dispenser located outside of the resident's room, hand rubbed for approximately 3-5 seconds and proceeded down the hallway. The mechanical sit to stand lift was not observed to have been cleaned (no wipes present to clean with). Interview with NA-M on 5/19/20 at 1:30 PM confirmed the mechanical sit to stand lift was not	F 835	probation. Administrator will complete a weekly administrator report that will be sent to one of the owners of Continental Springs. Department Heads (Maintenance-Transportation, Housekeeping-Laundry, Nursing, Activities, Social Services, Dietary and MDS) will do a bi-weekly report dealing with t heir department updates and COVID-19 related issues noticed in their department. the reports will also be sent to the administrator which will in turn send them to the Owner for 6 months. Updates will be given in QA weekly by Administrator/Designee monthly for 6 months. If needed an action plan will be designed by Administrator.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 835	Continued From page 60 cleaned after use. NA-M stated the night shift cleaned the lifts and would need to ask them. E. Review of the facility list provided on 5/12/20 identified Resident 4 as being on Transmission Based Precautions due to a potential exposure. Observation of Resident 4's room on 5/19/20 at 8:30 AM revealed the resident had no signage to indicate the resident should be on isolation. Interview with the DON revealed the resident had a potential exposure on either 5/7/20 or 5/8/20 with a COVID-19 positive resident (less than 14 days prior). F. Review of a the facility form "Residents on Isolation Precautions" dated 5/12/20 identified Resident 11 as being in Transmission Based Precautions due to symptoms [redacted] Review of a Progress Note dated 5/13/20 at 4:28 PM revealed the Resident 11 was on droplet isolation precaution related to [redacted]. Observation of Resident 11's room on the 5/19/20 revealed a "yield sign" on the resident's door name tag. Licensed Practical Nurse (LPN)-O was observed on 5/19/20 from 9:20 AM to 9:30 AM in Resident 11's room taking the resident's vital signs (blood pressure, oxygen level, temperature). LPN-O had a mask on but no gloves, face shield, or gown. LPN-O exited the resident's room with the reusable equipment in hand. Observed LPN-O clean the items with Sani Hand Sanitizing Wipes. The items had no visible wet time. LPN-O stated	F 835		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 835	Continued From page 61	F 835		

a bleach cleaner was not used on the items as it would discolor or potentially damage the items. LPN-O stated the residents on Transmission Based Precautions should have their own personal equipment. LPN-O was unaware that Resident 11 was supposed to be on Transmission Based Precautions. LPN-O stated they worked for a staffing company and got "very little" information in report.

On 5/19/20 at 9:31 AM, NA-B entered Resident 11's room with clean linens. NA-B had a mask on but no other PPE. NA-B's mask was positioned below the NA's nose (nares visible).

On 5/19/20 at 1:05 PM NA-B entered Resident 11's room to shut off the resident's call light and exited the room. NA-B was wearing only a mask and no other PPE. No hand hygiene was observed when NA-B exited the room.

G. Review of Resident 1's Progress Note dated 5/13/20 at 12:01 AM revealed the resident had tested [redacted]

Observation of Resident 1's room door on 5/19/20 at 8:10 AM revealed the resident had an Isolation Door Caddy on the room door. The resident's room did not have a room number, name tag, and did not have a red "stop" sign indicating the resident was on Transmission Based Precautions.

H. Review of Resident 3's Progress Note dated 5/11/20 revealed the resident enjoyed strolling in the hallways of the facility, enjoyed sitting in the back hallway, and enjoyed smoking outside with other residents.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 835	Continued From page 62 Review of Resident 3's Progress Note dated 5/11/20 at 5:13 PM revealed the resident had left the facility for [redacted] Review of a facility form "Residents on Isolation Precautions" dated 5/12/20 revealed Resident 3 was on Transmission Based Precautions related to [redacted]. Observation of Resident 3's room on 5/19/20 at 8:15 AM revealed no signage to indicate the resident was on Transmission Based Precautions. Interviews with the Administrator and the DON on 5/19/20 at 9:30 AM confirmed Resident 3 had a potential exposure [redacted] resident and also revealed the [redacted] had reported a large number of staff and residents at the [redacted] had tested positive [redacted] I. Resident 26 was observed on 5/19/20 at 8:30 AM to be within 2 feet of Resident 9 (the resident's roommate who had [redacted] On 5/19/20 at 9:15 Resident 5 returned from the smoking area to the resident's room without a mask on. Resident 5 passed less than 6 feet from Resident 26 in the hallway. On 5/19/20 at 1:00 PM Resident 5 exited the resident's room into the hallway without a mask on headed towards the smoking area. Resident 26 also entered the hallway. Residents 5 and 26 passed within 2-3 feet of each other in the hallway. Resident 26 had a mask with notable gapes between the mask edges and the	F 835		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	**3200 G STREET SOUTH SIOUX CITY, NE 68776**

(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 835	Continued From page 63 resident's nose. Resident 26 used the hand rail along the wall to help move the resident through the hallway. J. Review of an "In-Service Training Sign-In Sheet" dated 5/13/20 with the topic identified as "isolation identification, PPE, Handwashing" revealed 11 staff members had been educated. K. The facility was unable to provide monthly infection control surveillance. L. Interview with the Administrator on 5/19/20 at 9:30 AM confirmed the only education that had been done in the past week was "just what we did when you guys were here". Stated the other staff should have got the information "passed along in report". The Administrator stated they had a communication book at the front nurse's station, but confirmed they didn't have one for the back nurse's station. The Administrator did not know if the facility had any policies in place related to COVID-19 and in regards to when employees were safe to return work. The Administrator stated "not sure we have anything written on COVID-19 policies" but stated that they were "always talking about it". When asked about the staff screening process prior to work the Administrator stated the charge nurses should know how to screen the staff. When asking the Administrator about the difference between red "stop" signs and yellow "yield" signs on residents' doors and the precautions to be taken the Administrator stated staff needed full PPE on "anytime" a staff member went into a room with a red "stop" sign, but a yellow "caution" sign the staff doing direct care were to wear full PPE and but felt indirect care in the room the staff could use gloves and mask. When asked what	F 835		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 835	Continued From page 64 constituted "direct care" for residents in yellow "yield" sign rooms, such as taking vital signs, the Administrator felt that task would not necessarily warrant full PPE. Stated it would depend on the specifics on the resident and what they had going on. Stated if they were coughing then they should probably wear more PPE and if they weren't coughing then not necessarily. The Administrator stated "I honestly don't know" what Resident 11 has. Further interview revealed the staff were entering the building through the back entrance and then going through the building to the front entrance to be screened. Interview with the DON on 5/19/20 at 9:40 AM confirmed the facility had initiated staff training the week prior (5/13/20) and thought maybe 10 staff had received that education and confirmed no other documented training had occurred since. The DON stated all reusable resident equipment, including that used to check vital signs should be cleaned using Sani disinfectant wipes, not the Sani hand sanitizing wipes. The DON confirmed yellow "yield" sign and red "stop" sign resident should all be treated "exactly the same" in regards to transmission-based precautions and PPE. When asked when a resident that was in a yellow yield sign room could come out of transmission-based precautions the DON was unsure and stated they shouldn't be taking residents out of precautions that they should remain that way to ensure safety.	F 835		
F 880 SS=L	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	F 880		6/10/20

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	**3200 G STREET SOUTH SIOUX CITY, NE 68776**

(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 65 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: (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	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
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 66 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 observation, interview, and record review; the facility failed to implement infection control practices and Centers for Medicare and Medicaid Services (CMS) guidelines to prevent potential cross contamination including the spread of COVID-19 (A highly contagious virus primarily spread from person to person through respiratory droplets, which can lead to serious illness and even death) related to: 1) staff members unaware of residents on Transmission Based Precautions (the second tier of basic infection control and are to be used in addition to Standard Precautions for patients who may be	F 880	All residents have the potential to be affected. Temporary Manager arrived to the facility on 5/23/2020. A conference call was conducted on 5/23/2020 at 2 pm with NE ICAP Medical Director, Dakota County Department of Health, Administrator of Continental Springs, Rural Health Development Nurse Consultant, and Facility Temporary Manager. There has been constant communication by Facility Temporary Manager and NE ICAP, Dakota County Department of Health and ICAP Medical Director.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 67 infected with certain infectious agents for which additional precautions are needed to prevent infection) and/or not wearing appropriate PPE (Personal Protective Equipment- can include items such as gowns, gloves, masks, goggles, face shields, and foot coverings) when in rooms of resident's that should have been on Transmission Based Precautions, 2) residents that required Transmission Based Precautions did not have any indication on their rooms to identify this, 3) breaks in gloving and hand hygiene practices, 4) a [redacted] resident leaving the residents room and within 6 feet of another resident without a mask on, 5) residents in the hallway without face masks, 6) cleaning of reusable equipment and facility cleanliness, and 7) symptomatic residents without ongoing monitoring and isolation not initiated at the time that symptoms were first identified. This had the ability to affect all residents. The total sample size was 28 and the facility census was 54. Findings are: A. Review of the Centers for Medicare and Medicaid Services 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 (Center for Disease Control) website for information and resources. Per the CDC, prompt detection, triage, and isolation of potentially infectious residents are essential to prevent unnecessary exposures among residents and healthcare personnel; -restriction of all visitors and non-essential	F 880	The facility has been able to increase staffing numbers with agency assistance. So far, the facility has 3 temporary aides and 3 agency nurses. We are lookin to interview staff for different positions. 8 Residents re sent to MercyOne Hospital in order to establish zones and clean rooms. Professional cleaning company that has been trained in COVID-19 cleaning was called on 5/23/2020 to clean 8 resident rooms on 5/24/2020 and 7 more rooms cleaned on 5/27/2020. A housekeeping in-service was held by the Environmental Services/Maintenance Director for all housekeeping staff, some activity staff, and resident transportation staff. The ICAP/Nebraska Med environmental cleaning in healthcare videos were used. A cleaning checklist was discussed and implemented for all rooms on 5/26/2020. An all staff education I-service by Mercy Hospital Infection Control Educational Nurses, Administrator, Maintenance and Housekeeping Supervisor, and Temporary Manager by video conference) occurred on 5/826/2020 to address the deficient COVID-19 infection control practices. the following is a list of topics discussed at the in-services. Staff that were not at this in-service will receive the same education. 1) COVID-19 Procedures (given to staff and reviewed with staff) 2) Proper donning and doffing with all staff (handouts for all staff and	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 68 healthcare personnel except for certain end of life situations; -cancel all group activities and communal dining; -implement active screening of residents for fever and respiratory symptoms; -screen all staff at the beginning of their shift for fever and respiratory symptoms. Actively take their temperatures and document the absence of shortness of breath, new or change in cough and sore throat. If they are ill, have them put on a mask and then self-isolate at home; -the facility should identify staff that work at multiple facilities (such as agency staff) and actively screen and restrict them appropriately to ensure they do not place individuals in the facility at risk for COVID-19; and -properly clean, disinfect, and limit sharing of medical equipment between residents and areas of the facility. B. Review of the CMS Clinical Standards and Quality, Safety and Oversight Group dated 3/23/20 revealed additional guidance. Where the patient/resident was sleeping at the health care facility, signage on the patient's room was important to ensuring that all staff were aware of the necessary infection control steps. C. Review of Resident 13's Progress Notes revealed the resident was admitted to the facility on [redacted]. Review of the Resident's Progress Notes, Skilled Charting, and Facility Temperature Logs revealed no evidence the resident was screened for COVID-19 symptoms on [redacted] Review of Resident 13's Progress Notes revealed	F 880	competencies given by MercyOne Hospital educational infection control trained nurses). 3) Review of Red Zones/Yellow Zones/Gray/and Green Zones (currently we only have Yellow but waiting on results from all residents that were tested by the National Guard at the facility on 5/21/2020. 4) Educated staff about new screening sheet implemented on 5/24/2020 to include O2 stats as well 5) Educated staff of the importance of the nurse or designee that has been trained to screen staff getting all the vital signs and additional screening information. 6) Educated all staff of the mandate that no staff self-screen. 7) Educated all staff on the importance of screening 2 times during their shift. 8) Hand washing 9) Location of the COVID-19 binder 10) Educated all staff about the information that is in the COVID-19 binder 11) Explain the Colored Zones on the doors/walls (RED and YELLOW)it was decided there would be no Green Zone because with the number of positive resident and staff it was determined all staff and residents might have been exposed. 12) Explain proper donning/doffing posters are hanging by clean PPE drawers by hallway door entrances. 13) Educated all staff about hooks to hang your face mask (make sure your name is on it) clean N95 mask every break period and end of day with	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 69 the resident was admitted to the hospital on [redacted]. D. Review of the facility form "Residents on Isolation Precautions" dated 5/12/20 identified Resident 8 as being on Transmission Based Precautions related to [redacted]. Observation on 5/13/20 at 10:20 AM revealed LPN-A in the resident's room with a mask on but no other PPE. LPN-A was helped move the resident's wheelchair towards the resident's bedside tray table and helped reposition the resident's feet on the base of the table. LPN-A then went and got gloves (didn't complete hand hygiene first) and then assisted the residents roommate (Resident 28) to the bathroom. The curtain was not pulled and the residents passed within 6 feet of each other. E. Review of the facility form "Residents on Isolation Precautions" dated 5/12/20 identified Resident 11 as being in Transmission Based Precautions due to [redacted] Observation of Resident 11's room door/entry-way on 5/13/20 at 8:30 AM revealed no indication that the resident was supposed to be on Transmission Based Precautions. The room door/entry-way had no yellow Isolation Door Caddy, no signage, and no table outside of the door for dietary to deliver meals. The divider curtain between the resident and the resident's roommate was open. F. Review of Resident 16's Progress Notes dated 5/1/20 at 12:33 AM revealed the resident was very pleasant with staff, asked for an [redacted] and [redacted] Then stated the resident was going	F 880	alcohol-wipe. 14) Educated all staff about bags with staff names on them located in the service hallway. Put N95 mask in your bag and your name should be on the N95 mask as well. Can be reused until soiled. All residents that smoke and are in isolation have been restricted from smoking to protect from the potential spread of COVID-19. Alternative methods other that smoking have been sought. The DON/Designee have educated staff on the electronic pocket care plans. Administrator/Designee will attend the ICAP weekly update meetings along with the weekly Governor update information on COVID-19 requirements for opening the state. Any updates will be communicated in Center Cats, Morning Meetings and in the COVID-19 Binder. The facility will start to implement a white board that will keep current information that is pertinent to residents in a secure location for privacy but will allow for better communication amongst employees. This white board will include residents with COVID-19, infections and other pertinent information The white board will be covered by a curtain or some other material that will provide the privacy needed regarding this resident information. DON/Designee will check that the White Board is regularly updated. The Administrator/Designee will monitor	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 70 to go make rounds. The resident then rode around the facility in the resident's wheelchair. Interview with the Administrator on 5/13/20 at 7:50 AM revealed 4 residents had [redacted] Observation of Resident 16's room on 5/13/20 from 8:00 AM to 10:00 AM revealed no sign on the door and no yellow Isolation Door Caddy to indicate the need for isolation. Observation of Resident 16 on 5/13/20 from 9:20 AM to 9:25 AM revealed Resident 16 self-propelled down the hallway (east of the dining room) in the resident's wheelchair and through the dining room. Resident 16 had a mask on that was below the resident's mouth and nose. Resident 15 also self-propel down the hallway (east of the dining room) and through the dining room at the same time passing with 3 to 4 feet of Resident 16. Resident 15 did not have a mask on. Resident 16 knocked on the door to be let out to smoke with the other smoking residents. Nursing Assistant (NA)-C opened the door and told Resident 16 that they would have to smoke by themselves and that the resident should have the mask on. NA-A then closed the door. NA-A did not direct Resident 16 back to the resident's room and did not ensure other residents remained over 6 foot from the resident. As NA-A closed the door Resident 16 yelled out loudly. Resident 16 then pulled the mask up covering the resident's mouth and nose. Resident 16 backed up to the side of the hallway outside by the door leading to the smoking area. Resident 15 passed by Resident 16 within 2 to 3 feet and knocked on the door to be let out to smoke. NA-A let Resident 15 outside at that time.	F 880	the CDC website for information and resources frequently for updates and those updates will be added to the COVID-19 Binder and be included in the infectious control monthly in-service or more often as needed. A QA performance improvement plan (IP) was created on 6/7/2020 and will be monitored during QA progress. The facility is advertising for a nurse with infection control background to assist the facility in implementing a strong infection control program. This infection control nurse will oversee implementation of policies and procedures related to a robust infection control program along with assisting with in-service trainings for all staff. The Infection Control nurse/Designee will hold monthly all staff in-services designed specifically for infection control. These in-services will be centered around an infection control educational videos, discussion, print outs, competencies, or educational nurse speakers. These in-services will have minutes along with educational material and employee signatures documented in a folder specifically for infection control. The Administrator/Designee will complete infection control bi-weekly updates to the State to show their progress toward t he implementation of a strong infection control program. First report to the State will be 6/21/2020 per probation sections identified in letter from State. DON/Designee will observe 5 staff	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	**3200 G STREET SOUTH SIOUX CITY, NE 68776**

(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 71 Interview with the Director of Nursing (DON) on 5/13/20 at 9:30 AM revealed the resident was non-compliant with isolation and would leave the residents room and go into the hallway. The resident had been given a mask to wear, but would not always wear it. No other interventions had been identified to protect other resident's from Resident 16 related to the resident's non-compliance. Interview with the Administrator and the DON on 5/13/20 at 1:30 PM revealed the facility had attempted to put signage up on Resident 16's door but the resident became angry and removed it as the resident was in denial about being [redacted]. The DON and Administrator revealed no other steps had been taken to ensure staff in all departments knew about Resident 16's need for Transmission Based Precautions when interacting/assisting the resident. G. Review of the facility form "Residents on Isolation Precautions" dated 5/12/20 identified Resident 4 as being on Transmission Based Precautions due to [redacted]. Observation of breakfast meal delivery on 5/13/20 from 8:00 AM to 8:30 AM revealed Dietary Aide (DA)-D delivered drinks to room 302, prior to going to room 301 DA-D changed gloves but failed to perform hand hygiene after removing gloves. DA-D continued down the hallway changing gloves between residents but not performing hand hygiene when changing gloves. DA-D then got to Resident 4's room. The table outside of the room had PPE setting on top of it. DA-D commented "what is going on with"	F 880	members 5 time weekly different shifts for handwashing, proper donning and doffing of PPE until 4 consecutive weeks o no negative findings and then 5 staff members 3 times weekly for no less than 6 months. Resident Room Cleaning-Maintenance Director/Designee will monitor Housekeeping Staff 2 X;s weekly for proper cleaning and use of checklist of resident rooms until 4 consecutive weeks with no negative findings then once weekly for no less that 6 months. DON/Designee will monitor staff screening 3X X weekly for accurate/complete documentation until 4 consecutive weeks with no negative findings, then one weekly for at least 6 months. Results will be submitted through the QA/QAPI process by the DON and/or Designee monthly for review/recommendations. Any patterns will e identified. If necessary, and Action Plan will be written by the IDT and monitored by the DON/Admin weekly until resolved.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 72 Resident 4. Housekeeper-E walked by at that time and said the resident was [redacted] and that "this" wasn't needed anymore (while moving the PPE off of the table). NA-D then entered Resident 4's room to deliver breakfast drinks, touched items in the resident's room including bedside table, came back out and took a packet of creamer from a plastic baggie with multiple packets in it and took a milk of out the ice bin with multiple individual milks without changing gloves/hand hygiene prior. After completing Resident 4's drinks NA-D changed gloves but didn't complete hand hygiene prior to moving on to the next resident. The gown NA-D was wearing while delivering all meals remained in place after Resident 4's room as well. H. On 5/13/20 at 10:21 AM NA-B entered Resident 18's room with NA-B's face mask not covering the NA's nose (bilateral nares visible) and was within 6 feet of the resident. I. Review of the facility staff/visitor screening logs dated 4/22/20 to 5/12/20 revealed all staff members did not have screening completed related to signs/symptoms of COVID-19. In those cases the staff members' temperature was listed but no indication as to whether the staff had symptoms of COVID-19 was recorded. Further review RN-H did not have documentation of screening for signs/symptoms of COVID-19 on the night of 5/7/20 when the RN worked the over-night shift into 5/8/20. (RN-H was identified as testing COVID-19 positive on 5/9/20) Interview with the Administrator on 5/12/20 at 1:45 PM revealed the staff members had been screening themselves prior to working.	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
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 73	F 880		

J. Review of the "Handwashing Sign in Sheet In-service" dated 4/9/20 revealed only 14 staff members had completed the competency training.

Review of a "Staff Meeting Agenda" dated 3/12/20 and 4/1/20 confirmed staff were to wear masks. Another review was completed with staff on when to wash hands and how to properly use hand gel. Anyone that entered the building was to be screened, and "99 percent of exposure is not because virus on hands, but touching face".

Review of the facility employee listing revealed the facility had approximately 59 staff employed in the nursing home.

K. Confidential resident interview on 5/12/20 at 2:00 PM revealed the resident had a potential exposure with a COVID-19 positive resident. The resident was upset that there was no indication on the other resident's door that this resident shouldn't enter. The resident was upset and felt the facility had put the resident at risk.

Review of the resident's Progress Notes dated 3/20/20 to 5/12/20 revealed no evidence that the resident had been educated on not going into other resident rooms.

L. Observations made throughout the facility on 5/12/20 from 1:45 PM to 2:00 PM revealed small linen carts with clean linens on them located on the Center and North hallways were completely uncovered.

Observations were made of Residents in the hallways throughout the day on 5/12/20. This included Resident 14 who self-ambulated

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 74 throughout all the hallways in the facility without a mask on and Resident 27 who self-propelled in the resident's wheelchair throughout the Center hallway. (This could have potentially contaminated the clean linens) M. On 5/12/20 at 2:00 PM the facility floors had soiled areas throughout. The North hallway had distinct foot prints on the floor and a white/pink substance near the North wing corridor that was dried with a footprint impression in it. Down the Center and Back hallway were round dried circles of an unknown substance. On 5/13/20 at 7:50 AM noted the facility floor had soiled areas throughout. The North hallway had distinct foot prints on the floor and a white/pink substance near the North wing corridor that was dried with a footprint impression in it remained. Down the Center and Back hallway the round dried circles of an unknown substance remained. Resident 14 noted to be ambulating in the hallways on 5/13/20 at 7:45 AM with gripper socks on and no shoes. Interview with Housekeeper-E on 5/13/20 at 7:50 AM confirmed floor in the hallways should be cleaned daily but wasn't sure if that had happened on 5/12/20. N. On 5/12/20 at 4:20 PM Transportation Staff -F entered the facility from the service wing, without wearing a mask. Transportation Staff-F walked down the Center hall, spoke with another staff regarding a transport, and then walked back out through the service door. O. Further staff interviews revealed:	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
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 75 - Interview with RN-I (who was identified as the facility infection preventionist) on 5/12/20 at 2:10 PM revealed RN-I was unaware of who was on isolation. When asked if the residents with yellow Isolation Door Caddies or signage on their doors meant the residents were on transmission-based precautions RN-I stated "I don't know I just got here today", when asked when RN-I worked last RN-I stated "last night". When RN-I was asked how the staff were cleaning the reusable blood pressure cuff RN-I was unsure and didn't know if it was actually being cleaned between uses. - During an interview with Registered Nurse (RN)-L on 5/12/20 at 2:11 PM (who had keys and was in the medication cart on the back hallway), RN-L stated they were "agency" and hadn't worked at the facility in "over a year" and was not sure who was on Transmission Based Precautions. - Interview with the DON on 5/12/20 at 2:45 PM revealed Resident 13 was transferred to the hospital from the [redacted] When asked if the staff were utilizing N-95 masks when working with residents on isolation the DON stated "I can't say that they are". The DON was unsure how the staff were supposed to be cleaning the reusable wrist blood pressure cuff. The DON confirmed RN-I worked Monday through Friday 2:00 PM to 10:00 PM as a charge nurse and was supposed to work on infection control during those shifts, as time allowed. RN-I had no time designated to infection control. -Interview with Housekeeper-E on 5/13/20 at 7:50 AM confirmed their department was not informed of which residents were on Transmission Based Precautions. Housekeeper-E stated there were "four of them" but wasn't sure which actual	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
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 76	F 880		

residents were involved. Housekeeper-E stated the only way they know if a resident was on Transmission Based Precautions was if they had a sign or a yellow Isolation Door Caddy, if they didn't have one of those items then they would assume they were not on Transmission Based Precautions.
-Interview with DA-D on 5/13/20 at 8:10 AM revealed DA-D did not know what residents were currently on Transmission Based Precautions. DA-D stated they looked for signage on the residents' doors to indicate this or an Isolation Door Caddy. DA-D stated they were not supposed to go into any rooms with residents on Transmission Based Precautions, they were to leave the meals on the table outside of the resident's door and then nursing would take it from there.
- Interview with the Administrator on 5/13/20 at 12:43 PM revealed the residents that were admitted/re-admitted were put into a 14 day "quarantine" and therefore full PPE was not being required. The administrator confirmed N-95 masks should be worn when entering the room for residents that were positive for COVID-19 or symptomatic.
- Interview with the Director of Nursing and Administrator on 5/12/20 at 1:00 PM revealed the facility had 1 resident [redacted] who had been transferred to the hospital and [redacted] and had 2 staff members Dietary Aide-J and Registered Nurse-H who had tested positive for COVID-19. No current residents in the facility with [redacted] Three resident's had direct contact with [redacted] and were supposed to be on Transmission Based Precautions now. The facility was supposed to be screening all residents. All staff

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 77	F 880		

were to wear masks at all times, and residents had to wear masks when leaving their rooms. The DON reported they had some trouble with compliance of residents and the staff were to remind and educate the residents when they saw this. The staff should encourage residents to return to their rooms. All new admissions were to be put on a 14 day quarantine. (The facility did not indicate residents that had direct contact with RN-H had been identified and placed on Transmission Based Precautions).

An abatement plan was provided by the facility on 5/13/20 at 3:45 PM with additional information sent via email on 5/13/20 at 5:17 PM. As part of the abatement plan the facility was to mark all rooms that required transmission-based precautions with either a red "stop" sign (meaning COVID-19 positive) or a yellow "yield" sign (meaning the resident was symptomatic of COVID-19, had an exposure, or was a new/re-admission).

Additional on-site investigated was completed on 5/19/20 with additional concerns identified.

P. Review of the facility [redacted] Tracking Log sent 5/18/20 revealed a total of 8 staff members and 6 residents had [redacted]

Q. Review of the facility [redacted] Screening Tool dated 5/15/20 to 5/19/20 revealed:
- Not all staff were identified as being screened before working. Transportation Aide-F was not identified as screened prior to working on 5/19/20 (The Administrator confirmed the staff member was working).
- From 5/14/20 to 5/19/20 10 staff members didn't

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 78 address if they did or didn't have symptoms of COVID-19. - From 5/14/20 to 5/19/20 staff members identified 14 times they presented with COVID-19 symptoms. There was no evidence the cause of the symptoms were investigated prior to the staff members being allowed to work and provide care for the residents. -The staff member completing the screening was not identified 48 out of 72 times. Interview with the Administrator and the DON on 5/13/20 at 9:00 AM confirmed the staff were allowed to work with COVID-19 symptoms, the DON stated I currently have symptoms (cough and a sore throat) and don't know if I should be here right now. R. Review of Resident 18's Progress Note dated 5/14/20 at 3:17 PM revealed the resident [redacted] On 5/19/20 at 1:30 PM NA-M was observed to open Resident 18's room door (coming out of the room) and pushed the mechanical sit to stand lift out of Resident 18's room into the hallway. NA-M had on a face shield, mask, and gown and placed the sit/stand lift in the hallway. NA-M stood in Resident 18's doorway and proceeded to remove the gown, this took multiple tries with NA-M touching multiple surfaces on the outside of the gown with bare hands. NA-M then discarded all of the PPE in a trash bin in the hallway approximately 15 feet from the resident's room. NA-M then re-entered the resident's room with no PPE/no mask on and walked over by the sink in the room, mumbles a few words and exited without washing hands. NA-M then got some hand sanitizer out of the dispenser located	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
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	**3200 G STREET SOUTH SIOUX CITY, NE 68776**

(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 79 outside of the resident's room, hand rubbed for approximately 3-5 seconds and proceeded down the hallway. The mechanical sit to stand lift was not observed to have been cleaned (no wipes present to clean with). Interview with NA-M on 5/19/20 at 1:30 PM confirmed the mechanical sit to stand lift was not cleaned after use. NA-M stated the night shift cleaned the lifts and would need to ask them. S. Review of the facility list provided on 5/12/20 identified Resident 4 as being on Transmission Based Precautions due to a potential exposure. Observation of Resident 4's room on 5/19/20 at 8:30 AM revealed the resident had no signage to indicate the resident should be on Transmission Based Precautions. Interview with the DON revealed the resident had a potential exposure on either 5/7/20 or 5/8/20 with a COVID-19 positive resident (less than 14 days prior). T. Review of a the facility form "Residents on Isolation Precautions" dated 5/12/20 identified Resident 11 as being in Transmission Based Precautions [redacted] Review of a Progress Note dated 5/13/20 at 4:28 PM revealed the Resident 11 was on droplet isolation precaution related to [redacted] Observation of Resident 11's room on the 5/19/20 revealed a "yield sign" on the resident's door name tag.	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
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	**3200 G STREET SOUTH SIOUX CITY, NE 68776**

(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 80	F 880		

LPN-O was observed on 5/19/20 from 9:20 AM to 9:30 AM in Resident 11's room taking the resident's vital signs (blood pressure, oxygen level, temperature). LPN-O had a mask on but no gloves, face shield, or gown. LPN-O exited the resident's room with the reusable equipment in hand. Observed LPN-O clean the items with Sani Hand Sanitizing Wipes. The items had no visible wet time. LPN-O stated a bleach cleaner was not used on the items as it would discolor or potentially damage the items. LPN-O stated the residents on Transmission Based Precautions should have their own personal equipment. LPN-O was unaware that Resident 11 was supposed to be on Transmission Based Precautions. LPN-O stated they worked for a staffing company and got "very little" information in report.

On 5/19/20 at 9:31 AM, NA-B entered Resident 11's room with clean linens. NA-B had a mask on but no other PPE. NA-B's mask was positioned below the NA's nose (nares visible).

On 5/19/20 at 1:05 PM NA-B entered Resident 11's room to shut off the resident's call light and exited the room. NA-B was wearing only a mask and no other PPE. No hand hygiene was observed when NA-B exited the room.

U. Review of Resident 1's Progress Note dated 5/13/20 at 12:01 AM revealed the resident had [redacted].

Observation of Resident 1's room door on 5/19/20 at 8:10 AM revealed the resident had an Isolation Door Caddy on the room door. The resident's room did not have a room number, name tag, and did not have a red "stop" sign

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 81 indicating the resident was on transmission-based precautions. V. Review of Resident 3's Progress Note dated 5/11/20 revealed the resident enjoyed strolling in the hallways of the facility, enjoyed sitting in the back hallway, and enjoyed smoking outside with other residents. Review of Resident 3's Progress Note dated 5/11/20 at 5:13 PM revealed the resident had left the facility for [redacted] Review of a facility form "Residents on Isolation Precautions" dated 5/12/20 revealed Resident 3 was on Transmission Based Precautions related to a potential exposure. Observation of Resident 3's room on 5/19/20 at 8:15 AM revealed no signage to indicate the resident was on Transmission Based Precautions. Interviews with the Administrator and the DON on 5/19/20 at 9:30 AM confirmed Resident 3 had a potential exposure [redacted] resident and also revealed the [redacted] had reported a large number of staff and residents at the [redacted] W. Resident 26 was observed on 5/19/20 at 8:30 AM to be within 2 feet of Resident 9 (the resident's roommate who had symptoms of COVID-19). On 5/19/20 at 9:15 Resident 5 returned from the smoking area to the resident's room without a mask on. Resident 5 passed less than 6 feet from	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
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	**3200 G STREET SOUTH SIOUX CITY, NE 68776**

(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 82 Resident 26 in the hallway. On 5/19/20 at 1:00 PM Resident 5 exited the resident's room into the hallway without a mask on headed towards the smoking area. Resident 26 also entered the hallway. Residents 5 and 26 passed within 2-3 feet of each other in the hallway. Resident 26 had a mask with notable gaps between the mask edges and the resident's nose. Resident 26 used the hand rail along the wall to help move the resident through the hallway. X. Review of an "In-Service Training Sign-In Sheet" dated 5/13/20 with the topic identified as "isolation identification, PPE, Handwashing" revealed 11 staff members had been educated. Y. The facility was unable to provide monthly infection control surveillance. Z. Interview with the Administrator on 5/19/20 at 9:30 AM confirmed the only education that had been done in the past week was "just what we did when you guys were here". Stated the other staff should have got the information "passed along in report". The Administrator stated they had a communication book at the front nurse's station, but confirmed they didn't have one for the back nurse's station. The Administrator did not know if the facility had any policies in place related to COVID-19 and in regards to when employees were safe to return work. The Administrator stated "not sure we have anything written on COVID-19 policies" but stated that they were "always talking about it". When asked about the staff screening process prior to work the Administrator stated the charge nurses should know how to screen the staff. When asking the	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
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	**3200 G STREET SOUTH SIOUX CITY, NE 68776**

(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 83	F 880		

Administrator about the difference between red "stop" signs and yellow "yield" signs on residents' doors and the precautions to be taken the Administrator stated staff needed full PPE on "anytime" a staff member went into a room with a red "stop" sign, but a yellow "caution" sign the staff doing direct care were to wear full PPE and but felt indirect care in the room the staff could use gloves and mask. When asked what constituted "direct care" for residents in yellow "yield" sign rooms, such as taking vital signs, the Administrator felt that task would not necessarily warrant full PPE. Stated it would depend on the specifics on the resident and what they had going on. Stated if they were coughing then they should probably wear more PPE and if they weren't coughing then not necessarily. The Administrator stated "I honestly don't know" what Resident 11 has. Further interview revealed the staff were entering the building through the back entrance and then going through the building to the front entrance to be screened.

Interview with the DON on 5/19/20 at 9:40 AM confirmed the facility had initiated staff training the week prior (5/13/20) and thought maybe 10 staff had received that education and confirmed no other documented training had occurred since. The DON stated all reusable resident equipment, including that used to check vital signs should be cleaned using Sani disinfectant wipes, not the Sani hand sanitizing wipes. The DON confirmed yellow "yield" sign and red "stop" sign resident should all be treated "exactly the same" in regards to transmission-based precautions and PPE. When asked when a resident that was in a yellow yield sign room could come out of transmission-based precautions the DON was unsure and stated they shouldn't be taking

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 84 residents out of precautions that they should remain that way to ensure safety. A determination was made that the facility's noncompliance placed all residents in immediate jeopardy. On 5/19/20, the IJ cited on 5/12/20 remained ongoing. AA. Review of Resident 17's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 3/25/20 revealed the resident was admitted to the facility on [redacted] Review of Resident 17's Nursing Progress Notes revealed the following: -4/14/20 at 2:48 PM the resident was assessed as having a temperature of [redacted] -4/17/20 at 8:42 AM the resident's temperature was [redacted]. The resident's physician was notified of these concerns; -4/20/20 at 4:56 PM the resident complained of [redacted]. A new order was received for [redacted] -4/25/20 at 9:11 PM the resident had complaints of [redacted]; -4/28/20 at 10:52 AM the resident voiced complaint [redacted]; -4/30/20 at 12:32 AM a facsimile (fax) was received from the resident's physician which identified new orders for [redacted] nd for	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
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 85	F 880		

[redacted] every 6 hours as needed [redacted]

-5/5/20 at 1:02 PM the resident complained [redacted]

-5/7/20 at 11:06 AM the resident was admitted to the hospital with a diagnoses of [redacted];
and
-5/12/20 at 6:43 PM the resident was re-admitted from the hospital. [redacted] was inserted 5/10/20 to the resident's [redacted] Further review of the resident's medical record revealed no evidence from 4/4/20 through 5/12/20 the resident was placed on Transmission Based Precautions despite the resident having [redacted] and a recent hospitalization.

An observation on 5/13/20 at 09:20 AM revealed a wheelchair was positioned in the corridor outside of Resident 17's room. Further observation revealed there were several packaged isolation gowns and blue plastic disposable gowns positioned on the seat of the wheelchair. In addition, a box which contained several containers of disposable gloves in various sizes was observed on the foot pedals of the wheelchair. There were no signs on the closed door of the resident's room or on the walls outside of the room to indicate the resident was [redacted] or

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 86 that the resident was on Transmission Based Precautions. During an interview on 5/13/20 at 9:25 AM, Medication Aide (MA)-K identified Resident 17 had been re-admitted from the hospital the evening of 5/12/20. MA- was unaware if the resident was currently on Transmission Based Precautions but indicated the resident's roommate remained in the room with Resident 17. MA-K was unable to identify which of the facility's current residents were to be on Transmission Based Precautions. Review of Resident 17's Nursing Progress Notes revealed the following: -5/14/20 at 3:25 PM the resident's physician was notified the resident had complaints [redacted] -5/14/20 at 6:23 PM a fax was received from the resident's physician with an order to [redacted] -5/15/20 at 1:38 PM the resident left the facility for a [redacted] appointment; -5/19/20 at 6:43 PM the resident was complaining of [redacted] An order was received to transfer the resident to the hospital; and -5/19/20 at 7:49 PM the facility received a call from the hospital indicating the resident was now [redacted]. BB. Review of Resident 7's MDS dated 3/14/20 revealed the resident was admitted on [redacted]	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
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 87 Review of Resident 7's Nursing Progress Notes revealed the following: -3/25/2020 at 7:59 PM the resident was observed to [redacted] The resident was placed on [redacted] and -3/26/2020 at 3:09 AM the resident was observed to sleep long intervals with eyes closed and [redacted]. Further review of the resident's medical record revealed no evidence the resident was placed on Transmission Based Precautions [redacted] Review of Resident 7's Nursing Progress Notes revealed the following: -5/9/20 at 8:48 PM the resident was identified as receiving [redacted]; -5/12/20 at 11:52 PM the facility was notified Resident 7 had [redacted] Isolation precautions were put into place. The note further indicated staff were to complete vital signs every 4 hours as ordered by the resident's physician; -5/13/20 at 3:48 PM the resident's [redacted]	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
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 88 -5/13/20 at 4:34 PM a fax was sent to the resident's physician regarding [redacted] -5/13/20 at 8:53 PM the resident's [redacted] The resident's physician was notified of the resident's condition; -5/13/20 at 9:23 PM a new order was received for [redacted] The facility was to encourage the resident to stay up in a wheelchair as much as possible to prevent pneumonia. The resident refused the need for hospitalization at this time; -5/14/20 at 5:30 PM the resident's [redacted] -5/16/20 at 3:55 PM the resident's [redacted] The resident requested to be transported to the hospital. Review of the resident's medical record revealed no evidence the resident was assessed with vital signs completed every four hours as indicated by the resident's physician. CC. Review of Resident 6's MDS dated 4/28/20 revealed the resident was admitted on [redacted]	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
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 89 Review of Resident's 6's Nursing Progress Notes revealed the following: -5/8/20 at 3:52 PM the resident's emergency contact was notified the resident had a potential exposure to another facility resident who had been [redacted] -5/9/20 at 9:08 PM the resident was [redacted] -5/10/20 at 8:50 PM the resident voiced a complaint [redacted] -5/11/20 at 2:55 AM the resident's [redacted] -5/11/20 at 11:43 AM the resident had [redacted] nd -5/12/20 at 7:43 AM the resident has complaints [redacted] During an observation on 5/12/20 at 11:00 AM, the resident's room door was closed. A yellow isolation caddy was hanging over the room door. Further observation revealed the storage caddy was empty. There were no signs on or around the resident's door to indicate the resident was to be on Transmission Based Precautions. Review of a Nursing Progress Noted dated	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
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 90 5/12/20 at 11:56 PM revealed the facility was notified the resident's [redacted].	F 880		

Further review of the resident's Nursing Progress Notes revealed the resident was not placed into Transmission Based Precautions until 5/12/20 at 11:56 PM despite the resident's exposure on 5/8/20 and the resident's [redacted]

An observation on 5/13/20 at 9:00 AM revealed the resident's room door remained closed. The yellow isolation caddy remained hanging from the door and now contained disposable gloves, shoe covers and isolation gowns. The wall outside of the resident's room revealed a sign which indicated staff should not enter the resident's room until talking with a nurse.

DD. During an observation of the 100 corridor on 5/13/20 from 7:50 AM to 8:10 AM, Dietary Aide (DA)-G distributed breakfast meals to the resident's room. DA-G had a cart in the corridor which contained several Styrofoam containers. DA-G was wearing a disposable mask, isolation gown, shoe coverings and gloves. DA-G was observed entering Rooms 111, 110 and 108. A bedside table was positioned in each of these resident rooms. The bedside tables contained various items which included television remote controls, Kleenex boxes, and pieces of loose paper, newspapers and magazines. Without cleansing the tables, DA-G moved aside items on the tables and placed Styrofoam containers onto the bedside tables. DA-G proceeded to open the containers and to provide set-up assistance which included placing straws into cups, opening silverware packets and assisting to cut up food

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 91	F 880		

items for the residents. After exiting the rooms, DA-G removed disposable gloves but failed to wash hands or to use hand sanitizer before putting on a clean pair of gloves, returning to the cart in the corridor and passing the next breakfast meal.

During an interview on 5/13/20 at 8:10 AM, DA-G was unable to identify the residents who were currently on Transmission Based Precautions for positive and/or presumed positive COVID-19. In addition, DA-G confirmed no education had been provided to the dietary staff as to what personal protective equipment (PPE) should be worn when entering the rooms of residents on Transmission Based Precautions or the correct way to put on and to take off the required PPE.

EE. On 5/13/20 from 8:11 AM to 8:30 AM, an observation of medication administration for Resident 19 revealed the following:
-the medication cart was positioned in the corridor outside of room 101. Licensed Practical Nurse (LPN)-A was wearing a disposable mask, isolation gown, shoe coverings and gloves. LPN-A while wearing gloves, opened a drawer of the medication cart and removed several bubble packs which were then placed on the top of the cart, next to a medication cup. LPN-A removed medications from the bubble packs by popping the medications into LPN-A's gloved hands and then placing into the medication cup;
-LPN-A opened the top drawer of the cart and began rummaging through the drawer. LPN-A picked up each individual container in the drawer stating LPN-A was looking for [redacted]. All containers were returned to the drawer and drawer was closed;
-LPN-A opened another drawer of the cart and

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 92 was able to locate [redacted] labeled for Resident 19. LPN-A placed the 3 items on the top of the medication cart; -LPN-A picked up the [redacted] 2 medication cups, a wrist blood pressure cuff, a thermometer, an oximetry machine and 2 individually packaged alcohol wipes from the top of the medication cart. LPN-A adjusted the items several times and finally balanced the items against the staff's isolation gown and took all the items at one time, into the resident's room; -while continuing to hold all of the items, LPN-A removed a paper towel from a dispenser next to the resident's hand-washing sink and placed the paper towel as a barrier on a bedside table in the resident's room. LPN-A failed to cleanse and/or disinfect the surface of the bedside table prior to placing the barrier. LPN-A positioned all of the items carried into the resident's room onto the paper towel barrier; -LPN-A removed gloves and washed hands at resident's sink; -without putting on a clean pair of gloves, LPN-A proceeded to administer the resident's [redacted]; -the resident identified complaints [redacted] and vocalized the inability to consume the breakfast meal. LPN-A indicated [redacted] would not be administered at this time and the LPN would contact the resident's physician; -the blood pressure cuff was placed on the resident's wrist and the cuff malfunctioned; -without washing or sanitizing hands, LPN-A exited the resident's room, opened a drawer of the medication cart and removed another blood pressure wrist cuff from the cart; -still without washing or sanitizing hands, LPN-A placed the second cuff on the resident's wrist and	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
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 93 obtained a blood pressure. LPN-A placed the wrist cuff on the paper towel barrier without cleaning; -LPN-A placed the oximetry machine on the resident's finger and obtained an [redacted] LPN-A questioned the resident regarding a sore throat, cough or shortness of breath. The resident denied any respiratory complaints. LPN-A opened a pre-packaged alcohol wipe and used to cleanse the oximetry machine before returning the machine to the paper towel barrier; -LPN-A used the thermometer to obtain a temperature of [redacted] from the resident's forehead. LPN-A placed the thermometer back on the paper towel barrier without cleansing; -LPN-A reached under the staff's isolation gown and removed a pen from a uniform pocket. LPN-A then used the pen to document the resident's vital signs directly onto the paper towel barrier then returned the pen to the uniform pocket; -LPN-A without washing or sanitizing hands, removed the [redacted] the oximetry machine, the thermometer, the 2 blood pressure wrist cuffs and the paper towel barrier from the resident's room and placed all items on top of the medication cart; and -LPN-A returned the thermometer and 2 blood pressure wrist cuffs to a drawer of the medication cart without cleansing the reusable resident care equipment. During an interview on 5/13/20 at 9:00 AM, LPN-A confirmed the following: -LPN-A had not changed the disposable isolation gown, mask and shoe coverings the LPN was wearing despite going into and out of several resident's rooms including residents who were	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
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 94 [redacted]; -Resident 19's medications and the reusable resident care equipment used to obtain the resident's vital signs should have been cleansed before bringing into the resident's room and the items should not have been held against the LPN's isolation gown; -Resident 19's bedside table should have been cleansed and/or sanitized prior to placing paper towel barrier; -gloves should have been worn with administration of [redacted] -hands should have been washed or sanitized before entering and exiting the resident's room; -all reusable resident care equipment should have been cleansed and/or sanitized after resident use and before returning the items to the medication cart; and -unaware of residents who were currently on Transmission Based Precautions. Findings are: FF. Review of Resident 21's Minimum Data Set MDS dated 3/22/2020 revealed: -the resident received supervision for dressing, toileting, bed mobility and dressing, and -the resident received [redacted] 6 out of 7 days with 1 [redacted] order change. Review of Resident 21's Care Plan dated 3/30/20 revealed no indication that the resident was placed on transmission based precautions. Review of Resident 21's Progress Notes revealed: [redacted] the resident was admitted to the facility.	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
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 95 [redacted] the facility faxed the PCP (primary care physician) requesting [redacted] and reporting parameters. [redacted] the facility received a reply to the fax generated on [redacted] with orders for daily [redacted] monitoring, and an order to submit [redacted] monitoring log to the PCP every 2 weeks. -5/6/20 at 11:30 AM the resident was found lying on the bed, unresponsive, diaphoretic (sweating profusely), and having "seizure-like" activity. The resident had a [redacted] was treated with an [redacted] and transported to the ER (emergency room) for further treatment. -5/6/20 at 5:12 PM the resident returned to the facility with no new orders. The discharge Patient Education Material did recommend [redacted] monitoring for patients receiving [redacted] at least 2 times daily. -5/8/20 at 2:21 PM the resident's family was notified [redacted] -5/8/20 at 9:33 PM the resident was placed in transmission based precautions [redacted] The family and physician were notified. -5/9/20 at 8:50 PM the resident was tested [redacted] -5/13/20 at 12:53 AM the resident's [redacted] -5/15/20 at 3:00 PM the resident had a [redacted] by lunch time, had not eaten breakfast or lunch, and the staff administered [redacted] to raise the resident's [redacted] level. The physician was faxed a	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
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 96 request to change or hold the resident's [redacted] -5/18/20 at 5:27 AM the resident was found [redacted] Further review of the Progress Notes revealed: -no evidence that transmission based precautions were implemented on 3/16/20 at the time of admission. -no evidence that transmission based precautions were implemented following the resident's ER visit on 5/6/20. GG. Review of Resident 9's MDS dated 4/19/20 revealed: -the resident had a [redacted] -the resident received supervision for eating and extensive assistance for bed mobility, transfers, toileting, and dressing. -the resident had [redacted]. Review of Resident 9's Care Plan dated 1/2/20 revealed no evidence that the resident was placed on transmission based precautions. Review of Resident 9's Progress Notes revealed: -on 5/1/20 at 12:25 AM the resident complained of [redacted] and was given medications for the relief of symptoms. -on 5/8/20 at 3:09 PM the resident's emergency contact was informed of [redacted] -on 5/9/20 at 9:25 PM the resident [redacted]	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
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 97 -on 5/11/20 at 2:00 AM the resident [redacted] The physician was notified and recommended transmission based precautions, [redacted] -on 5/14/20 at 3:24 PM the facility was notified the resident's [redacted]. -on 5/16/20 at 5:09 PM the resident had [redacted] and was transferred to the hospital. Further review of the Progress Notes revealed: -no evidence the facility implemented transmission based precautions on 5/1/20 when the resident [redacted] HH. Review of Resident 16's MDS dated 4/21/20 revealed: -the resident received supervision with bed mobility, transfers, dressing, toileting and ate independently -the resident had a [redacted] Review of Resident 16's Care Plan revealed no evidence that the resident was placed on transmission based precautions. Review of Resident 16's Progress Notes revealed: [redacted] the resident was admitted to the facility. -4/1/20 at 9:30 AM the resident left the facility against medical advice in a cab. -4/1/20 at 7:33 PM (10 hours after leaving) the resident returned to the facility in a cab with a police escort. -4/6/20 at 3:17 PM the resident had [redacted] The physician was	F 880		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 98 contacted and ordered [redacted] -4/14/20 at 12:10 PM the residents physician was updated on resident's recent decline and occupational therapy was ordered. -4/16/20 at 5:05 PM the resident's physician order an [redacted] -4/17/20 at 2:02 PM the residents lab tests [redacted] The resident's provider was informed and [redacted] were ordered. -5/9/20 at 9:01 PM the resident was tested for [redacted] -5/13/20 at 12:08 AM the residents [redacted] was reported to the facility as [redacted] and transmission based precautions were implemented. Further review of the Progress Notes revealed: -no evidence that the facility implemented transmission based precautions at the time of admission on [redacted], after the resident left the facility for 10 hours on 4/1/20, when the resident complained [redacted] on 4/6/20, or on 4/16/20 when the physician ordered the [redacted] II. Review of Resident 22's MDS dated 4/27/20 revealed: -the resident was independent with bed mobility and eating, received supervision with toileting and dressing, and received moderate assistance with transfers. -the resident had a [redacted] and	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
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 99 -the resident received [redacted] 5 days in the past 7 days. Review of Resident 22's Care Plan dated 5/7/20 revealed no indication that the resident was placed on transmission based precautions. Review of Resident 22's Progress Notes revealed: -4/21/20 at 6:01 PM the resident was admitted to the hospital, -4/23/20 at 6:07 PM the resident was readmitted to the facility, -5/7/20 at 8:40 AM the resident complained [redacted] The physician was contacted and increased the dose of the resident's [redacted] -5/8/20 at 5:11 PM the resident's family was contacted and informed of positive case(s) of COVID-19 in the facility. -5/9/20 at 9:02 PM the resident was tested [redacted] -5/11/20 at 2:51 AM the resident reported [redacted] -5/14/20 at 2:36 PM the facility was notified that the resident [redacted] and transmission based precautions were started. Further review of the Progress Notes revealed: -no evidence the resident was placed on transmission based precautions on 4/23/20 after being hospitalized, on 5/7/20 when [redacted] or on 5/11/20 when [redacted] JJ. Review of Resident 10's Medical Diagnosis	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
	285082	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL SPRINGS, LLC	3200 G STREET SOUTH SIOUX CITY, NE 68776

(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 100 revealed the resident had [redacted] Review of Resident 10's Care Plan dated 5/6/20 revealed no indication that the resident was placed on transmission based precautions. Review of Resident 10's Progress Notes revealed: [redacted] the resident was admitted to the facility. -5/11/20 at 1:12 PM the resident strolled the hallways of the facility and smoked outside with other residents. Further review of the Progress Notes revealed: -no evidence that transmission based precautions were implemented at the time of admission. KK. Interview on 5/19/20 at 1:30 PM with the DON confirmed that newly admitted residents, resident's readmitted following a hospitalization, resident with a potential high risk exposure, and resident's symptomatic of respiratory infections should be placed on transmission based precautions due to the current COVID-19 pandemic.	F 880		

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

Pete Ricketts, Governor

June 24, 2020

Kristi Jarecki, Administrator
Countryside Home
703 North Main Street
Madison, NE 68748-6009

CMS CERTIFICATION NUMBER:
285207

Dear Ms. Jarecki:

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

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

Pete Ricketts, Governor

June 29, 2020

Heather Jordan, Administrator
Crest View Care Center
420 Gordon Avenue
Chadron, NE 69337

CMS CERTIFICATION NUMBER: 285150

Dear Ms. Jordan:

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

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

Pete Ricketts, Governor

July 7, 2020

Jaclyn Svendgard, Administrator
Crowell Memorial Home
245 South 22nd Street
Blair, NE 68008-1893

CMS CERTIFICATION NUMBER: 285210

Dear Ms. Svendgard:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 26, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

Pete Ricketts, Governor

July 2, 2020

Barbara Aldrich, Administrator
David Place
260 South 10th Street
David City, NE 68632

CMS CERTIFICATION NUMBER: 285074

Dear Ms. Aldrich:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 23, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

Pete Ricketts, Governor

June 24, 2020

Erin Nelson, Administrator
Douglas County Health Center
4102 Woolworth Avenue
Omaha, NE 68105-1899

CMS CERTIFICATION NUMBER: 285019

Dear Ms. Nelson:

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

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

Pete Ricketts, Governor

July 23, 2020

Erin Nelson, Administrator
Douglas County Health Center
4102 Woolworth Avenue
Omaha, NE 68105-1899

CMS CERTIFICATION NUMBER: 285019

Dear Ms. Nelson:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 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
	285119	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNKLAU GARDENS	**450 EAST 23RD STREET FREMONT, NE 68025**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on June 16, 2020. The facility was found to not be in compliance with 42 CFR §483.80 infection control regulations and has not implemented CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total residents: 78	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		

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

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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285119	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNKLAU GARDENS	**450 EAST 23RD STREET FREMONT, NE 68025**

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

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285119	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNKLAU GARDENS	**450 EAST 23RD STREET FREMONT, NE 68025**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement an ongoing system of surveillance designed to identify possible communicable diseases or infections in order to prevent the transmission of these diseases or infections to other persons in the facility. Findings include: An interview on 6/16/20 at 4:30pm, with the Director of Nursing showed: She watches cares regularly and addresses cross-contamination issues as they come up. She does not have a surveillance or tracking log, that is kept on an ongoing basis, for identification of infectious organisms that could be transmitted to the residents. The Infection Preventionist does the monthly tracking of infections by unit. An interview on 6/16/20 at 4:45pm, with the Infection Preventionist showed: She is the Infection Preventionist for the hospital and health center and comes to the facility part-time. She reviews infections in the facility monthly at the QAPI (Quality Assurance Performance Improvement) meeting. She looks at the central lines (intravenous line that goes into a large blood vessel near the center of the body) daily and is primarily concerned with the central lines and UTIs (urinary tract infections).	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
	285119	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNKLAU GARDENS	**450 EAST 23RD STREET FREMONT, NE 68025**

(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 3 The number of infections for the facility are reviewed on a monthly basis. Care is watched on an ongoing basis and staff is educated at the time of the observation. No specific surveillance, tracking, and trending of communicable diseases is in place. There is not an ongoing surveillance log of infections. Record Review of the Infection Control Policy, dated November 2017, showed: The purpose of the policy is to minimize the transmission of diseases and/or microorganisms in a long-term care setting between residents, healthcare personnel, and visitors. The Infection Control Program will be implemented, monitored, and evaluated by the Infection Control Committee. The surveillance program for the ongoing collection, review, and recommendations of health care associated infections will be maintained by the Infection Preventionist, as designated by the Infection Control Committee. The Infection Preventionist will run antibiotic reports from Keane to do surveillance of infections. Record review of the Facility Healthcare Acquired Surveillance, dated 2019, showed: No documentation of monthly infections for May, 2020 and incomplete information for April, 2020. No antibiotic reports were available for review for January, February, March, May, and June of 2020 No infection surveillance reports were available for review for April, May, or June of 2020.	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
	285119	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNKLAU GARDENS	**450 EAST 23RD STREET FREMONT, NE 68025**

(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 Centers for Medicare & Medicaid Services (CMS) on June 16, 2020. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6).	E 000		

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

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.

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

MIDWEST DIVISION OF SURVEY AND CERTIFICATION

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 9, 2020

Rachel Reiman, Administrator
Dunklau Gardens
450 East 23rd Street
Fremont, NE 68025

CMS Certification Number: 285119

Subject: Survey Results
Cycle Start Date: June 16, 2020

Dear Ms. Reiman,

COVID-19 FOCUSED INFECTION CONTROL SURVEY

The Secretary of the U.S. Department of Health and Human Services (DHHS) has the duty and responsibility to protect the health, safety, welfare and rights of Medicare/Medicaid beneficiaries. The Secretary has delegated authority to administer and provide oversight of the Medicare program to Centers for Medicare & Medicaid Services (CMS).
The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-31-All, CMS and the State Survey Agency are conducting unannounced onsite surveys at certain Medicare certified provider and supplier types.
SURVEY RESULTS
On June 16, 2020, a survey was completed at Dunklau Gardens by CMS to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the enclosed form CMS 2567.

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

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

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

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

Kristin Allen, Nurse Consultant
Kristin.Allen@cms.hhs.gov

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

Directed Plan of Correction:
In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction (DPOC) is imposed on the facility. In accordance with 42 CFR § 488.402(f), this remedy is effective July 24, 2020. The DPOC may be completed before or after that date. The effective date is not a deadline for completion of the DPOC. However, CMS will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice.
The DPOC requires that your plan of correction include the following:
- The Infection Preventionist shall develop and implement an infection surveillance or tracking log to be kept on an ongoing basis. The log must document the collection of data and the method that will be used in the tracking and trending of communicable diseases in the facility.

- A Root Cause Analysis (RCA) of the deficient practices cited, conducted with assistance from the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee and Governing Body. The RCA should be incorporated into the intervention plan. Information regarding RCAs can be found at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf

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

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

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

Payment will be denied for all NEW Medicare and Medicaid admissions, beginning August 23, 2020, in accordance with the statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal regulations at 42 CFR §488.417. Your Medicare Administrative Contractor will be notified of the date the denial of payment begins. DPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated.

INFORMAL DISPUTE RESOLUTION (IDR)

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

CDR Marsophia R. Powers, Long Term Care Branch Manager
Email: marsophia.powers@cms.hhs.gov

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

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

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

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

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

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

WITHDRAWAL OF APPROVAL FOR NURSE AIDE TRAINING PROGRAM

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

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

Has been subject to an extended or partial extended survey as a result of a finding of

substandard quality of care;

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

Has been subject to a denial of payment;

Appointment of a temporary manager;

Terminated from participation, and/or

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

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

APPEAL RIGHTS
The following remedies are being imposed:

- Directed Plan of Correction
- DPNA

If you disagree with this action imposed on your facility, you or your legal representative are required to file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/. To file a new appeal using DAB E-File, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.
The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:
Clicking the File New Appeal link on the Manage Existing Appeals screen, then clicking Civil Remedies Division on the File New Appeal screen. Entering and uploading the requested information and documents on the "File New Appeal- Civil Remedies Division" form.
At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. The DAB will set the location for the hearing. Counsel may represent you at a hearing at your own expense.
All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions for using DAB E-File in cases before the DAB’s Civil Remedies Division can be found by clicking the button marked E-Filing Instructions after logging-in to DAB E-File.
For questions regarding the E-Filing system, please contact E-File System Support at

OSDABImmediateOffice@hhs.gov.
Please note that all hearing requests must be filed electronically unless you have no access to the internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. Such a request should be made to:
Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201
A request for a hearing must be filed no later than 60 days from the date of receipt of this notice.
A copy of the hearing request shall be submitted electronically to:
kevin.wright@cms.hhs.gov

If you believe you have achieved substantial compliance, you should contact the CMS RO. In addition, if substantial compliance has not been achieved within six (6) months after the last date of the survey identifying noncompliance, June 2, 2020, we will terminate your Medicare provider agreement effective December 16, 2020.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

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

CONTACT INFORMATION

Thank you for the time and courtesy extended to our surveyors during the survey. If you have any questions regarding the survey, please contact Eddie Grimes, Nurse Consultant. For questions regarding enforcement, Kevin Wright, Health Insurance Specialist. Both can be reached in our Kansas City Regional Office at (816) 426-2011.

Sincerely,

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

Enclosures
CMS 2567

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

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

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 14, 2020

Beth Nelsen, Administrator
Eastmont Towers
6315 O Street
Lincoln, NE 68510 **CMS Certification No. 285036**

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

Dear Administrator,

UNANNOUNCED COVID-19 SURVEY

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

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

SURVEY RESULTS

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

PLAN OF CORRECTION

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

The PoC must contain the following:

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

ENFORCEMENT REMEDIES

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

- **Directed Plan of Correction:**

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

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

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

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

Connie Vogt, RN, BSN

dhhs.healthcarefacilities@Nebraska.gov

In the Subject Line please put: DPOC

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

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

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

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

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

WITHDRAWAL OF APPROVAL FOR NURSE AIDE TRAINING PROGRAM

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

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

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

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

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

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

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

APPEAL RIGHTS

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

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

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

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

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

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

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

CONTACT INFORMATION

If you have any questions please contact this office.

Sincerely,

Connie F Vogt RN,BSN

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

CV/kd

Enclosures: CMS 2567

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

Nebraska DHHS Licensure Unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING: _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTMONT TOWERS	6315 O STREET LINCOLN, NE 68510

(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 242	12-006.17 Infection Control The facility must maintain facility practices to provide a sanitary environment and to avoid sources and transmission of infections and communicable diseases. This includes the establishment and maintenance of an infection control program for the prevention, control, and investigation of infections and communicable disease. This Standard is not met as evidenced by: Based on observation, record review, and interview; the facility failed to implement infection control practices and Centers for Medicare and Medicaid Services (CMS) guidelines to prevent potential cross contamination including the spread of COVID-19 related to failing to ensure staff temperature screening was completed in the facility. The facility census was 15. Findings are: A) Observation on 6/30/20 at 1:43 PM of the front door and screening area revealed NA-B (Nurse Aide) entered the building, performed hand hygiene and entered the screening room. NA-B filled out the screening paper and put it in a small box sitting on the table. NA-B did not check their temperature. Interview on 6/30/20 at 1:45 PM with NA-B revealed NA-B filled out the daily screening form and put it in the box. NA-B revealed staff came in the front door, went into the screening room to complete the form, then report for shift. NA-B revealed NA-B checked their temperature at home and used that number for the screening sheet. Review of the daily assignment sheet dated 6/27/20 revealed NA-B worked the day shift on the Meadow View wing.	O 242	This plan of correction serves as the Allegation of Compliance. Eastmont is committed to the safety and well-being of our residents and staff by using infection prevention and control practices to limit the spread of COVID-19. Eastmont has been screening all visitors to our healthcare areas since March 10, 2020. Eastmont has changed our screening tool nine (9) times due to frequent CDC guidance updates. Prior to this survey, Eastmont strongly encouraged all staff to take their temperature at home before coming to work. This practice was intended to prevent staff with a fever from even entering our buildings. Eastmont has regularly educated our staff on the ever-changing symptoms of COVID and promoted self screening. We disagree with the response from the state surveyors that staff cannot be trusted to take and record their own temperature and that their supervisor instructed them (the surveyors) to cite this deficiency because "staff will lie" in order to be able to come to work. We trust our staff to "do the right thing" and to diligently follow the precautions in place at Eastmont, which has resulted in no confirmed positive	7/28/20

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

Electronically Signed | 07/23/20

Nebraska DHHS Licensure Unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING: _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTMONT TOWERS	6315 O STREET LINCOLN, NE 68510

(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 242	Continued From page 1 Review of the daily assignment sheet dated 6/28/20 revealed NA-B worked the day shift on the Meadow View wing. Review of the daily assignment sheet dated 6/29/20 revealed NA-B worked the day shift on the Meadow View wing. B) Interview on 6/30/20 at 11:20am with HK-D revealed HK-D took temperature at home and wrote that value down for the temperature on the facility self-screening sheet when HK-D came to work. HK-D revealed some shifts HK-D would self-screen in the facility, but some days HK-D would use a temperature value from monitoring at home. D) Review of the COVID-19 Self-Screening Tool dated 6/23/20 revealed the form had boxes for healthcare workers/visitors, residents, or "other". Under the healthcare worker/visitor heading was a box for that stated "I do/may work in a health care area." Bolded print under this box stated "You must be screened by another staff person before donning PPE and beginning your shift." Below that box was a space for temperature documentation. On the lower half of the page was a table listing signs and symptoms of COVID-19 with Yes/No boxes. Review of the COVID-19 Self-Screening Tool completed by MW-C (Maintenance Worker) on 6/29/20 revealed MW-C checked the box stating "I do/may work in a health care area." The space designated for documentation of temperature was blank. MW-C marked "No" for all screening questions on the table listing signs and symptoms of COVID-19. There was no evidence MW-C was screened by another staff person on the	O 242	COVID-19 residents throughout our entire continuum to date. Eastmont has modified our screening process to include that all staff entering our Eastmont Rehabilitation Center (ERC) will be screened by another staff member. This will include taking their temperature and documenting the absence of symptoms consistent with COVID-19 at the beginning of their shift. Eastmont will continue to follow the screening process for all visitors to healthcare as we have been. The Director of Nursing (DON) generated and distributed a new screening tool to all ERC staff. On July 6, 2020, temperatures of staff assigned to, or working in, the ERC are now taken and recorded by another staff member. This also applies to documenting the absence of symptoms consistent with COVID-19. Staff who are screening the employee must initial that they have completed the screening tool. The Director of Nursing will review and monitor all ERC screening tools for accuracy and completeness. As part of Eastmont's Quality Assurance Program, The DON will monitor this new process to ensure its effectiveness and sustainability. Eastmont feels that this three-layered approach to screening will more than meet the intent of CDC's screening guidance. 1. The employee is aware of their own body and will report any COVID-19 symptoms before reporting to work and anytime symptoms develop during work. 2. Another staff member will take a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING: _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTMONT TOWERS	6315 O STREET LINCOLN, NE 68510

(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 242	Continued From page 2 screening form. Interview on 6/30/20 with the IP (Infection Preventionist) revealed staff were screened at the start of the shift by completing the screening form and monitoring temperature. The IP revealed staff were able to check self-monitor temperature at the start of shift, but staff were supposed to check the temperature in the facility. The IP revealed if the staff member's temperature is elevated the DON (Director of Nursing) should be notified.	O 242	co-worker's temperature, then complete and initial the most current screening tool at the beginning of each shift or upon entering the ERC. This process applies to staff assigned to the ERC and to staff who may work in the ERC from time to time. 3. The DON will review all screening tools for accuracy. The DON will provide quarterly reports to the QAPI Committee on the effectiveness of this change in the screening process. The goal will be 100% compliance of screening by another employee before entering the Eastmont Rehabilitation Center. The DON and Eastmont's Infection Preventionist will be responsible for monitoring of compliance. Implemented on July 6, 2020 Completed July 28, 2020	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285036	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTMONT TOWERS	**6315 O STREET LINCOLN, NE 68510**

(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 The facility is in compliance with the Emergency Preparedness tag at E0024.	E 000		

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

Electronically Signed | 07/23/2020

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

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

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 14, 2020

Mandy Broussard, Administrator
El Dorado Manor Nursing Home
71434 Hwy 25, Box 97
Trenton, NE 69044 **CMS Certification No. 285253**

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

Dear Administrator,

UNANNOUNCED COVID-19 SURVEY

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

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

SURVEY RESULTS

On June 30, 2020, a survey was completed at El Dorado Manor 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 24, 2020**, to the State Survey Agency Contact. **Failure to submit an acceptable PoC by July 24, 2020 may result in the imposition of additional remedies.**

The PoC must contain the following:

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

ENFORCEMENT REMEDIES

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

- **Directed Plan of Correction:**

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

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

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

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

Connie Vogt, RN, BSN

dhhs.healthcarefacilities@Nebraska.gov

In the Subject Line please put: DPOC

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

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

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

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

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

WITHDRAWAL OF APPROVAL FOR NURSE AIDE TRAINING PROGRAM

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

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

INFORMAL DISPUTE RESOLUTION (IDR)

You have one opportunity to dispute the deficiencies cited on the survey date through (IDR) in

accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

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

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

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

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

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

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

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

APPEAL RIGHTS

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

We request that you provide an electronic copy of the request for appeal to:
ROkcmSCB@cms.hhs.gov

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

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

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

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

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

CONTACT INFORMATION

If you have any questions please contact this office.

Sincerely,



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

CV/kd

Enclosures: CMS 2567

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

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285253	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL DORADO MANOR NURSING HOME	71434 HWY 25, BOX 97 TRENTON, NE 69044

(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		7/22/20

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

Electronically Signed | 07/15/2020

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
	285253	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL DORADO MANOR NURSING HOME	71434 HWY 25, BOX 97 TRENTON, NE 69044

(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 12-006.17B	F 880	Tag Cited: F-880 §483.80 – Infection Control	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285253	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL DORADO MANOR NURSING HOME	71434 HWY 25, BOX 97 TRENTON, NE 69044

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observations, interviews, and record review, the facility failed to 1. ensure that newly admitted residents and residents returning from appointments outside the facility were placed into 14 day quarantine with the use of appropriate PPE (Personal Protective Equipment) for 10 sampled residents (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, and 11), and 2. ensure that screening was completed appropriately for individuals entering the facility to prevent the possible spread of COVID-19 to all the residents of the facility. Sample size was 11, and the facility census was 22. Findings are: A. On 6/30/2020 at 7:40 AM during a preliminary interview by phone from the parking lot, MA (Medication Aide)-A who served as the facility's Activities director verified that there were no respiratory infections in the building and that all staff and residents had been tested last week for COVID-19 and were found to be negative. At 8:35 AM during a lengthy interview with LPN (Licensed Practical Nurse)-C who served as the facility's Infection Preventionist, they verified that testing was completed on 6/25/2020. General Infection Prevention and Control policies and procedures were reviewed with LPN-C as well as a separate book which included specific policies related to COVID-19. This book did not include specific guidance related to PPE (Personal Protective Equipment) to be used in different zones based on residents' COVID-19 status. However, LPN-C did explain that a portion of the facility was set aside for zones and that some residents had been in a "Gray Zone" in the past but there were no residents there at the present time. LPN-C revealed that if a resident in	F 880	Issue Cited: "Preventing Spread of Infection" A. Inappropriate PPE in the Grey Area 1. Immediate action(s) taken for the resident(s) found to have been affected include: On 06/30/2020, immediately during state survey, the Director of Nursing and Infection Preventionist immediately updated the 'Novel Coronavirus Prevention and Response Policy.' 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents had the potential to be affected by potentially exposing them to COVID-19. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: A copy of the policy 'Novel Coronavirus Prevention and Response Policy' was provided to all staff. Corrective action was provided as needed. All staff will be required to watch 'Closely Monitor Residents' YouTube video put out by the CDC by August 7th 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services (DNS) and/or Infection Preventionist will complete random Validation Checklists of five (5) staff performing full PPE while in grey area to ensure all staff are performing the procedure in accordance with our facility's Policy and Procedure	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285253	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL DORADO MANOR NURSING HOME	71434 HWY 25, BOX 97 TRENTON, NE 69044

(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 3 the "Gray Zone"had one negative test for COVID-19 staff caring for that individual wore only gloves and surgical masks. However, if a resident had no test or had any symptoms of respiratory illness then staff used full PPE including face shield and gown when providing care. LPN-C also verified that staff did not work only in the "Gray Zone" but came out of that area and cared for other residents as needed during their shift. At 9:20 AM, the facility's DON (Director of Nursing) also verified that staff only used full PPE when caring for residents in the "Gray Zone" who had not had a test for COVID-19 or who had respiratory symptoms. Review of a graphic showing "Review of Zones and PPE" with the DON showed that the "Gray Zone" was for residents transferred from the hospital or outside facilities with no known exposure to COVID-19 and called for use of gown, gloves, eye protection and N95 mask or surgical mask with face shield if no N95 was available. The DON verified this was not done consistently for all residents in the "Gray Zone" and the DON also verified that they did not remember seeing this guidance in the facility's policy book showing the kinds of PPE to be used in each zone. At 10:25 AM, the DON provided a list of all residents who had been in the "Grey Zone" which was initiated on 4/7/2020. The DON verified that when caring for those who had a negative test for COVID-19 in the "Grey Zone" staff wore only mask and gloves. However, when caring for those who had no test, full PPE was used at all times and doors were kept closed. At 11:00 AM, the DON also provided a list of resident admitted between 3/24/2020 and 4/7/2020 before "Grey	F 880	Guideline weekly for three (3) weeks . Findings of this audit will be discussed with staff and at the monthly Quality Assurance Meeting. Corrective action completion date: ___August 7th, 2020_____. B. Screening of those entering and exiting the building 1. Immediate action(s) taken for the resident(s) found to have been affected include: On 06/30/2020, immediately during state survey, the Director of Nursing and Infection Preventionist immediately updated the Novel Coronavirus Prevention and Response Policy, sign-in document/questionnaire, and posted signs at both entry points. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents had the potential to be affected by potentially exposing them to COVID-19. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: A copy of the policy 'Novel Coronavirus Prevention and Response Policy' was immediately provided to all staff. Corrective action was provided as needed. All staff will be required to watch 'Keep COVID-19 Out' YouTube video put out by the CDC by August 7th 4. How the corrective action(s) will be	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285253	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL DORADO MANOR NURSING HOME	71434 HWY 25, BOX 97 TRENTON, NE 69044

(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 Zone" was set up and verified that those residents were isolated in private rooms, and staff did not use full PPE for their care but did wear gloves and mask. The doors to their rooms were also kept closed. The DON also acknowledged residents were not placed in "Gray Zone" after leaving the facility for appointments because staff remained with them at all times to ensure use of masks and social distancing Review of "Admissions 3-1 to 4-7 (prior to Grey Zone) showed that Resident 2 and Resident 3 were admitted on [redacted] and were kept in isolation until [redacted], and Resident 4 was admitted on [redacted] was kept in isolation until [redacted]. These residents were admitted before the facility initiated the use of zones and were isolated in their own rooms where staff work masks and gloves when caring for them. The "Departmental Notes" for Resident 2 during this time did not indicate whether or not the resident was in quarantine. The "Departmental Notes" for Resident 3 on [redacted] stated since return from the hospital the resident had been in a different room by themselves, and on [redacted] stated the resident was moved from [redacted] where they had been in quarantine following return from the hospital to [redacted] "Departmental Notes" for Resident 4 on [redacted] indicated the resident was in a room by themselves for quarantine after having been in the hospital. Review of "Isolation/Grey Area Residents" showed Resident 5 was in isolation 4/8 to 4/10 using full PPE and from 4/15 to 4/24 following a [redacted]. "Departmental Notes" for Resident 5 showed the resident was admitted to the facility on [redacted] and was sent back to the hospital on [redacted] due to	F 880	monitored to ensure the practice will not recur: The Director of Nursing Services (DNS), or designee, will complete Validation Checklists of staff performing second person verification when entering or exiting the building to ensure all staff are performing the procedure in accordance with our facility's Policy and Procedure Guideline weekly for three (3) weeks. Findings of this audit will be discussed with staff and at the monthly Quality Assurance Meeting. Corrective action completion date: ___August 7th, 2020_____. Novel Coronavirus Prevention and Response Policy: This facility will respond promptly upon suspicion of illness associated with a novel coronavirus in efforts to identify, treat, and prevent the spread of the virus. Definitions: "Coronavirus" is a virus that causes mild to severe respiratory illness. "COVID-19" (short for coronavirus disease 2019) is a new respiratory disease caused by a novel (new) coronavirus that was first identified during an investigation into an outbreak in Wuhan, China. Because it is new, much is still to be learned about the virus. What is currently known is that it is spread person-to-person, mainly between people who are within 6 feet of one another	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285253	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL DORADO MANOR NURSING HOME	71434 HWY 25, BOX 97 TRENTON, NE 69044

(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 [redacted]. The "Departmental Notes" also indicated that Resident 5 returned to the facility on [redacted]. On 4/23/2020 at 3:54 PM "Departmental Notes" showed a note from Activities which revealed the resident had "wheeled around and sat in the courtyard" and seem to enjoy time outside. "Isolation/Grey Area Residents" showed Resident 3 was in isolation 4/15-4/16 with use of full PPE but no indication of why this isolation ended after only two days. The list also showed that Resident 6 was in isolation with use of full PPE from 4/30 to 5/15 and also from 6/2 to 6/22 following a [redacted]. Review of "Departmental Notes" for Resident 6 showed they returned from an overnight stay in the hospital on [redacted] and on 5/2/2020 a notes stated the resident was on isolation precautions due to recent hospitalization. "Departmental Notes" on [redacted] showed the resident had returned from a hospital stay and was to be kept in quarantine 14 days before returning to his room. A note on 6/17/2020 stated that the resident was seen by the Nurse Practitioner with [redacted] and that [redacted] were ordered. There was no indication that a change to the use of full PPE was made at that time related to these [redacted]. "Isolation/Grey Area Residents" showed Resident 7 was in isolation 5/4 to 5/18 and had one [redacted]. "Departmental Notes" fo[redacted] showed that Resident 7 returned from the hospital and was placed in room 111 for 14 day isolation but had tested [redacted]. A note on[redacted] showed the resident remained in isolation.	F 880	through respiratory droplets produced when an infected person coughs or sneezes. Policy Explanation and Compliance Guidelines: 1. The Infection Preventionist will assess facility risk associated with COVID-19 through surveillance activities of emerging diseases in the community and illnesses present in the facility. a. No current risk – the facility will implement interventions for prevention and prepare for a potential outbreak. b. Threat detected – the facility will respond promptly and implement emergency and/or outbreak procedures. 2. Staff shall be alert to signs of COVID-19 and notify the resident's physician if evident: a. Fever b. Cough c. Shortness of breath 3. Staff will "Think COVID-19" when a resident or employee exhibits the following clinical features and epidemiologic risk: Clinical Features Epidemiologic Risk Fever or cough/shortness of breath AND Has had close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset Fever and cough/shortness of breath AND A history of travel from affected geographic areas, within 14 days of symptom onset Fever with severe acute lower respiratory illness (e.g., pneumonia, ARDS) without an alternative explanatory diagnosis such	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285253	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL DORADO MANOR NURSING HOME	71434 HWY 25, BOX 97 TRENTON, NE 69044

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6 "Isolation/Grey Area Residents" showed Resident 8 was in isolation 5/12 to 5/26 and 6/8 to 6/16 and had one negative test for COVID-19 each time. "Departmental Notes" on 5/12/2020 showed the resident had returned from a week stay at [redacted] and was placed in [redacted] in isolation precautions for 14 days. A note on 6/8/2020 showed the resident returned from [redacted] hospital and was taken to [redacted] in the quarantine area for a 14 day stay. "Departmental Notes" from 6/16/2020 indicated that the resident had passed away while on Hospice care. "Isolation/Grey Area Residents" showed Resident 9 was in isolation 5/18 to 6/1 and had one [redacted] "Departmental Notes" showed the resident returned from a four day hospitalization and was admitted to [redacted] for 14 day isolation. "Isolation/Grey Area Residents" showed Resident 10 was in isolation 3/19 to 4/2 and again 5/7 to 5/13 using full PPE both times. "Departmental Notes" showed the resident was admitted to the facility on [redacted]. A message included with a fax from the facility on 7/1/2020 clarified that Resident 10 was in isolation with use of full PPE following this initial admit and again following an appointment at which there was a [redacted] "Departmental Notes" on 5/13/2020 revealed the resident was in isolation for a few days after visiting the hospital for a procedure but had since been cleared and moved back to his regular room. "Isolation/Grey Area Residents" showed that Resident 11 was in isolation 6/1 to 6/3 and a note attached to a fax from the facility on 7/1/2020	F 880	as influenza AND No identified source of exposure 4. Considerations/priorities for testing: a. Use clinical judgment on case-by-case basis to determine if a resident has signs and symptoms compatible with COVID-19. b. Test for other causes of respiratory illness, such as influenza or other respiratory panels. c. Consider known community transmission. d. Prioritize symptomatic residents 65 years of age and older and those with underlying conditions that may put them at higher risk for poor outcomes (e.g., diabetes, heart disease, receiving immunosuppressive medications, chronic lung disease, and chronic kidney disease). 5. Interventions to prevent the introduction of respiratory germs into the facility: a. Limit points of entry to the facility. All facility entrances shall be locked b. Post signs at the entrance instructing visitors not to visit if they have symptoms of respiratory infection. Restrict visitors in accordance with local, state, and national directives. c. Enforce sick leave policies that allow employees to stay home if they have symptoms of respiratory infection. Follow facility policy regarding work restriction when an employee has an infectious disease. d. There will be a designated area of the	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285253	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL DORADO MANOR NURSING HOME	71434 HWY 25, BOX 97 TRENTON, NE 69044

(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 clarified that this resident was very agitated [redacted] and the new move and was coming out of isolation multiple times and so was taken out of isolation and put into a private room. "Departmental Notes" on 6/1/2020 showed the resident was to remain in quarantine for 14 days following admission but was up wandering the halls and becoming anxious. No notes were found to indicate when or why the quarantine was stopped. Review of "Departmental Notes" for Resident 1 on 6/29/2020 revealed they left the facility for several hours [redacted]. A note at 1:57 PM stated the resident had been taken to the dining room for a late dinner and then to his room to rest. There was no evidence that the resident was quarantined in the "Gray Zone" after leaving the facility, and the DON verified that residents were not placed in that area after leaving the facility for appointments. Observation at 12:00 PM on 6/30/2020 showed an area marked off for isolation with no residents in that area. B. On 6/30/2020 at 7:45 AM, upon entry to the facility, a table was seen just inside the front door which contained papers for screening those entering the building, a non-contact electronic thermometer, and alcohol wipes. Upon entering the building, MA-A checked this surveyor's temperature using the thermometer and asked us to sign the "Release of Responsibility" form which was on the table. MA-A also indicated a sink located on the far side of the room and asked the surveyors to wash their hands. The "COVID-19 Screening Checklist-for Visitors and Staff" was	F 880	facility for residents with suspected or confirmed cases of COVID-19. i. For all residents who are to be admitted to the isolation area, enter through the North Door located in the isolation area ii. For new admissions, readmissions, or any appointments residents will be place in a 14 day quarantine in the designated private isolation rooms that have private bathrooms. iii. Full PPE, which includes Face Shield, Mask, Gown, and Gloves, is to be worn at all times the isolation rooms. PPE available in hallway of isolation area iv. Each room has its own vital signs basket that includes stethoscope, manual blood pressure cuff, pulse ox, and thermometer. v. Double bag laundry from the isolation area vi. Double bag trash and remove through the North exit door in the isolation area. vii. Limit staff that enter the isolation area e. Assess residents for symptoms of respiratory infection upon admission to the facility and implement infection prevention practices for incoming symptomatic residents. Inquire of travel history and contact with possible COVID-19 patients. 6. Interventions to prevent the introduction of respiratory germs into the Assisted Living Wing: a. Assisted Living Wing new admissions will quarantine in SNF room for 14 days before going to their room on ALW. b. Any current ALW resident that goes to	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285253	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL DORADO MANOR NURSING HOME	71434 HWY 25, BOX 97 TRENTON, NE 69044

(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 8 also on the table, but this surveyor was not asked any questions, and this form was not completed upon entry to the building. At 8:30 AM, an individual was observed entering building. This person used the thermometer to check their own temperature, signed the "Release of Responsibility" form and then went to the sink and washed their hands. At that time LPN-C was in the room but had their back to the table. LPN-C identified the individual washing their hands as working in the facility to procure supplies. LPN-C verified that screening should be done by someone who can check the temperature of the person entering the building and complete the questions on the checklist. LPN-C stated that most staff members enter the building through the back door into the lounge at shift change and are able to screen each other and complete the questions together at that time. At 10:50 AM, another individual was observed entering the building who also checked their own temperature, signed the "Release of Responsibility" form, and then went to the sink to wash their hands. No staff members were in the area at the time this individual entered the building. At 11:09 AM, the same individual was observed leaving the building and did not recheck their temperature or complete the checklist. At 11:10 AM, an interview with LPN-C identified the individual who had signed the "Release of Responsibility" form at 10:50 AM as Speech Therapist (ST)-D. LPN-C revealed that this individual came into the facility regularly and was familiar with the code to enter the locked front door. LPN-C verified that screening of everyone entering the facility should occur both when	F 880	the hospital will return to a SNF room for at least 14 days of quarantine. c. ALW resident that shows any symptoms of a respiratory illness or tests positive for COVID 19 will be transferred to a higher level of care facility. d. ALW residents that go out to a medical appointment will quarantine to their own room for 14 days following the appointment. 7. Interventions to prevent the spread of respiratory germs within the facility: a. Keep residents and employees informed by answering questions and explaining what they can do to protect themselves and their fellow residents (i.e. handwashing, spatial separation, respiratory hygiene/cough etiquette). b. Communal dining is limited. i. Only one hall of residents per assigned day may go out to the dining room, the other hall will continue to have meals in their rooms that day. A. Residents in the designated isolation area will not be allowed in the dining room B. Any resident's with fever or respiratory symptoms will remain in their room for meals ii. Residents must be spaced at least 6 feet apart or with appropriate barriers in place, such as Plexiglas, with no more than 2 people at a table. Only roommates are to share tables. iii. No more than 50% of capacity in the dining area at one time. iv. If staff assistance is required, appropriate hand hygiene must occur between assisting residents, as well as use of appropriate PPE.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285253	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL DORADO MANOR NURSING HOME	71434 HWY 25, BOX 97 TRENTON, NE 69044

(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 9 coming in and going out and should be monitored by staff to ensure all screening questions were completed to reduce the risk of the spread of COVID-19. At 11:20 AM, LPN-C placed new sign on the table containing screening materials which asked those entering to have someone check them in. LPN-C placed this notice on top of the "Release of Responsibility" form on the table. The "COVID-19 Screening Checklist-for Visitors and Staff" document stated "All individuals (staff, other health care workers, family, visitors, government officials, etc.) entering the building must be asked the following questions." The questions on that document asked about hand washing on entry, symptoms, temperature, and whether they have worked in a location with recognized COVID-19 cases. The facility's "Coronavirus Surveillance" policy stated that "Heightened surveillance activities will be implemented to limit the transmission of COVID-19" which include screening visitors, staff, and residents. At 12:20 PM, these concerns were reviewed with the facility's Administrator, DON, and LPN-C who all agreed that residents in the "Gray Zone" on admission or after leaving the facility should be cared for by staff wearing full PPE and screening of everyone entering the building should be monitored by staff because these concerns had the potential to affect all residents in the facility by potentially exposing them to COVID-19.	F 880	c. Group Activities are limited i. Small group activities with no more than 10 people may occur for only COVID-19 negative or asymptomatic residents with appropriate social distancing, hand hygiene ii. The resident must wear a cloth face covering or facemask at all times iii. No activities that involve multiple residents to handle the same objects (ie. ball toss) d. Medical Trips outside the facility shall be limited. i. Telemedicine should be utilized whenever possible ii. For medically necessary trips A. The resident must wear a cloth face covering or facemask at all times B. The facility must share the resident's COVID-19 status with the transportation service and with the entity with whom the resident has the appointment C. Transportation staff, at minimum, must wear a facemask. Additional PPE may be required. D. Transportation vehicles must be sanitized in accordance with the CDC Cleaning and Disinfection for Non-Emergency Transport Vehicles guidelines at the beginning and end of each shift and between transporting resident, using disinfectants known to be effective against emerging viral pathogens or novel coronavirus SARS-CoV-2 (EPA List N agent). e. Monitor residents for fever, oxygen saturation, and respiratory symptoms twice daily. i. Restrict residents with fever or acute	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285253	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL DORADO MANOR NURSING HOME	**71434 HWY 25, BOX 97 TRENTON, NE 69044**

(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 10	F 880	respiratory symptoms to their room. Have them wear a facemask if they must leave the room for medically necessary procedures. ii. In general, for care of residents with undiagnosed respiratory infection use Standard, Contact, and Droplet Precautions with eye protection unless suspected diagnosis requires Airborne Precautions (e.g., tuberculosis). iii. Implement heightened surveillance activities. Report any clusters of respiratory illness within 24 hours or any suspected/confirmed COVID-19 cases within 4 hours to health department (or per state/local health department requirements). iv. Restrict employees from work in accordance with current CDC guidelines for health care professionals. f. Monitor staff for fever and respiratory symptoms. i. Staff must take their temperature and be verified by a second person upon entering and exiting the facility. ii. Restrict from work and follow current guidance about testing and returning to work (e.g., local health department, CDC). iii. Staff must wear a cloth face covering or facemask at all times g. Support hand hygiene and respiratory/cough etiquette by residents, visitors, and employees by making sure tissues, soap, paper towels, and alcohol-based hand rubs are available. h. Educate staff on proper use of personal protective equipment and application of standard, contact, droplet, and airborne precautions, including eye	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285253	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL DORADO MANOR NURSING HOME	71434 HWY 25, BOX 97 TRENTON, NE 69044

(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 11	F 880	protection. i. Promote easy and correct use of personal protective equipment (PPE) by: i. Posting signs on the door or wall outside of the resident room that clearly describe the type of precautions needed and required PPE. ii. Make PPE, including facemask, eye protection, gowns, and gloves, available immediately outside of the resident's room. iii. Position a trash can near the exit inside any resident room to make it easy to discard PPE. 8. Procedure when COVID-19 is suspected or confirmed: a. Notify physician, Director of Nursing, Infection Preventionist, and family. b. Place resident in a private isolation room (containing a private bathroom) with the door closed. c. Evaluate the need for hospitalization. If transfer is warranted: i. Arrange for transfer to a facility with the appropriate capacity to manage the resident. ii. Inform ambulance personnel of suspicion of COVID-19 when arranging transportation. iii. Inform staff at transfer location of suspicion of COVID-19. iv. Place facemask on resident for transfer. v. The Infection Preventionist shall maintain communication with the transfer facility to obtain results of the medical evaluation (i.e. COVID-19 is confirmed or ruled out). d. Limit the number of people who enter	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285253	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL DORADO MANOR NURSING HOME	**71434 HWY 25, BOX 97 TRENTON, NE 69044**

(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 12	F 880		

the resident's room. Maintain a log of all people who enter the room.
e. Notify local health department of suspected or confirmed COVID-19. Follow any instructions.
f. Implement standard, contact, and droplet precautions. Wear gloves, gowns, goggles/face shields, and masks upon entering room and when caring for the resident.
g. Restrict resident to his/her room. Place facemask on resident if leaving the room for medically-necessary activities.
h. Dedicated medical equipment (preferably disposable, when possible) should be used for the provision of care. Clean and disinfect all other equipment used for care.
i. Avoid aerosol-generating procedures (i.e. suctioning, nebulizer treatments, and trach care) as possible. If required, take the following precautions:
i. Perform in private room (AIIR preferred) with door closed.
ii. Wear an approved respirator, eye protection, gloves, and a gown.
iii. Limit the number of health care personnel present to essential personnel.
iv. Clean and disinfect room surfaces promptly after procedure.
j. Cohort residents with COVID-19, if needed, following current CDC guidelines.
k. Restrict other residents to their rooms (to the extent possible) except for medically necessary purposes. If they leave their room, have them wear a facemask, perform hand hygiene, limit movement in the facility, and perform social distancing (efforts are made to

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285253	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL DORADO MANOR NURSING HOME	**71434 HWY 25, BOX 97 TRENTON, NE 69044**

(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 13	F 880	keep them at least 6 feet away). 9. Environmental infection control: a. Immediately disinfect items soiled with blood and other body fluids. b. Housekeeping staff shall adhere to transmission-based precautions. c. Perform routine and terminal cleaning of high-touch areas using disinfectants known to be effective against emerging viral pathogens or novel coronavirus SARS-CoV-2 (EPA List N agent). 10. Implement procedures to identify and monitor others who may have been exposed if COVID-19 disease is confirmed. 11. Managing a resident who has been treated for COVID-19 illness: a. Verify treatment was completed and the treatment plan for ongoing therapeutic support. b. Utilize transmission-based precautions as determined for the individual when caring for the resident (in collaboration with local health department). Symptomatic patients with COVID-19 should remain in Transmission-Based Precautions until either: i. Test-based strategy A. Resolution of fever, without use of fever-reducing medications, and B. Improvement in respiratory symptoms (e.g., cough, shortness of breath), and C. Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive nasopharyngeal swab specimens collected = 24 hours apart	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285253	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL DORADO MANOR NURSING HOME	**71434 HWY 25, BOX 97 TRENTON, NE 69044**

(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 14	F 880	(total of two negative specimens). D. Note: Consider other conditions that would require specific precautions (e.g., TB, c. difficile) when determining the duration of transmission-based precautions. ii. Symptom Based Strategy A. At least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); and, B. At least 10 days have passed since symptoms first appeared. c. Patients with laboratory-confirmed COVID-19 who have not had any symptoms should remain in Transmission-Based precautions until either: i. Test-based strategy A. Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive nasopharyngeal swab specimens collected =24 hours apart (total of two negative specimens). Note, because of the absence of symptoms, it is not possible to gauge where these individuals are in the course of their illness. There have been reports of prolonged detection of RNA without direct correlation to viral culture. ii. Time-based strategy A. 10 days have passed since the date of their first positive COVID-19 diagnostic test assuming they have not subsequently developed symptoms since their positive	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285253	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL DORADO MANOR NURSING HOME	**71434 HWY 25, BOX 97 TRENTON, NE 69044**

(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 15	F 880	test. Note, because symptoms cannot be used to gauge where these individuals are in the course of their illness, it is possible that the duration of viral shedding could be longer or shorter than 10 days after their first positive test. d. Indicate COVID-19 history on the resident's plan of care and monitor for recurrent symptoms. e. If the resident is transferred or discharged, communicate information related to treatment for COVID-19 to the receiving facility/provider. 12. Considerations for admitting residents with suspected or confirmed COVID-19: a. Maintain situational awareness of COVID-19 in the community and impact on hospital capacity. Prepare to create separate wings, units, or floors by moving current residents to handle hospital admissions. b. In absence of public health directives or mandates, follow this general guidance: i. If there is no suspected or confirmed COVID-19 cases in the facility, do not admit until the resident has recovered. ii. If the facility currently has suspected or confirmed COVID-19 cases, admit to a private room on transmission-based precautions or cohort in rooms with other COVID-19 patients. Do not admit if the facility is unable to meet the level of care needs or the requirements for transmission-based precautions.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285253	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL DORADO MANOR NURSING HOME	71434 HWY 25, BOX 97 TRENTON, NE 69044

(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 16	F 880	Date Reviewed/ Revised: 06/30/2020 Reviewed/ Revised By: KM/DW/BS References: 1. Centers for Disease Control and Prevention. Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings. Located at: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control.html. Accessed March 27, 2020. 2. Centers for Disease Control and Prevention. Preparing for COVID-19: Long-term Care Facilities, Nursing Homes. Located at: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-lo	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285253	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL DORADO MANOR NURSING HOME	71434 HWY 25, BOX 97 TRENTON, NE 69044

(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 17	F 880	ng-term-care-facilities.html. Accessed March 27, 2020. 3. Centers for Disease Control and Prevention. Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19. Located at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html, Accessed May 1, 2020. 4. Centers for Disease Control and Prevention. Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19). Located at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html. Accessed March 27, 2020.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285253	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL DORADO MANOR NURSING HOME	**71434 HWY 25, BOX 97 TRENTON, NE 69044**

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

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

Electronically Signed | 07/15/2020

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.

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

Pete Ricketts, Governor

July 10, 2020

Kate Reiners, Administrator
Elwood Care Center
P O Box 315, 607 Smith Avenue
Elwood, NE 68937-0315

CMS CERTIFICATION NUMBER: 285215

Dear Ms. Reiners:

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

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

Pete Ricketts, Governor

June 24, 2020

Chelsey Roan, Administrator
Emerald Nursing & Rehab Columbus
P O Box 625, 2855 40th Avenue
Columbus, NE 68602-0625

CMS CERTIFICATION NUMBER: 285092

Dear Ms. Roan:

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

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

Pete Ricketts, Governor

July 23, 2020

Kiley Goff, Administrator
Emerald Nursing & Rehab Cozad
318 West 18th Street
Cozad, NE 69130-1166

CMS CERTIFICATION NUMBER: 285093

Dear Ms. Goff:

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

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 17, 2020

Jessica Lawless, Administrator
Emerald Nursing & Rehab Lakeview
1405 West Hwy 34
Grand Island, NE 68801

CORRECTED LETTER

CMS Certification No. 285106

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

Dear Administrator,

UNANNOUNCED COVID-19 SURVEY

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

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

SURVEY RESULTS

On June 9, 2020, a survey was completed at Emerald Nursing & Rehab Lakeview 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 27, 2020**, to the State Survey Agency Contact. **Failure to submit an acceptable PoC by July 27, 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 1, 2020 which is 15 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 9, 2020 survey, you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board (DAB). The appeal rights are set forth at 42 C.F.R. § 498.5 and the procedures for requesting a hearing are set forth at §498.40, et seq. You must file your hearing request electronically by using the DAB's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov/, unless you obtain a waiver from the DAB (*see* DAB Civil Remedies Division Procedures, § 6(a)(i)(1)). Your appeal must be filed no later than 60 days from the date of receipt of this letter.

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

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

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

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

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

CONTACT INFORMATION

If you have any questions please contact this office.

Sincerely,



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

CV/ls

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
	285106	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD NURSING & REHAB LAKEVIEW	**1405 WEST HWY 34 GRAND ISLAND, NE 68801**

(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=K	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		8/3/20

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

Electronically Signed | 07/22/2020

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
	285106	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD NURSING & REHAB LAKEVIEW	**1405 WEST HWY 34 GRAND ISLAND, NE 68801**

(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 12-006.17B	F 880	F880 Infection Prevention and Control	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285106	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD NURSING & REHAB LAKEVIEW	1405 WEST HWY 34 GRAND ISLAND, NE 68801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 LICENSURE REFERENCE NUMBER 175 NAC 12-006.17D Based on observation, interview, and record review; the facility staff failed to follow the CMS (Centers for Medicare and Medicaid) guidelines to prevent the potential spread of Covid-19 by failing to follow the guidelines for quarantine of a resident newly admitted to the facility (Resident 11). The failure to follow quarantine guidelines for residents newly admitted to the facility had the potential to affect the 7 residents [redacted] and still had the potential to contract Covid-19 (Residents 17, 18, 1, 19, 20, 8, and 21) and 1 of 2 newly admitted residents who had not been tested [redacted] The facility staff also used the same face shield when entering a resident room under quarantine placing them at risk for cross contamination between [redacted] and the 7 facility residents [redacted] The facility staff also failed to perform hand hygiene to prevent potential cross contamination during [redacted] administration which affected 5 of 5 residents (Resident 22, 4, 5, 7, and 10); failed to change gloves and perform hand hygiene during [redacted] checks which affected 8 of 8 residents (22, 4, 6, 12, 7, 8, 10, and 9); failed to clean the [redacted] machine between residents to prevent potential cross contamination which affected 8 of 8 residents (22, 4, 6, 12, 7, 8, 10, and 9); failed to perform hand hygiene to prevent potential cross contamination when exiting resident rooms for 6 of 6 residents (Residents 12, 13, 14, 7, 15, and 16), and before putting on gloves and after taking off gloves for 2 of 2 residents (Residents 19 and 20). The facility identified a census of 50 at the time of survey.	F 880	Correction to Resident The facility will be educated to follow all guidelines and CDC requirements for all newly admitted patients to the facility to ensure each patient is quarantined for 14 days and monitored with infection control procedures in place. On 6/9/20, the date learned of the deficient practice an immediate abatement was conducted and staff moved to full quarantine and monitoring procedures. The facility staff will wear new face shields when entering a room under quarantine to prevent cross contamination and will follow the guidelines for newly admitted patients.. Residents 17, 18, 1, 19, 20, 8, and 21 had no negative findings or s/s of Covid related to staff failing to utilize a new face shield when entering a resident room under quarantine to prevent cross contamination and not following the guidelines for quarantine of a newly admitted resident (11) who had not been tested for Covid. The facility staff will perform proper hand hygiene to prevent potential cross contamination during insulin administration. Resident 22, 4, 5, 7, and 10 had no negative findings related to facility failing to perform hand hygiene to prevent potential cross contamination during insulin administration. The facility staff will change gloves, perform hand hygiene and clean glucometer between residents to prevent	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285106	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD NURSING & REHAB LAKEVIEW	1405 WEST HWY 34 GRAND ISLAND, NE 68801

(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 3 Findings are: A. Interview with the facility Administrator on 6/8/2020 at 11:09 AM revealed the following: The facility had Covid-19 cases with the facility and the staff in the past. The facility is considered "Green" right now. The facility nurse consultant was working with the local health department and DHHS (Department of Health and Human Services) on their cases and that determination has been made at this time. The facility did not have any active Covid-19 cases at this time. The administrator revealed the facility currently had a "quarantine" unit for any residents who returned from the hospital and they resided in quarantine on that unit for 14 days. They are currently not accepting any residents who are confirmed positive for Covid-19. The administrator revealed the entire facility did not have any Covid-19 positive residents at this time. All staff were required to wear masks when entering resident rooms and residents were to wear a mask if they came out of their room. Interview with RN-I (Registered Nurse) on 6/8/2020 at 11:30 AM revealed the 500 unit was the "quarantine" unit where residents were required to reside for 14 days when they were admitted to the facility. Observation of the "quarantine" unit on 6/8/2020 at 11:35 AM revealed there were no residents observed residing on that unit. There were signs on some of the doors dated June 1, 2020 that read: 500 Hallway-will be required to wear all PPE (Personal Protective Equipment) which is N95 (a type of mask), gown, gloves, and face shield while working with residents.	F 880	cross contamination. Resident 22, 4, 6, 12, 7, 8, 10, and 9 had no negative findings related to facility failing to change gloves, perform hand hygiene, and clean glucometer between residents to prevent cross contamination when obtaining blood sugars. The facility staff will perform proper hand hygiene when existing resident rooms and prior to putting on and off gloves. Residents 12, 13, 14, 7, and 15 had no negative findings related to facility failing to do hand hygiene when exiting resident rooms and prior to putting on and taking off gloves for resident 19 and 20. System changes and correction to all other residents The facility will be educated to follow all guidelines and CDC requirements for all newly admitted patients to the facility to ensure each patient is quarantined for 14 days and monitored with infection control procedures in place. All other newly admitted residents were audited to ensure all quarantine and monitoring protocols were in place with no issues identified. Immediate education to all staff on PPE requirements and definition of quarantine for any newly admitted residents to grey zone. Education with demonstration by presenter to all staff on hand hygiene when going in and out of resident rooms, don and doff gloves with repeat	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285106	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD NURSING & REHAB LAKEVIEW	1405 WEST HWY 34 GRAND ISLAND, NE 68801

(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 Interview with the facility Administrator on 6/8/2020 at 12:30 PM revealed 1 resident was scheduled to be admitted to the facility from the hospital tomorrow and they would reside on the "quarantine" unit for 2 weeks. Interview on 6/8/2020 at 1:06 PM with Resident 1 who was sitting out in the hall in the "green" Zone in a power wheelchair revealed they had not tested positive for Covid-19. Observation of NA-H (Nursing Assistant) on 6/9/2020 at 8:40 AM revealed they were working on the quarantine unit. Interview with NA-H at this time confirmed they were working on the quarantine unit today. NA-H revealed there was 1 resident who was admitted to the facility [redacted]. NA-H revealed the procedure for entering the resident's room was that it was their understanding that the staff were protecting the resident from the staff so they just wore a mask and a face shield. NA-H revealed it was their understanding that the resident had [redacted] and had been in the hospital for a year before coming to the facility. Interview with NA-H on 6/9/2020 at 8:58 am revealed they did "float" to other units in the facility to provide care to residents. NA-H revealed they helped get people up this morning on the other units. NA-H revealed no one in the building was considered contagious so NA-H understood they could provide care to the residents on the other units as well as caring for the residents on the quarantine unit. Observation on 6/9/2020 At 9:00 revealed NA-H	F 880	demonstration by staff member Education with demonstration by presenter to nurses and Med aids on procedure to clean blood glucose machine, hand hygiene, and changing gloves in order to prevent cross contamination with repeat demonstration by staff member. All staff to watch the following you tube video by July 31, 2020 1. Sparkling Surfaces 2. Clean Hands 3. Closely Monitor Residents 4. Keep Covid 19 out 5. Lessons Facility to hire for a Full time staff development/ Infection Control Nurse for ongoing education related to Covid and sustain infection control practices within the facility. Monitoring Process for System Change: DON/Designee will audit all newly admitted patients to the facility to ensure each patient is quarantined for 14 days and monitored with infection control procedures in place. 3 x per week for 1 month, 1 x per week for 1 month and then monthly x 3. DON/Designee will visually audit staff for utilizing appropriate PPE requirements between zones (grey and green) and placement of newly admitted residents on	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285106	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD NURSING & REHAB LAKEVIEW	1405 WEST HWY 34 GRAND ISLAND, NE 68801

(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 went into Resident 11's room where the new resident was residing on the "Gray" or quarantine unit after using hand sanitizer and donning a face shield. NA-H did not don gown or gloves. NA-H was already wearing a surgical face mask. NA-H talked to Resident 11 then left the room, took the face shield off and laid it on top of the PPE cart sitting outside of Resident 11's door and used hand sanitizer for hand hygiene from a dispenser hanging on the wall. Observation on 6/9/2020 at 9:26 AM revealed MA-J (Medication Aide) walked to the doorway of Resident 11. MA-J was wearing a face mask and donned the face shield that was laying on the top of the PPE cart. MA-J did not don a gown or gloves. MA-J then entered Resident 11's room. MA-J then came out of Resident 11's room and put the same face shield on top of the cart, do hand hygiene with hand sanitizer and walked down the hall to the other units in the facility that were "Green". Observation of Resident 11's room on 6/9/2020 at 9:00 AM revealed a sign on the door that read: 14 Day Admission Precaution. Staff Mask (May wear face shield). Resident mask when in room. Resident to wear mask when outside of room. There were no other directions for other PPE use or precautions on the sign. Interview on 6/9/2020 at 9:32 with RN-K revealed the quarantine hall Resident 11 was residing on was a Gray Zone. RN-K revealed Resident 11 had been in the hospital for 8 months and the facility felt the staff were to protect that resident from the staff; not protect the staff from the resident. RN-K revealed the facility had tested all of the residents for Covid-19 but not the staff.	F 880	grey zone while facility is still in phase 1 and 2 3x week for 1 month, 1x week for 1 month and then monthly X 3. DON/Designee will visually audit the hand hygiene of 6 random staff when going in and out of resident rooms, don and doff gloves 3x week for 1 month, 1x week for 1 month and then monthly X 3. DON/Designee will visually audit 4 med aid/nurses for appropriate [redacted] cleaning between residents, proper hand hygiene to prevent cross contamination with insulin administration, and changing gloves to prevent cross contamination 3x week for 1 month, 1x week for 1 month and then monthly X 3. QAPI committee will review results monthly for 3 months to validate education and system changes were effective.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285106	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD NURSING & REHAB LAKEVIEW	**1405 WEST HWY 34 GRAND ISLAND, NE 68801**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6	F 880		

RN-K revealed the facility had 5 residents who had never tested positive for Covid-19 and they had been directed by the SIP (State Infection Preventionist) to monitor those 5 daily for signs and symptoms of Covid-19. When RN-K was asked if the Resident 11 had been tested for Covid-19 prior to admission RN-K said they did not know and would need to look into that.

Interview on 6/9/2020 at 9:54 am with RN-K confirmed Resident 11 did not have a baseline Covid-19 test, or was not tested prior to admission.

Interview with RN-K on 6/9/2020 at 11:00 AM revealed the staff were only using a face mask and face shield to enter Resident 11's room as RN-K said Resident 11 was kind of an exception. RN-K revealed the facility typically didn't get a resident who [redacted] RN-K reported they did not feel Resident 11 could have had any potential exposure as Resident 11 did not come from home. RN-K confirmed the facility still had residents who never tested positive and not all of the staff tested positive either and the staff were leaving the facility and returning ad lib. RN-K revealed the facility as a whole was on the "downhill slide" of the Covid-19 disease. RN-K revealed they did not feel Resident 11 was a risk for transmission because Resident 11 [redacted] RN-K revealed they had not consulted with the health department regarding the situation with Resident 11 and they would do that.

Record review of an email sent by RN-K revealed they had sent an email to the SIP (State Infection Preventionist) at 11:27 AM on 6/9/20 for clarification on required PPE for the facility Gray

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285106	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD NURSING & REHAB LAKEVIEW	**1405 WEST HWY 34 GRAND ISLAND, NE 68801**

(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	F 880		

Zone. Response by the SIP was returned to RN-K at 12:09 PM on 6/9/20 and indicated the facility needed to follow the Gray Zone guidelines for Resident 11. Facility began mitigation to place Gray Zone in full PPE prior to response from SIP was received.

Observation on 6/9/20 at 12:12 PM Revealed NA-H wearing N95 mask, face shield, gown, and gloves when they took a meal into Resident 11's room. NA-H then removed the gown and gloves and face shield and performed ABHR (Alcohol Based Hand Rub) after they left Resident 11's room. NA-H then donned new gloves and cleaned the face shield. NA-H removed gloves and performed ABHR. NA-H then donned a new gown, face shield, and gloves then delivered a meal to Resident 22 indicating the facility had abated the immediate jeopardy.

On 6/9/20 at 12:20 PM the RDO (Regional Director of Operations) expressed concern with the requirement for staff to wear gloves, gown, mask, and face shield when in the rooms of the newly admitted residents residing in the facility quarantine unit. The RDO revealed that Resident 11 had been hospitalized for the past 8 months before admitting to the facility and the facility felt that the resident was not at risk for exposure to Covid-19. The RD stated that the facility and staff had put much thought into how to care for the newly admitted residents. The facility administrator was present. At 12:40 PM RN-K revealed that they had e-mailed the SIP for clarification on the required PPE use for newly admitted residents. The email response from the SIP confirmed that any new resident was to be put into a Gray Zone (a transitional or quarantine unit used to monitor residents admitted to the

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285106	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD NURSING & REHAB LAKEVIEW	1405 WEST HWY 34 GRAND ISLAND, NE 68801

(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 8	F 880		

facility for Covid-19 to prevent the potential for spread of Covid-19 in the facility) for 14 days and that the facility was to follow the PPE requirement for a Gray Zone (Gown, Gloves, Eye protection and N95 mask). The facility changed their procedure and all staff will don full PPE (gown, gloves, mask, face shield) when they enter the rooms of newly admitted residents on the "Gray" Zone. At 12:45 PM the DON revealed that the Gray Zone guidelines were implemented and that the staff was educated.

On 6/11/2020 an e-mail was sent to the administrator with a request for the documentation of when they did the transition on the Gray unit and when they educated staff and what this entailed for the corrective action to abate the situation on site 6/9/2020. The administrator was also asked for a list of staff who had never tested positive to determine if there was still a risk of staff bringing it into the facility or contracting it from another resident in the facility and passing it on to residents including the new resident and the 7 residents who never tested positive.

Review of the undated list of staff Covid-19 test results revealed 22 of 117 staff listed tested positive. MA-J was not on the list at all and NA-H was not listed as testing positive so there was the potential they could become infected and spread to the residents in the Gray unit or the other residents in the facility who had not tested positive by working on both the Gray and Green units without using the PPE per guidelines.

Review of the staff training dated 6/9/2020 revealed the staff were trained that all admissions will be on a 14 day droplet precautions (Gray

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285106	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD NURSING & REHAB LAKEVIEW	**1405 WEST HWY 34 GRAND ISLAND, NE 68801**

(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 9	F 880		

Zone). Full PPE is to be worn when in room with resident for droplet precautions. This was documented as completed at 12 PM.

Review of the e-mail communication with the SIP dated 6/9/2020 at 12:09 PM revealed the facility was directed to follow the Gray Zone procedure for the new residents on the Gray Zone for 14 days. The SIP directed the facility that Gray Zone PPE should be worn: N95, eye protection (face shield or goggles), gown, gloves.

Review of the facility Covid-19 Line Listing report revealed 20 residents who were Covid-19 positive had expired during the time frame from April 6, 2020 to May 13, 2020. 43 of the residents currently residing in the facility had tested positive for Covid-19 and had recovered.

Review of the list of residents who have tested negative identified by the facility as the residents who had never tested positive for Covid-19 were: Residents 17, 18, 1, 19, 20, 8, and 21. These residents had never had Covid-19 or tested positive so they were still at risk for contracting it.

Review of the ICAP (Infection Control and Prevention) Review of Zones and PPE (Personal Protective Equipment) revealed the following guidelines for the zones and PPE: Gray Zone: Residents who are being transferred from the hospital/outside facility (but have no known exposure to Covid-19) are usually kept in this Zone for 14 days, and if remains asymptomatic at the end of 14 days will be moved to Green Zone. PPE to be used: Gown, gloves, eye protection and N95 mask (N95 mask preferred if no N95 then surgical mask with face shield).
Green Zone (Covid-19 free Zone): Asymptomatic

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285106	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD NURSING & REHAB LAKEVIEW	1405 WEST HWY 34 GRAND ISLAND, NE 68801

(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 10	F 880		

residents without any exposure to Covid-19: PPE to be used: Surgical mask and PPE per standard precautions.

The facility abated the Immediate Jeopardy by implementing the Gray Zone precautions and educating staff by 12:00 PM on 6/9/2020; however, the new resident (Resident 11) and the 7 residents who had not contracted or tested positive for Covid-19 (Residents 17, 18, 1, 19, 20, 8, and 21) were placed at risk for contracting Covid-19 due to the staff failure to follow the Gray Zone precautions and working on both the Gray and Green Zones. Therefore, the Immediate Jeopardy was abated to an E, as the residents were still at risk for contracting Covid-19 due to the 14 day incubation period.

B. Observation on 6/9/2020 at 9:00 revealed NA-H went into Resident 11's room where the new resident was residing on the "Gray" or quarantine unit after using hand sanitizer and donning a face shield. NA-H did not don gown or gloves. NA-H was already wearing a surgical face mask. NA-H talked to Resident 11 then left the room, took the face shield off and laid it on top of the PPE cart sitting outside of Resident 11's door and used hand sanitizer for hand hygiene from a dispenser hanging on the wall. NA-H then walked away from the cart and left the face shield on top of the cart. The face shield was not cleaned.

Observation on 6/9/2020 at 9:26 AM revealed MA-J (Medication Aide) walked to the doorway of Resident 11. MA-J was wearing a face mask and donned the face shield that was laying on the top of the PPE cart, which was the same face shield that had been used and not cleaned by NA-H.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285106	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD NURSING & REHAB LAKEVIEW	1405 WEST HWY 34 GRAND ISLAND, NE 68801

(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 11	F 880		

MA-J then entered Resident 11's room. MA-J then came out of Resident 11's room and put the same face shield on top of the cart, do hand hygiene with hand sanitizer and walk down the hall to the other units in the facility that were designated as "green". The face shield was not cleaned.

C. Observation of LPN-G (Licensed Practical Nurse) on 6/9/2020 at 11:33 MA revealed LPN-G (Licensed Practical Nurse) was doing [redacted] checks and administering [redacted] to residents using supplies from a treatment cart with several drawers and the computer was sitting on top of it with a mouse on a mouse pad. Interview with LPN-G at this time revealed the facility residents shared a [redacted] at the bedside). The [redacted] LPN-G were using were labeled [redacted].

Observation on 6/9/2020 at 11:35 AM revealed LPN-G donned gloves. The [redacted] was sitting on top of the cart on a piece of paper. It was not wrapped with a disinfectant wipe. LPN-G gathered an alcohol wipe, cotton ball, [redacted] from the drawer by touching the drawer with the gloved hands, picked up the [redacted] and went into Resident 22's room and checked Resident 22's [redacted]. LPN-G pricked Resident 22's finger with the [redacted]. LPN-G touched Resident 22's hand with the gloves and the [redacted] as well as a cotton ball LPN-G placed on Resident 22's finger after LPN-G lanced it and placed a drop of blood from Resident 22's finger onto the [redacted] After the result appeared on

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285106	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD NURSING & REHAB LAKEVIEW	1405 WEST HWY 34 GRAND ISLAND, NE 68801

(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 12 the screen of the [redacted] LPN-G left the room, put the [redacted], then LPN-G used a Clorox "non-bleach" wipe and cleaned the [redacted] with the wipe and placed it on a paper square on top of the cart. LPN-G wiped the [redacted] quickly and discarded the wipe. The [redacted] was dry in seconds. LPN-G then used the same gloved hands to open the drawer on the cart and get out an [redacted] that was in a clear plastic bag. LPN-G then opened a drawer and retrieved a pre-packaged [redacted] LPN-G opened the needle, placed it on the [redacted], primed the [redacted] dialed the dose, entered Resident 22's room and injected the [redacted] into Resident 22's arm. LPN-G then came out of the room with the same gloves on, discarded the needle in the sharps container, put the [redacted] in a bag that was lying on top of the cart. LPN-G then removed the gloves and did hand hygiene with ABHR (Alcohol Based Hand Rub). LPN-G then placed the [redacted] in the bag back into the drawer. Observation on 6/9/2020 at 11:40 AM revealed LPN-G donned gloves, opened the drawer and got a [redacted], cotton ball, alcohol wipe, and [redacted] out of the drawer. LPN-G touched the same drawer LPN-G had touched with the gloved hands LPN-G had used for Resident 22. LPN-G picked up the [redacted] off the top of the cart and went into Resident 4's room and checked their [redacted] by lancing their finger and placing a drop of blood on the test strip that LPN-G had inserted into the [redacted] LPN-G touched Resident 4's hand while obtaining the blood sample. LPN-G then left Resident 4's room with the [redacted] took a Clorox non-bleach wipe out of the container on the cart, wiped the [redacted] threw the wipe away and	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
	285106	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD NURSING & REHAB LAKEVIEW	1405 WEST HWY 34 GRAND ISLAND, NE 68801

(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 13	F 880		

placed the [redacted] on a barrier on top of the cart. The [redacted] was dry in seconds. LPN-G still had the same gloves on. LPN-G documented the [redacted] by touching the computer mouse on top of the cart. LPN-G then used keys to open the cart then opened a drawer on the cart and got Resident 4's [redacted] bag out of the drawer. LPN-G then removed a pre-packaged needle from the drawer, opened it and put it on the [redacted]. LPN-G still has the same gloves on. LPN-G then went in and gave Resident 4 the [redacted] by injecting it into their left arm. LPN-G then left Resident 4's room and went back to the cart and put the [redacted] back into the bag after discarding the needle into the sharps container. LPN-G then unlocked the cart with their keys. LPN-G then removed the gloves, opened the drawer, and put the bag with the [redacted] back into the drawer. LPN-G then charted on the computer on the cart by touching the mouse and the keyboard. LPN-G then gave keys to the administrator who had come up and requested a set of keys to get into the storeroom. LPN-G did not do hand hygiene after removing their gloves. LPN-G then got gloves out of a box and laid them on top of the cart. LPN-G did hand hygiene with ABHR and put on the gloves.

Observation on 6/9/2020 at 11:45 AM revealed LPN-G got a bag containing and [redacted] out of the drawer for Resident 5. LPN-G touched the drawers with the same gloved hands and the bag the [redacted] was in. LPN-G retrieved a prepackaged [redacted] needle and alcohol swab from the cart. LPN-G opened the needle and placed it on the [redacted]. LPN-G then entered Resident 5's room and wiped their site on their skin with alcohol and injected the [redacted] using the same gloved hands. LPN-G then left

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285106	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD NURSING & REHAB LAKEVIEW	1405 WEST HWY 34 GRAND ISLAND, NE 68801

(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 14 Resident 5's room and put the needle in the sharps container, placed the cap back on the [redacted], removed gloves, put the [redacted] in the bag, opened the drawer on the cart, put the bag with the [redacted] into the drawer, then touched the computer. LPN-G then did hand hygiene using ABHR hand sanitizer and LPN-G charted touching the computer mouse. Observation on 6/9/2020 at 11:50 AM revealed LPN-G took the [redacted] not wrapped and put it into the drawer. LPN-G took the wipes to a different cart and got a [redacted] out of the drawer. At 11:53 AM LPN-G donned gloves then got an alcohol wipe, [redacted], lancet, and cotton ball out of the drawer. LPN-G took the [redacted] into Resident 6's room and checked Resident 6's [redacted] by lancing their finger, placing a drop of blood on the machine then wiping their finger with a cotton ball using the gloved hands. Observation on 6/9/2020 at 11:57 AM revealed LPN-G brought the [redacted] out of Resident 6's room, wiped it with the Clorox non-bleach disinfectant wipe and discarded it. The [redacted] surface was dry in seconds. LPN-G then removed their gloves and charted touching the computer mouse. LPN-G then did hand hygiene with ABHR. LPN-G then retrieved supplies from the cart out of the drawer including an alcohol wipe, [redacted], lancet, and cotton ball. LPN-G then donned gloves and took the same [redacted] into Resident 12's room and checked Resident 12's [redacted] at 12:00 PM. LPN-G then took the [redacted] out of the room, wiped it with the Clorox non-bleach wipe and discarded the wipe. LPN-G wiped the [redacted] very quickly and it was visibly dry in seconds. At 12:02 PM LPN-G took the same [redacted] and put a [redacted] in	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
	285106	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD NURSING & REHAB LAKEVIEW	**1405 WEST HWY 34 GRAND ISLAND, NE 68801**

(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 15 after donning gloves and opening the drawer to retrieve the alcohol wipe, cotton ball, and lancet. Observation on 6/9/2020 at 12:03 PM revealed LPN-G took the [redacted] into Resident 7's room and checked Resident 7's BS. LPN-G came out the room and got keys out of their pocket with the same gloves hands. LPN-G then dropped the keys on the floor then picked them up with the same gloved hands and laid them on top of the cart. LPN-G then changed gloves with no hand hygiene, charted by touching the mouse then opened the drawer and got an insulin pen out that was in a plastic bag. LPN-G then opened another drawer and got a prepackaged needle and put it on the [redacted], took it into Resident 7 and administered the [redacted] to Resident 7 at 12:06 PM by injecting them. LPN-G then came out of Resident 7's room and used the same gloved hands to open the drawer after unlocking it with the keys. LPN-G quickly wiped the [redacted] with the Clorox bleach free wipe and discarded into their gloves when they removed them. The [redacted] was dry in seconds. Observation on 6/9/2020 at 12:10 PM revealed LPN-G discarded an empty alcohol wipe box in trash can on the cart. LPN-G touched the inside of the trash can with their bare hand and did not perform hand hygiene. LPN-G then touched the computer mouse, opened the drawer and retrieved a lancet, alcohol wipe, and cotton ball. LPN-G then donned gloves and took the [redacted] into Resident 8's room and checked Resident 8's [redacted] LPN-G then brought the [redacted] out of Resident 8's room at 12:13 PM and wiped it with the Clorox non-bleach wipe and discarded the wipe in their gloves. The [redacted] was dry in seconds.	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
	285106	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD NURSING & REHAB LAKEVIEW	1405 WEST HWY 34 GRAND ISLAND, NE 68801

(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 16 Observation on 6/9/2020 at 12:16 PM revealed LPN-G went back to the other cart. LPN-G handled the keys and unlocked the cart. LPN-G then opened the drawer with bare hands that LPN-G had not cleaned and retrieved an alcohol wipe, cotton ball, and lancet from the drawer. LPN-G picked up the [redacted] and donned gloves. At 12:17 PM LPN-G took the [redacted] into Resident 10's room and checked Resident 10's [redacted]. At 12:18 PM LPN-G brought the [redacted] out of Resident 10's room to the cart and wiped the [redacted] with the Clorox non-bleach wipe and discarded the wipe. It was dry in seconds. LPN-G then used the same gloved hands to open the drawer and get 2 prepackaged needles and Resident 10's [redacted] out of the drawer that was in a bag. Using the same gloved hands, LPN-G opened the needles and placed them on 2 [redacted] and took them into Resident 10 and administered the [redacted] at 12:21 PM. LPN-G came out of Resident 10's room and used the same gloved hands to unlock the cart with their keys, open the drawer and put the bag with the [redacted] back into the cart by opening the drawer. LPN-G then removed the gloves. LPN-G touched the computer mouse to chart then did hand sanitizer. At 12:23 PM LPN-G put a [redacted] into the [redacted] LPN-G then donned gloves then opened the drawer to get an alcohol wipe, cotton ball and lancet. LPN-G then went into Resident 9's room at 12:24 PM checked their [redacted] using the [redacted] Review of the facility policy [redacted] Disinfection dated 5/2017 revealed the following: 1. Retrieve disinfectant wipe from container. 2. Cleanse the [redacted] with the disinfectant	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
	285106	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD NURSING & REHAB LAKEVIEW	1405 WEST HWY 34 GRAND ISLAND, NE 68801

(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 17 wipe. 3. Discard disinfectant wipe in waste receptacle. 4. Allow device to dry for minimum of five (5) minutes or per manufacturer recommendations. 5. Wash hands or use alcohol gel as appropriate. Review of the facility policy [redacted] revised August 2011 revealed the following: The purpose of this procedure is to guide the safe handling of [redacted] to prevent transmission of blood borne diseases to residents and employees. Steps in the procedure: 1. Wash hands. 2. Don gloves. 3. Place [redacted] device on clean field. 4. Wipe the area to be lanced with an alcohol pledget. 5. Obtain the blood sample, following the manufacturer's instructions for the device. 6. Discard lancet into the sharps container. 7. Following the manufacturer's instructions, clean and disinfect [redacted] device after each use with 10% bleach preparation. 8. Remove gloves, and discard into appropriate receptacle. 9. Wash hands. 10. Replace [redacted] device in storage area after cleaning. Review of the undated Guidelines for Cleaning and Disinfecting the [redacted] revealed the following: To minimize the risk of transmitting blood-borne	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
	285106	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD NURSING & REHAB LAKEVIEW	1405 WEST HWY 34 GRAND ISLAND, NE 68801

(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 18	F 880		

pathogens, the cleaning and disinfecting procedure should be performed as recommended in the instructions below. The [redacted] may only be used for testing multiple patients when standard precautions and the manufacturer's disinfecting procedures are followed. The meter should be cleaned and disinfected after use on each patient. The cleaning procedure is needed to clean dirt, blood and other bodily fluids off the exterior of the [redacted] before performing the disinfecting procedure. The disinfecting procedure is needed to prevent the transmission of blood-borne pathogens. ARKRAY recommends using these wipes to clean and disinfect the [redacted] Clorox Healthcare Bleach Germicidal Wipes. Option 1: Obtain a commercially available EPA-registered disinfectant detergent or germicide wipe. Carefully review the manufacturer's instructions. Clean and disinfect the meter following step-by-step instructions. Options 2: Clean the outside of the [redacted] with a lint-free cloth dampened with soapy water or isopropyl alcohol. Disinfect the [redacted] by diluting 1 ml of household bleach (5-6% hypochlorite solutions) in 9 ml water to achieve a 1:10 dilution. Use a lint-free cloth dampened with the solution to thoroughly wipe down the [redacted] Cleaning and Disinfecting Procedures: Open the cap of the disinfectant container and pull out 1 towelette and close the cap. Wipe surface of the [redacted] to clean blood and other body fluids. Carefully wipe around the test strip port by inverting the meter so that the test strip port is facing down. This prevents disinfectant liquid from entering the [redacted] Dispose of the used towelette in a trash bin. The [redacted] should be cleaned prior to each disinfection step. Pull out 1 new towelette and wipe the entire

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285106	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD NURSING & REHAB LAKEVIEW	1405 WEST HWY 34 GRAND ISLAND, NE 68801

(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 19 surface of the [redacted] horizontally and vertically to remove blood borne pathogens. Carefully wipe around the [redacted] port by inverting the [redacted] so that the [redacted] port is facing down. This prevents disinfectant liquid from entering the [redacted] Treated surface must remain wet for recommended contact time. Please refer to wipe manufacturer's instructions. Do not wrap the [redacted] in a wipe. Dispose of the used towelette in a trash bin. Record review of the label on the Clorox non-bleach wipes read the following: Wipe surface to be disinfected. Use enough wipes for treated surface to remain visibly wet for 4 minutes. Interview with RN-K on 6/9/2020 at 12:34 PM revealed staff were expected to throw the face shield away after use and get a new one or clean it and use for 1 staff person only. The staff were not to use the same face shields. The staff were also expected to clean the face shield and wait for the disinfectant for work if they were going to re-use it and for only 1 staff person. RN-K revealed the staff were expected to follow the package directions on the disinfectant for contact or "wet set" time when cleaning the [redacted] Staff were expected to do hand hygiene after they removed gloves and change the gloves when they were contaminated. Interview with DON-A (Director of Nursing) on 6/9/2020 at 12:34 PM revealed the staff were expected to disinfect the [redacted] with the wipes for 5 minutes or whatever it read on the package of the disinfectant.	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
	285106	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD NURSING & REHAB LAKEVIEW	**1405 WEST HWY 34 GRAND ISLAND, NE 68801**

(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 20 D. Observation on 6/9/2020 at 8:49 AM revealed that Housekeeping Aide-D (HA-D) removed cleaned laundry from the rack on the laundry cart in the hallway. HA-D carried the laundry into the room of Residents 12 and 13 and hung the laundry in the closet. HA-D exited the resident room carrying empty hangers from the resident closet and hung the used hangers on the rack of the laundry cart. HA-D did not perform 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). HA-D removed cleaned laundry from the rack on the laundry cart and carried the laundry into the room of Residents 14 and 7. Resident 14 took the hanger from HA-D and removed the cleaned laundry item and HA-D carried the empty hanger out of the resident room and hung it on the rack of the laundry cart. HA-D did not perform hand hygiene. HA-D removed cleaned laundry from the rack on the laundry cart and carried the laundry into the room of Residents 15 and 16 and hung the laundry in the closet. Resident 16 told HA-D that the resident had placed several empty hangers on the end of the rack in the closet and requested that HA-D remove the empty hangers. HA-D removed the empty hangers from the closet and exited the resident room and hung the empty hangers on the rack of the laundry cart. Interim Director of Nursing-F (DON-F) walked up to HA-D and told HA-D something that this surveyor was unable to hear. HA-D responded "oh, sorry" to DON-F and then performed hand hygiene with alcohol based hand rub. HA-D removed cleaned laundry from the rack on the laundry cart and carried the laundry into the room of Residents 2 and 17. HA-D exited the room carrying empty	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
	285106	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD NURSING & REHAB LAKEVIEW	**1405 WEST HWY 34 GRAND ISLAND, NE 68801**

(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 21 hangers from the resident closet and hung the used hangers on the rack of the laundry cart. HA-D performed hand hygiene using alcohol based hand rub. Record review of the facility policy titled Infection Prevention and Control Program dated 05-20-2017 revealed step 4. Hand Hygiene Protocol: a. All staff shall wash their hands when coming on duty, between resident contacts, after handling contaminated objects, after Personal Protective Equipment (PPE- gloves, gowns, masks) removal, before/after eating, before/after toileting, and before going off duty. Step 10. Linens: a. Laundry and direct care staff shall handle, store, process, and transport linens so as to prevent the spread of infection. E. Observation on 6/8/2020 at 1:57 PM revealed that Nursing Assistant-B (NA-B) and Nursing Assistant-C (NA-C) entered the room of Resident 20 with a sit to stand lift (a mechanical assistive device used to transfer a resident with difficulty standing up on their own from a seated position) to transfer Resident 20 from the wheelchair to the recliner. NA-B and NA-C put on disposable gloves without performing 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) prior to putting the gloves on. NA-B placed the lift sling (a fabric device with straps that is placed around the back of a resident when a sit to stand lift is used to transfer a resident with difficulty or inability to	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
	285106	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD NURSING & REHAB LAKEVIEW	1405 WEST HWY 34 GRAND ISLAND, NE 68801

(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 22	F 880		

stand up on their own from a seated position) behind the resident's back and then hooked the sling hooks to the lift on one side while NA-C hooked the lift sling to the lift on the other side of the lift. The resident was lifted to a standing position from the wheelchair and transferred to the front of the recliner. The resident was then lowered onto the recliner and the lift sling was disconnected from the lift and removed from behind the resident. NA-B wiped down the lift surfaces including the area the resident gripped during the lift process using a disinfectant wipe. NA-C removed and discarded the disposable gloves and left the room without performing hand hygiene. NA-B removed the disposable gloves and did not perform hand hygiene.

Observation on 6/9/2020 at 9:52 AM revealed that Nursing Assistant- B (NA-B) wiped the total body lift (a mechanical assistive device used to transfer a resident with difficulty standing up on their own) in the hall outside of Resident 19's room using a disinfectant wipe. Nursing Assistant-E (NA-E) arrived at Resident 19's room with a lift sling (a fabric device with straps that is placed underneath a resident when a total body lift is used to transfer a resident with difficulty or inability to stand up on their own from a seated or lying position). NA-B and NA-E put on disposable gloves without performing hand hygiene prior to putting the gloves on. NA-B and NA-E placed the lift sling under Resident 19 in the recliner. NA-E got the total body lift from the hallway and brought it into Resident 19's room and placed it in front of Resident 19 seated in the recliner. NA-B and NA-E attached the lift sling to the total body lift and transferred Resident 19 to bed. NA-B and NA-E unhooked the lift sling from the total body lift and moved the lift away from the bed and

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285106	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD NURSING & REHAB LAKEVIEW	**1405 WEST HWY 34 GRAND ISLAND, NE 68801**

(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 23 performed cleaning of the resident's private area after Resident 19 had a bowel movement. NA-B and NA-E connected the lift sling to the total body lift and transferred Resident 19 from the bed to the wheelchair. NA-E wiped the total body lift with disinfectant wipes. NA-E removed the disposable gloves and did soap hand washing for 12 seconds and left the room. NA-B removed the used trash bag from the trash can in the room and placed a new trash bag into the trash can. NA-B carried the used trash bag across the hallway from Resident 19's room and entered the code on the door lock of the soiled utility room and opened the door and discarded the trash. NA-B returned to Resident 19's room and entered the room and removed the disposable gloves. NA-B washed hands with soap and water scrubbing for 10 seconds. Record review of the undated facility Skills Check Personal Protective Equipment revealed the Steps of Procedure: Applying Gloves: -Wash and dry hands. Remove and secure any jewelry which may tear gloves. -Remove gloves from box one at a time. -Place hand in opening and pull glove up to wrist. Repeat with second glove. -Adjust gloves to cover wrists or cuff of gown. -Do not touch any part of your body with gloved hands. Removing Gloves: -Grasp one glove at the wrist below the hand on the outside of the glove. Do not touch skin. -Pull down glove turning it inside out and pull off hand. Hold glove in the still gloved hand. -Insert fingers of ungloved hand under the cuff of remaining glove, pull down turning inside out and pulling over glove in hand.	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
	285106	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD NURSING & REHAB LAKEVIEW	**1405 WEST HWY 34 GRAND ISLAND, NE 68801**

(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 24 -Discard gloves into trash container. -Wash hands. Record review of the facility policy titled Infection Prevention and Control Program dated 05-20-2017 revealed step 4. Hand Hygiene Protocol: a. All staff shall wash their hands when coming on duty, between resident contacts, after handling contaminated objects, after Personal Protective Equipment (PPE- gloves, gowns, masks) removal, before/after eating, before/after toileting, and before going off duty. b. Staff shall wash their hands before and after performing resident care procedures. c. Hands shall be washed in accordance with our facility's established hand washing procedure. Record review of the facility policy titled COVID-19 Guideline dated 5/16/20 revealed Prevention Measures step 2: The facility maintains an Infection Prevention and Control Program. Everyday standard precautions and preventive actions should be used and include: a. Appropriate hand hygiene: Wash your hands for at least 20 seconds especially after using the restroom, before eating and after blowing your nose, coughing or sneezing. Always wash your hands when they are visibly soiled. b. Use an alcohol-based sanitizer if soap and water is not readily available and/or when hands are not visibly soiled. The immediate jeopardy began ion 4/6/2020 when the facilty began admitting residents without isolation or grey zone until 6/9/2020. On 6/9/2020 the facility abated the deficient practice to a level C.	F 880		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285106	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD NURSING & REHAB LAKEVIEW	**1405 WEST HWY 34 GRAND ISLAND, NE 68801**

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

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

Electronically Signed | 07/22/2020

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
	285219	A. BUILDING _____ B. WING _____	06/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHLAKE VILLAGE REHABILITATION & CARE CENTER	**9401 ANDERMATT DRIVE LINCOLN, NE 68526**

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

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

Electronically Signed | 07/09/2020

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

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

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

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

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

Electronically Signed | 07/23/2020

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

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

Pete Ricketts, Governor

July 10, 2020

Tamara Scheil, Administrator
Fairview Manor
255 F Street
Fairmont, NE 68354-0427

CMS CERTIFICATION NUMBER: 285206

Dear Ms. Scheil:

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

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 8, 2020

Valerie Buckminster, Administrator
Falls City Care Center
2800 Towle Street
Falls City, NE 68355 **CMS Certification No. 285114**

Subject: Survey Results
Cycle Start Date: June 15, 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 15, 2020, a survey was completed at Falls City Care Center by the State Survey Agency to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the CMS 2567 and will be posted on the ePOC system.

PLAN OF CORRECTION

A Plan of Correction (PoC) for the deficiencies must be submitted **by July 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 15, 2020 survey, you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board (DAB). The appeal rights are set forth at 42 C.F.R. § 498.5 and the procedures for requesting a hearing are set forth at §498.40, et seq. You must file your hearing request electronically by using the DAB's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov/, unless you obtain a waiver from the DAB (*see* DAB Civil Remedies Division Procedures, § 6(a)(i)(1)). Your appeal must be filed no later than 60 days from the date of receipt of this letter.

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

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

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

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

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

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

CONTACT INFORMATION

If you have any questions please contact this office.

Sincerely,

Connie F Vogt RN,BSN

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

CV/kd

Enclosures: CMS 2567

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

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

Pete Ricketts, Governor

August 31, 2020

Ms. Valerie Buckminster, Administrator
Falls City Care Center
2800 Towle Street
Falls City, NE 68355

Dear Ms. Buckminster:

We would like to place your facility back into compliance for the June 15, 2020 survey, however, in order to do that we need you to provide written evidence that shows that you have completed all corrective actions outlined in your Plan of Correction (POC). These examples could be, but are not limited to, new policies and procedures, attendance sign in sheets for education, invoices showing supplies ordered or completed, audits as outlined in the POC, etc. Failure to provide this information may impact your provider agreement with CMS.

Please email the requested information to **dhhs.healthcarefacilities@nebraska.gov** by September 4, 2020.

If you have any questions, please contact this office at the number listed below.

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

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285114	A. BUILDING _____ B. WING _____	06/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS CITY CARE CENTER	2800 TOWLE STREET FALLS CITY, NE 68355

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

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

Electronically Signed | 07/17/2020

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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285114	A. BUILDING _____ B. WING _____	06/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS CITY CARE CENTER	2800 TOWLE STREET FALLS CITY, NE 68355

(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	Correction to resident(s) affected:	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285114	A. BUILDING _____ B. WING _____	06/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS CITY CARE CENTER	2800 TOWLE STREET FALLS CITY, NE 68355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observation, interview, and record review; the facility failed to implement infection control practices and Centers for Medicare and Medicaid Services (CMS) guidelines to prevent potential cross contamination including the spread of COVID-19 related to failing to verify screening results for facility employees which had the potential to effect all residents and failed to implement isolation procedures for shingles for 1 (Resident 4) of 4 sampled residents. The facility staff identified a census of 57. Findings are: A. Record review of a Admission Record sheet printed on 6-15-2020 revealed Resident 4 was admitted to the facility on [redacted]. Review of Resident 4's Progress Notes (PN) dated [redacted] revealed Resident 4 [redacted] Review of Resident 4's PN dated [redacted] revealed Resident 4's practitioner order a medication for the treatment of the [redacted] Record review of Resident 4's PN dated dated [redacted] revealed Resident 4 was on medication [redacted] with the current skin issue identified as [redacted] Record review of Resident 4's PN dated [redacted]	F 880	(A) On 6/15/20 resident 4 was immediately placed in contact isolation, signage added to resident room door, affected areas covered with dressing & NA E, NA F and Charge Nurse were immediately educated on isolation protocols. There was no evidence of spread of contagious illness among staff or residents of the facility following the survey. Nursing Assistant E was re-educated on proper hand hygiene and glove changing policy & procedure at time of survey. Director of Nursing & Infection Control Preventionist were educated on date of survey of the expectation to follow-up on all known communicable diseases or infections to assure isolation protocol was put in place immediately. System Changes (Identification & Correction for Other Residents): All residents with identified symptoms of suspected illness will be placed in isolation immediately by Charge Nurse and/or designee until confirmed diagnosis received. DON/ICP will follow-up on all symptoms and/or illness requiring isolation precautions to assure protocol is followed. Review of 24 hour progress notes required daily & findings will be discussed in Quality Conference meetings. All nursing staff will be educated on general infection control practices including hand hygiene and glove changing procedure by 7/23/20 by DON and/or designee. All nursing staff will be educated on recommended YouTube training videos Clean Hands & Closely	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285114	A. BUILDING _____ B. WING _____	06/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS CITY CARE CENTER	2800 TOWLE STREET FALLS CITY, NE 68355

(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 3 Record review of Resident 4's Medication Administration Record (MAR) for June 2020 revealed Resident 4 practitioner order the [redacted] Observation on 6-15-2020 at 11:28 AM revealed Nursing Assistant (NA) E and NA F donned gowns and had facial mask. NA E and NA F entered Resident 4's room, washed hands and donned gloves. NA E obtained a wipe and completed personal care for Resident 4 who had been incontinent of urine. NA E with the same soiled gloves touched Resident 4's arm, pants, blouse, clean brief, blanket and Resident 4's leg. NA E removed the soiled gloves and without handwashing or sanitizing,donned new gloves. NA E assisted NA F with transferring Resident to a wheelchair, removed the gloves, a gown and did not handwash and left Resident 4's room. Further observations revealed Resident 4 had [redacted] NA E reported Resident 4 has On 6-15-2020 at 11:57 AM an interview was conducted with NA E. During the interview NA E confirmed the soiled gloves were not changed and should have been. On 6-15-2020 at 2:13 PM an interview was conducted with the Infection Control Preventionist (ICP). During the interview the ICP confirmed Resident 4 had [redacted] and should be in isolation. The ICP confirmed there was not signage indicating Resident 4 was in isolation further reported seeing Resident 4's [redacted]	F 880	Monitor Residents and on standard infection control practices of facility by DON and/or designee by 7/23/20. Monitoring Process for the System Change Including Frequency and Title: DON and/or designee will audit progress notes, hand hygiene, glove changing procedure and isolation precautions. Weekly audits x 8 weeks, monthly x 4 months, quarterly thereafter until resolved on next survey. The results of audits will be reviewed and discussed at monthly QAPI committee meeting for input to increase, decrease or discontinue the audits. Correction to resident(s) affected: (B,C,D,E) Employee H, I, J, symptoms were resolved at time of survey, DON was tested for COVID-19 and found to be negative prior to returning to work as noted on screening form at time of survey. No residents displayed symptoms, were diagnosed with communicable disease, infection or confirmed for COVID-19 for the 14 days following the date of each employee screening form. System Changes (Identification & Correction for Other Residents): All Employees will be educated by DON and/or Designee on revised Building Entrance Screening Process Protocol, Employee Screening Form and Employee Health □ Infection Control Policy, YouTube training for Keep Covid-19 Out & Closely Monitor Residents recommended	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285114	A. BUILDING _____ B. WING _____	06/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS CITY CARE CENTER	2800 TOWLE STREET FALLS CITY, NE 68355

(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 B. A record review of a [redacted] Illness STAFF Questionnaire (RISQ, a screening for [redacted] sheet dated 6/12/20 revealed that NA-H had symptoms of [redacted] Further review of NA H's RISQ sheet dated 6/12/20 revealed there was no evidence NA H's symptoms were evaluated prior to allowing NA H to work. On 6-15-2020 at 4:10 PM an interview was conducted with the facility Administrator. During the interview, review of NA H's RISQ sheet dated 6-12-2020 was completed. The facility Administrator confirmed there should have been follow up with NA H's symptoms and was not. C. A record review of a RISQ form for NA-I dated 6/11/20 revealed that NA-I had been in contact with a person who had traveled outside the state in the last 14 days and documented a low grade temperature. Further review of NA I's RISQ sheet dated 6/11/20 revealed there was no evidence of evaluation of NA I's responses prior to NA-I being allowed to work. On 6-15-2020 at 4:10 PM an interview was conducted with the facility Administrator. During the interview, review of NA H's RISQ sheet dated 6-12-2020 was completed. The facility Administrator confirmed there should have been follow up with NA H's symptoms and was not. D. A record review of the RISQ form for dietary aide-J dated 6/12/20 revealed that dietary aide-J had a temperature of [redacted]. Further review of dietary aide J's RISQ sheet dated 6/12/20 revealed no evidence dietary aide J's temperature had been evaluated prior to allowing dietary aide J to work.	F 880	videos. Administrator will educate all designated screeners & licensed nurses by 7/23/20 on process to follow when negative screening form is completed per facility policy. Screening investigation log will be completed by screener to track all investigations and decisions on work permitted or excluded. All Work/No work decisions will be made by Administrator, DON or designee. DON and/or designee will review forms with spot checks twice per day and report adverse findings to Administrator. Monitoring Process for the System Change Including Frequency and Title: DON and/or designee will monitor all employee screens for accuracy & follow-up investigation process 2 x per day x 8 weeks, daily x 4 weeks, weekly x 3 months, quarterly thereafter until resolved on next survey visit. The results of audits will be reviewed and discussed at monthly QAPI committee meeting for input to increase, decrease or discontinue the audits.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285114	A. BUILDING _____ B. WING _____	06/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS CITY CARE CENTER	2800 TOWLE STREET FALLS CITY, NE 68355

(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 On 6-15-2020 at 4:10 PM an interview was conducted with the facility Administrator. During the interview, review of NA H's RISQ sheet dated 6-12-2020 was completed. The facility Administrator confirmed there should have been follow up with NA H's symptoms and was not. E. A record review of the RISQ form for the Director of Nursing (D.O.N.) dated 6/11/20 revealed that the D.O.N. had a symptom of [redacted] Further review of the D.O.N.'s RISQ sheet revealed there was no evidence that the D.O.N.'s symptoms were evaluated prior to allowing the D.O.N. to work. On 6-15-2020 at 4:10 PM an interview was conducted with the facility Administrator. During the interview, review of the D.O.N.'s RISQ sheet dated 6-11-2020 was completed. The facility Administrator confirmed there should have been follow up with the D.O.N's symptoms and was not.	F 880		

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

Pete Ricketts, Governor

July 20, 2020

Ann Erickson, Administrator
Florence Home
7915 North 30th Street
Omaha, NE 68112

CMS CERTIFICATION NUMBER: 285173

Dear Ms. Erickson:

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

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

Pete Ricketts, Governor

July 20, 2020

Ann Erickson, Administrator
Florence Home
7915 North 30th Street
Omaha, NE 68112

Dear Ms. Erickson:

An unannounced visit was conducted to investigate a complaint at Florence Home on July 15, 2020-July 16, 2020, by representatives of the Department of Health and Human Services Division of Public Health. To complete this investigation, a representative sample of the residents who reside in the facility or had resided in the facility was selected. The investigative process included review of resident records; observation of the provision of care and services; and interviews with residents, family members and staff.

ALLEGATION:
The facility fails to report change in condition as required.

FINDINGS:
The facility reported change in condition as required. To make this determination, record reviews of residents identified as having had a change in condition revealed resident representatives were notified as required. Interviews with staff revealed staff were aware of who the residents emergency contact is and how to notify the emergency contact of a change in condition of the resident. The facility was found to be in compliance with the 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

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

Pete Ricketts, Governor

July 2, 2020

Larry Van Hunnik, Administrator
Gateway Senior Living
225 North 56th Street
Lincoln, NE 68504

CMS CERTIFICATION NUMBER: 285266

Dear Mr. Van Hunnik:

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

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

Pete Ricketts, Governor

July 23, 2020

Larry Van Hunnik, Administrator
Gateway Senior Living
225 North 56th Street
Lincoln, NE 68504

CMS CERTIFICATION NUMBER: 285266

Dear Mr. Van Hunnik:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 20, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

Pete Ricketts, Governor

June 24, 2020

Jeff Fritzen, Administrator
Gold Crest Retirement Center
200 Levi Lane
Adams, NE 68301

CMS CERTIFICATION NUMBER: 285065

Dear Mr. Fritzen:

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

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285203	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BEATRICE	401 S 22ND STREET BEATRICE, NE 68310

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS References to Title 175 of the Nebraska Administrative Code, Chapter 12- "Regulations Governing Licensure of Skilled Nursing Facilities, Nursing Facilities, and Intermediate Care Facilities" have been included in survey report as they apply to deficient practices identified.	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		7/15/20

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
	285203	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BEATRICE	401 S 22ND STREET BEATRICE, NE 68310

(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 12-006.17B	F 880	Statement of Compliance: Preparation and execution of this response and plan	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285203	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BEATRICE	401 S 22ND STREET BEATRICE, NE 68310

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observation, record review and interview; the facility failed to ensure staff donned (put on) N95 or surgical mask with face shield to enter grey zone isolation room; and failed to properly doff (take off) PPE (Personal Protective Equipment) before exiting grey zone isolation room and to properly doff gown to prevent the potential for cross contamination. This had the potential of affect all residents on the 300 and 400 hallways, 24 residents total. The facility census was 64. Findings are: Observation on 6/24/20 at 10:00am of LPN B and LPN C donning PPE to go into a grey zone isolation room revealed both LPN B and LPN C used hand sanitizer and donned gown and gloves, N95 mask and face shield were already worn by both LPN B and LPN C and entered grey zone room 316. When ready to leave grey zone isolation room, both LPN B and LPN C exited the room and outside of the room, removed gloves, hand sanitized and removed gown and placed in trash can and the performed hand hygiene. LPN B and LPN C then walked to the medication cart where they unlocked the medication cart and obtained disinfectant wipes and wiped face shield. Observation on 6/24/20 at 10:06am of Housekeeper A revealed that Housekeeper A was standing outside room [redacted] with surgical mask on. Housekeeper A donned gown and gloves and	F 880	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 purposes of any allegation that the center is not in substantial compliance with the federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with the State Operations Manual LPNs B and C and Housekeeper A were re-educated by IP Nurse immediately on 6/24/2020 regarding correct PPE as well as donning and doffing PPE in gray zone rooms. A touchless garbage can was placed inside room [redacted] to assure staff doff PPE and discard it into bag/bin before leaving room. All current gray zone rooms have been audited to assure they are equipped with touchless garbage cans placed inside the rooms to assure staff doff PPE and discard it into the bag/bin before leaving room, and to assure disinfectant is located at the room entrance for immediate accessibility to sanitize face shields. To protect residents in similar situations, DNS, Household Services Director or designee will audit at random future gray zone rooms for compliance. Staff educated by IP nurse or designee	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285203	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BEATRICE	401 S 22ND STREET BEATRICE, NE 68310

(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 3 went into grey zone isolation room 308 with 2 bottles of chemicals. At 10:07am, Housekeeper A walked out of room [redacted] with PPE on and put the 2 bottles of chemicals back onto housekeeping cart and then walked back into room 308. At 10:08am Housekeeper A walked out of isolation room with PPE on and threw trash from room 308 into trash can outside of room and took mop from mop bucket and went back into room 308. At 10:09am Housekeeper A came out of room 308 and put mop back in bucket and then took a rag from the housekeeping cart and went back into room [redacted] and at 10:11am, Housekeeper A came out of room [redacted] and removed gown by pulling straight down on front of gown and then ripped the front of the gown all the way down and put hands straight out with front of the gown exposed and moving the front of the gown toward both sides away from self. Record review of Droplet Precaution educational material from Emory University provided by facility revealed that gowns should be removed by rolling the gown inward and gown and gloves should be removed before exiting the isolation room. Record review of Infection Control Assessment and Promotion Program (ICAP), revised 4/20/20 states to place a laundry bag/bin near the exit of each resident room in isolation for staff members to doff PPE and discard it into bag/bin before leaving the room. Record review of CDC (Centers for Disease Control and Prevention), Interim Infection	F 880	regarding correct PPE for gray zone rooms and correct donning and doffing of PPE. DPoC completed with all staff educated using the online videos: Sparkling Surfaces, Clean Hands, Closely Monitor Residents, Keep COVID-19 Out!, and Lessons--Use Personal Protective Equipment Correctly for COVID-19. PPE guidelines for zones and donning/doffing guidelines have been posted in break rooms, common areas, nursing stations for quick reference. A PIP has been initiated regarding proper donning and doffing of PPE in gray zone areas including properly doffing before exiting gray zone room. DNS and Household Services Director or designee will conduct audits regarding PPE, donning and doffing and sanitizing will be conducted for all gray zone rooms weekly for 4 weeks and random gray zone rooms monthly for 3 months. PIP sustainability tool will be implemented by QAPI team to assure sustainability and that the problem will not recur. Results will be reported and reviewed by QAPI committee.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285203	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BEATRICE	401 S 22ND STREET BEATRICE, NE 68310

(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 Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 in Healthcare Settings, revised 6/19/20 revealed that gloves and gowns should be removed before leaving the patient room. Record review of CDC (Centers for Disease Control and Prevention), FAQ's (Frequently Asked Questions) for Health Care Infection Prevention and Control guidance, updated April 23, 2020 reveals that if Environmental Services Personnel are in isolation rooms, they should wear all recommended PPE when in the room. PPE should be removed upon leaving the room, immediately followed by performance of hand hygiene. Management of laundry, food service utensils and medical waste should also be performed in accordance with routine procedures. Interview on 6/24/20 at 2:48pm with QAPI Coordinator revealed that the expectation of staff entering a grey zone isolation room would be to have a mask on, either a N95 or a surgical mask with a face shield, that PPE would be removed before exiting the isolation room and that gowns be removed by rolling the gown inward.	F 880		

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

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 8, 2020

Kassandra Schultz, Administrator
Good Samaritan Society - Grand Island Village
4061 Timberline Street & 4055 Timberline Street
Grand Island, NE 68803 **CMS Certification No. 285285**

Subject: **Survey Results**
Cycle Start Date: June 18, 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 18, 2020, a survey was completed at Good Samaritan Society - Grand Island Village by the State Survey Agency to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the CMS 2567 and will be posted on the ePOC system.

PLAN OF CORRECTION

A Plan of Correction (PoC) for the deficiencies must be submitted **by July 18, 2020**, to the State Survey Agency Contact. **Failure to submit an acceptable PoC by July 18, 2020 may result**

in the imposition of additional remedies.

The PoC must contain the following:

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

ENFORCEMENT REMEDIES

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

- **Directed Plan of Correction:**

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

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

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

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

Connie Vogt, RN, BSN

Email: dhhs.healthcarefacilities@Nebraska.gov

In the Subject Line please put: DPOC

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

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

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

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

  Payment will be denied for all NEW Medicare and Medicaid admissions, beginning August 10, 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)

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
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

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 18, 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
DPOC

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
	285285	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GRAND ISLAND VILLAGE	4061 TIMBERLINE STREET & 4055 TIMBERLINE STREET GRAND ISLAND, NE 68803

(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=G	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		8/7/20

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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285285	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GRAND ISLAND VILLAGE	4061 TIMBERLINE STREET & 4055 TIMBERLINE STREET GRAND ISLAND, NE 68803

(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 12-006.17B	F 880	Preparation and execution of this response and plan of correction does not	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285285	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GRAND ISLAND VILLAGE	4061 TIMBERLINE STREET & 4055 TIMBERLINE STREET GRAND ISLAND, NE 68803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 LICENSURE REFERENCE NUMBER 175 NAC 12-006.17D LICENSURE REFERENCE NUMBER 175 NAC 12-006.18C LICENSURE REFERENCE NUMBER 175 NAC 12-006.11E Based on observation, interview, and record review; the facility staff failed to implement measures to prevent the potential spread of Covid-19 by failing to store disposable PPE (Personal Protective Equipment) to prevent potential cross contamination which had the potential to affect 2 of the 23 residents residing on the Cottonwood unit (Residents 14 and 15); failing to change gloves and perform hand hygiene during cares for Resident 11; failing to clean the STS (Sit to Stand) lift between residents to prevent potential cross contamination which had the potential to affect 10 of 37 residents residing on the Cottonwood and Ash Grove units (Residents 16, 9, 17, 18, 11, 20, 12, 21, 22, and 8); failing to distribute clean clothing to prevent potential cross contamination for 1 of 3 residents observed (Resident 13); failing to clean the whirlpool bathtub to prevent potential cross contamination for 6 of 6 residents who used the whirlpool bathtub on the Cottonwood unit (Residents 19, 11, 20, 13, 21, and 23); failing to cover drinks during the distribution of meal trays which affected all 22 of the residents on the Cottonwood unit who received a meal tray; and the facility failed to ensure that staff used N95 masks (a filtering facemask worn to protect healthcare professionals from inhaling infectious particles and preventing the spread of respiratory infection between healthcare professionals and patients) to prevent the potential for cross contamination of Covid-19 for 3 residents	F 880	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 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 7305 of the State Operations Manual. F880 – Infection Prevention and Control A. • Immediate education was provided to all staff regarding appropriate storage of disposable PPE on June 19th, 2020. Additional education for all nursing staff was completed by June 30th, 2020. • An audit was conducted to ensure there was no additional disposable PPE that was at risk for cross contamination; all found were corrected immediately to protect all residents. • Additional education was provided to all staff regarding appropriate storage of disposable PPE through the recommended CDC YouTube videos through the Directed Plan of Correction by July 18th, 2020. • The Director of Nursing and/or designee will audit properly stored PPE for gray zoned rooms. This audit will be completed Monday-Friday for 2 weeks, 3x/week for 1 week, and 1x/week for 1	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285285	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GRAND ISLAND VILLAGE	4061 TIMBERLINE STREET & 4055 TIMBERLINE STREET GRAND ISLAND, NE 68803

(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 3 (Residents 1, 5, and 6) in the facility gray zone (a dedicated unit in the facility used to quarantine newly admitted residents who are at higher risk of getting exposed to COVID-19 but have no known exposure to COVID-19). The facility identified a census of 43 at the time of survey. Findings are: A. Observation on 6/17/2020 at 10:03 AM revealed 2 blue plastic gowns were hanging outside the door of Residents 14 and 15 (who resided in the room together) and 1 blue gown was hanging over the hand rail by their room that was touching the floor. The blue gowns hanging on the wall were touching each other. Observation on 6/17/2020 at 10:55 AM revealed the gowns were still hanging touching each other by the door and the gown was hanging over the hand rail touching the floor by the room occupied by Residents 14 and 15. Observation on 6/17/2020 at 11:31 AM revealed LPN-F (Licensed Practical Nurse) took one of the gowns off the wall hanging outside the door of the room occupied by Residents 14 and 15. It was a blue thin plastic gown that was hanging on the wall touching another gown hanging on the wall next to it. LPN-F put it on over their head and had to adjust the face shield they were wearing to get the gown on over it. LPN-F entered the room and did a BS (Blood Sugar) check for Resident 14. LPN-F then left the room and stopped outside the room door. LPN-F removed the gown from over their head and hung it back up on the wall, touching the gown hanging next to it. Interview with LPN-F at this time revealed they had to wear a gown and gloves in addition to a	F 880	week. • Findings from audits will be taken to the monthly QAPI Committee Meetings for further review and monitoring. B. • Immediate education was provided to all staff regarding wiping down lifts on June 19th, 2020 to protect all residents. Additional education for all nursing staff was completed by June 30th, 2020. • Additional education was provided to all staff regarding appropriate glove use, hand hygiene, and cleaning of surfaces through the recommended CDC YouTube videos through the Directed Plan of Correction by July 18th, 2020. • The Director of Nursing and/or designee will audit the following: glove use and hand hygiene during cares and sanitizing lifts. These audits will be completed Monday-Friday for 2 weeks, 3x/week for 1 week, and 1x/week for 1 week. • Findings from audits will be taken to the monthly QAPI Committee Meetings for further review and monitoring. C. • Immediate education was provided to all staff regarding distribution of clean clothing on June 19th, 2020 to protect all residents. Additional education for all nursing staff was completed by June 30th, 2020. • Additional education was provided to all staff regarding proper hand hygiene and distribution of clean linen/clothing through the recommended CDC YouTube	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285285	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GRAND ISLAND VILLAGE	4061 TIMBERLINE STREET & 4055 TIMBERLINE STREET GRAND ISLAND, NE 68803

(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 face shield and surgical mask when they went into the room being occupied by Resident 14 and 15 because Resident 15 went out of the facility to [redacted] so the staff always had to "gown up" when they entered that room. Observation on 6/17/2020 at 12:30 PM revealed the blue gowns were still hanging by the door touching each other and over the hand rail touching the floor by the room occupied by Residents 14 and 15. B. Observation on 6/17/2020 at 10:23 AM revealed NA-H (Nursing Assistant) using the STS lift to transfer Resident 11. NA-H took a STS lift from the hall and wheeled it into Resident 11's room. NA-H donned gloves. NA-H touched Resident 11's control on Resident 11's power wheelchair and the STS lift. NA-H tried to put shoes on Resident 11's feet by handling the bottom and sides of the shoes. They did not fit over the thick socks Resident 11 was wearing so NA-H took them off as they were tight. NA-H felt the bottom of Resident 11's foot which had a sock on it and said Resident 11 has the grippers on their socks. NA-H helped Resident 11 sit up by touching their shoulders and arms then NA-H grabbed the lift. NA-H then put the sling around Resident 11's mid torso. NA-H still had the same gloves on. NA-H was touching the sling, the resident, and the lift with the same gloves NA-H touched Resident 11's shoes and the bottom of their socks with. Resident 11 then grabbed the hand rails on the lift. NA-H then adjusted NA-H's face mask with the same gloved hands. NA-H then touched Resident 11's hand when NA-H was helping Resident 11 get into the STS. NA-H touched the controls to stand Resident 11 and positioned Resident 11 in front of their power	F 880	videos through the Directed Plan of Correction by July 17th, 2020. • The Laundry Supervisor and/or designee will audit distribution of clean linen/clothing to not touch any dirty surfaces and proper hand hygiene during delivery. This audit will be completed Monday-Friday for 2 weeks, 3x/week for 1 week, and 1x/week for 1 week. • Findings from audits will be taken to the monthly QAPI Committee Meetings for further review and monitoring. D. • Immediate education was provided to the 2 bath aides on June 18th, 2020 to protect all residents. Additional education for all nursing staff was completed by June 30th, 2020. • Additional education was provided to all staff regarding proper disinfecting of surfaces through the recommended CDC YouTube videos through the Directed Plan of Correction by July 17th, 2020. • The Director of Nursing and/or designee will audit the whirlpools being properly disinfected for 10 minutes following use. This audit will be completed Monday-Friday for 2 weeks, 3x/week for 1 week, and 1x/week for 1 week. • Findings from audits will be taken to the monthly QAPI Committee Meetings for further review and monitoring. E. • Immediate education was provided to all staff regarding covering drinks during the distribution of meal trays on June 19th, 2020 to protect all residents.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285285	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GRAND ISLAND VILLAGE	4061 TIMBERLINE STREET & 4055 TIMBERLINE STREET GRAND ISLAND, NE 68803

(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 wheelchair. Resident 11 let go of the STS lift after they were seated in their wheelchair and NA-H removed the sling with the same gloved hands. NA-H then touched Resident 11 on the shoulder to help Resident 11 slide back into the wheelchair. NA-H then removed the gloves and got Resident 11 a blanket. NA-H did not perform hand hygiene after removing their gloves. NA-H then tucked the blanket around Resident 11's waist and legs. NA-H touched the STS lift with bare hands to move it so NA-H could get into the bathroom as the lift was in front of the bathroom door. NA-H then went into the bathroom and washed hands. NA-H touched the door knobs on the room door and bathroom door and put the lift back out into the hall. NA-H did not clean the STS lift. NA-H put the STS lift in the hall and left it after NA-H and Resident 11 touched it. NA-H did not have Resident 11 do any hand hygiene. Resident 11 then used the control on the power wheelchair to drive down the hall. NA-H reported they were headed to the bath house for Resident 11's whirlpool bath. Review of the EZ Way Floor Lift & Stand Cleaning Guide revised 8/14/18 revealed the following: To keep your EZ Way floor lifts and stands clean and in good condition, recommend that you use a standard germicidal spray, Sani-Wipe, or similar product and that you follow these guidelines: Do not spray product directly on the machine. Spray the cleaner onto a cloth or paper towel then wipe the unit to clean it. The germicidal spray, Sani-Wipe, or similar product and be used on the control panel and front panel graphics. If not using a wipe, make sure to spray the cleaner onto a cloth or paper towel then wipe the unit to clean it.	F 880	Additional education for all nursing staff was completed by June 30th, 2020. • Additional education was provided to all staff through the recommended CDC YouTube videos through the Directed Plan of Correction by July 17th, 2020. • The Director of Food and Nutrition and/or designee will audit drinks being covered for meal delivery. This audit will be completed Monday-Friday for 2 weeks, 3x/week for 1 week, and 1x/week for 1 week. • Findings from audits will be taken to the monthly QAPI Committee Meetings for further review and monitoring. F. • Immediate education was provided to all staff regarding wiping down lifts on June 19th, 2020 to protect all residents. Additional education for all nursing staff was completed by June 30th, 2020. • Additional education was provided to all staff regarding cleaning surfaces through the recommended CDC YouTube videos through the Directed Plan of Correction by July 18th, 2020. • The Director of Nursing and/or designee will audit sanitizing lifts. This audits will be completed Monday-Friday for 2 weeks, 3x/week for 1 week, and 1x/week for 1 week. • Findings from audits will be taken to the monthly QAPI Committee Meetings for further review and monitoring. G. • Immediate education was provided to all staff regarding use of N95 masks for	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285285	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GRAND ISLAND VILLAGE	4061 TIMBERLINE STREET & 4055 TIMBERLINE STREET GRAND ISLAND, NE 68803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6 Review of the undated facility Safe Resident Handling Equipment Competency Validation Checklist revealed the following: Clean Sit-to Stand after use. Interview on 6/17/2020 at 10:35 AM with NA-K revealed they used the lifts for more than 1 resident. The unit had two STS lifts and they used whichever one was available for the residents. Observation on 6/17/2020 at 11:14 AM the STS that NA-H had not cleaned was still sitting in the hall on Cottonwood east. Observation on 6/17/2020 at 11:16 AM revealed Resident 11 was going down the hall with NA-H. Resident 11 was touching the control on their power wheelchair and driving down the hall. Observation on 6/17/2020 at 12:30 PM revealed the STS lift was in the hall on the Cottonwood unit. Record review of the list of residents who used the STS lift on Cottonwood received from the facility Administrator on 6/18/2020 revealed these residents used the STS on the Cottonwood unit: Residents 16, 9, 17, 18, 11, 20, 12, 21, and 22. Review of the facility policy Hand Hygiene and Handwashing date reviewed/revised 4/14/2020 revealed the following: The goal is to prevent the spread of infection between residents. Handwashing and changing gloves occurs after care is delivered to prevent the spread of organisms to other residents. During Patient Care: Wash hands with plain soap and water or with anti-microbial soap and water: if hands are visibly soiled, if hands are visibly contaminated	F 880	gray zones on June 19th, 2020 to protect all residents. Additional education for all nursing staff was completed by June 30th, 2020. • Additional education was provided to all staff regarding use of N95 masks for gray zoned rooms through the recommended CDC YouTube videos through the Directed Plan of Correction by July 17th, 2020. • The Director of Nursing and/or designee will audit use of N95 masks in gray zones. These audits will be completed Monday-Friday for 2 weeks, 3x/week for 1 week, and 1x/week for 1 week. • Findings from audits will be taken to the monthly QAPI Committee Meetings for further review and monitoring.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285285	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GRAND ISLAND VILLAGE	4061 TIMBERLINE STREET & 4055 TIMBERLINE STREET GRAND ISLAND, NE 68803

(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	F 880		

with blood or body fluids. If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based hand rub for routinely cleaning hands: before having direct contact with residents, patients and children; after having direct contact with another person's skin; after having contact with body fluids, wounds or broken skin; after touching equipment or furniture near the resident/patient; after removing gloves.

Review of the facility policy Putting On and Taking Off Personal Protective Equipment (PPE) revised 2/18 revealed the following: Gloves should be worn any time there is reasonably anticipated occupational exposure. Disposable gloves should be replaced as soon as practical when contaminated or as soon as feasible. When performing care services, remove gloves after contact with resident, patient and children and/or the surrounding environment using proper technique to prevent hand contamination. Change gloves during resident, patient and child care if the hands will move from a contaminated body site to a clean body site. Always wash hands between gloving.

C. Observation on 6/17/2020 at 10:55 AM revealed HA-L (Housekeeping Assistant) was in Resident 12's room touching the drawers to put clothes away. HA-L came back out of Resident 12's room and retrieved a shirt from the clothing cart in the hall and took it into Resident 12's room and hung it up in the closet. HA-L exited Resident 12's room and did not do any hand hygiene. HA-L then removed clothing from the cart and entered Resident 13's room doorway then brought the clothes back out and hung them back on the cart as Resident 13 was trying to get up unassisted. After HA-L got assistance for

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285285	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GRAND ISLAND VILLAGE	4061 TIMBERLINE STREET & 4055 TIMBERLINE STREET GRAND ISLAND, NE 68803

(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 8	F 880		

Resident 13, HA-L went back out to the cart and retrieved the clothes hanging on the cart and took them into Resident 13's room. As HA-L was waiting to get to the closet, HA-L draped the clothing over their arm and held the clothing up against their smock/top. HA-L also touched Resident 13's walker as Resident 13 was being assisted by another staff member. HA-L then hung the clothes in Resident 13's closet and gave Resident 13 the call light. HA-L then took clothing out of a bin that was in Resident 13's room and opened the drawers before placing the clothing into the drawers.

Review of the facility policy Laundering and Drying Clothes and Linens date reviewed/revised 1/1/2018 revealed the following: Package, transport and store clean clothes and linens to ensure their cleanliness and to reasonably protect them from dust and soil.

D. Observation on 6/17/2020 at 11:20 AM revealed NA-H cleaned the Penner Spa whirlpool bathtub in the bath house on the Cottonwood Cottage. Interview with NA-H at this time revealed more than 1 resident used the whirlpool. NA-H revealed they gave a couple of whirlpool baths a day. NA-H donned gloves then NA-H pushed the "disinfect jets" button and filled the reservoir in the bottom of the whirlpool. NA-H scrubbed the inside of the tub and the whirlpool chair with a brush at 11:21 AM. NA-H got all surfaces on the inside of the tub and the seat and back portion of the whirlpool lift seat wet which was completed at 11:22 AM then NA-H drained the whirlpool. NA-H rinsed the whirlpool and shower chair with the sprayer attachment on the whirlpool at 11:23 AM. NA-H was done rinsing the inside of the tub at 11:24 AM. NA-H rinsed the jets on the whirlpool

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285285	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GRAND ISLAND VILLAGE	4061 TIMBERLINE STREET & 4055 TIMBERLINE STREET GRAND ISLAND, NE 68803

(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 9	F 880		

for 3 seconds. NA-H did not run the air blower, clean the outside of the tub or the lift part of the chair and NA-H did not allow the disinfectant to sit on the tub and chair surfaces. NA-H removed gloves and did hand hygiene at 11:25 AM and reported they were done cleaning the whirlpool. NA-H then left the bath house.

Review of the facility policy "Bathing" date reviewed/revised 11/1/2019 revealed the following: Procedure for Cleaning Tub and Shower Stall: 1. Wearing gloves, use cleaning brush and spray bottle of approved cleaner/disinfectant solution. 2. Spray walls of tub or shower stall with disinfectant and brush across surfaces. Allow disinfectant to remain on surfaces for at least 10 minutes or according to manufacturer's recommendations. 3. Rinse walls with hot water for faucet/shower head. 4. Remove gloves, dispose of equipment and perform hand hygiene.

Review of the undated Penner Manual on System Cleaning revealed the following: System Cleaning (After Every Bath) Note. Penner Cleaner/Disinfectant is a special non-abrasive cleaning and disinfecting solution that will not harm the tub's fiberglass surface. Penner Cleaner/Disinfectant is the only cleaning solution designed and recommended for use with your Cascade Contour Tub. 1. With the Swivel Lift position inside the tub. 2. Close and lock the door. 3. Press the Tub Fill Button and turn the Temperature Control Knob all the way to the left to its warmest level to heat the disinfectant solution and maximize its effectiveness. 4. Remove any visible tissue, residue, or fluids from the tub by pressing the Shower Button and rinsing the inside tube surfaces with the shower sprayer.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285285	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GRAND ISLAND VILLAGE	4061 TIMBERLINE STREET & 4055 TIMBERLINE STREET GRAND ISLAND, NE 68803

(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 10 5. Press the Fill Button again to turn off the water. Allow the tub to drain, and place the drain plug over the drain. 6. Press and hold the Disinfect Button located on the control panel. As the button is held down, the properly mixed cleaning solution is running through the air injection system and out all of the air jets. Release the button after you see solution coming out of all the air jets and you have 1 to 1 ½ gallons of disinfectant solution in the foot well of the tub. 7. Using the long-handled brush, available from your Penner distributor, thoroughly scrub all interior surfaces of the tub and Swivel Lift chair with the solution that remains in the foot well of the tub. Let disinfectant stay on surface for 10 minutes (or, as recommended by the instructions on the disinfectant concentrate container.) 8. Remove the plug from the drain. 9. Rinse the tub's interior surfaces thoroughly with the shower sprayer. 10. Rinse most of the soapy water away with the shower sprayer. 11. Press and hold the Rinse button located on the control panel until clear water runs from all the air jets. Then release the Rinse button. 12. Finish rinsing the interior surfaces of the tub with the shower sprayer. 13. Start the air blower by pushing the Aqua-Aire Button. Allow it to run for 30 seconds. This pushes the rinse water out of the air injection system. If this was the last bath of the day, allow the blower to run for 2 minutes to dry out the system. 14. Stop the Aqua-Aire blower by again pushing the Aqua-Aire button. 15. Visibly check that the tub and reservoir was effectively cleaned during the disinfecting procedure. If not, repeat the procedure. 16. If there is a delay of one or more hours before the next bath, we recommend using a towel to wipe off all excess water.	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
	285285	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GRAND ISLAND VILLAGE	4061 TIMBERLINE STREET & 4055 TIMBERLINE STREET GRAND ISLAND, NE 68803

(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 11 Review of the undated Instructions for Classic Whirlpool Disinfectant Cleaner revealed the following: For broad spectrum disinfection of gram negative and gram positive bacteria, including Pseudomonas aeruginosa and Staphylococcus aureus, add two ounces Classic Whirlpool Disinfectant Cleaner to one gallon of water. Remove heavy soil or gross filth from the surface to be disinfected, then apply properly diluted solution with a mop, cloth, sponge, or hand pump trigger sprayer so as to wet the surface thoroughly. Allow to remain wet for 10 minutes and then let air dry. If higher detergency is desired, increase dilution to 4 to 6 ounces per gallon of water. Prepare a fresh solution for each use or when solution becomes visibly dirty. To disinfect hard, non-porous, inanimate surfaces (such as fiberglass and stainless steel tubs and chair surfaces, chrome plated intakes and lefts, etc.), apply properly diluted Classic Whirlpool Disinfectant Cleaner so as to wet all surfaces thoroughly. For routine disinfection, proper dilution is 1:64 (2 ounces of product per gallon of water). Allow to remain wet for 10 minutes, then let air dry. For heavily soiled areas, a pre-cleaning step is required. Prepare a fresh solution of reach use as above. For cleaning bath and therapy equipment: after using the whirlpool unit, drain the water and refill with fresh water to just cover the intake valve. Add 2 ounces of Classic Whirlpool Disinfectant Cleaner for each gallon of water in the unit at this point. Briefly start the pump to circulate the solutions. Turn off pump. Wash down the unit sides, seat of the chairlift and any/all related equipment with a clean swab or sponge. After the unit has been thoroughly cleaned, drain solutions from the unit and rinse any/all clean surfaces with fresh water.	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
	285285	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GRAND ISLAND VILLAGE	4061 TIMBERLINE STREET & 4055 TIMBERLINE STREET GRAND ISLAND, NE 68803

(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 12	F 880		

Review of the facility Monthly Infection Control Reports revealed the following UTI (Urinary Tract Infection) rates: April 2020: 10 nosocomial (facility acquired) UTI (Urinary Tract Infection). May 2020: 6 Nosocomial UTI. June 2020: 5 Nosocomial UTI.

Record review of the list of residents who used the whirlpool on Cottonwood received from the facility Administrator revealed the following residents used the whirlpool bath: Residents 19, 11, 20, 13, 21, and 23.

Review of Resident 21's Order Summary Report for Active Orders as of 5/28/2020 revealed an order for [redacted]

Review of Resident 21's MAR for May and June 2020 revealed documentation [redacted] as administered to Resident 21.

Review of Resident 21's Progress Notes from April 1st to June 18, 2020 revealed documentation of a [redacted] ..5/28/2020 [redacted] called to PCP office. Awaiting orders from PCP. Orders received from PCP for [redacted] On 6/1/2020 it was documented Resident 21 was [redacted]

Review of the POC (Point of Care) Response History Type of Bath for 5/19/2020 to 6/19/2020 revealed documentation Resident 21 received a whirlpool bath on June 1, 4, 8, 11, 15, and 18.

Review of Resident 20's Progress Notes dated 6/1/2020 revealed the following documentation:

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285285	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GRAND ISLAND VILLAGE	4061 TIMBERLINE STREET & 4055 TIMBERLINE STREET GRAND ISLAND, NE 68803

(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 13 "Resident has a [redacted] Dr ....ordered [redacted] Review of Resident 20's quarterly MDS (Minimum Data Set-a comprehensive assessment tool used to develop a resident's care plan) dated 5/20/2020 revealed Resident 20 was dependent upon staff for bathing. Review of Resident 20's MAR (Medication Administration Record) for June 2020 revealed documentation [redacted] was administered to Resident 20 from 6/1/2020 to 6/4/2020 and [redacted] as administered to Resident 20 from 6/4/2020 to 6/14/2020. Review of Resident 20's Order Summary Report for June 1, 2020 revealed an order for [redacted] with an order date of 6/4/2020. Review of the POC (Point of Care) Response History Type of Bath for 5/19/2020 to 6/19/2020 revealed documentation Resident 20 received a whirlpool bath on May 21, 25; June 1, 4, 8, 11, 15 and 18. Review of Resident 21's quarterly MDS dated 6/10/2020 revealed Resident 21 was dependent upon staff for bathing and had [redacted] in the last 30 days. Review of the POC (Point of Care) Response History Type of Bath for 5/19/2020 to 6/19/2020 revealed documentation Resident 13 received a whirlpool bath on June 18. Review of the POC (Point of Care) Response History Type of Bath for 5/19/2020 to 6/19/2020 revealed documentation Resident 19 received a	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
	285285	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GRAND ISLAND VILLAGE	4061 TIMBERLINE STREET & 4055 TIMBERLINE STREET GRAND ISLAND, NE 68803

(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 14	F 880		

whirlpool bath on May 22, 26, 29; June 2, 5, 9, 12, 16 and 19.

Review of the POC (Point of Care) Response History Type of Bath for 5/19/2020 to 6/19/2020 revealed documentation Resident 11 received a whirlpool bath on May 22, 25, 27, 29; June 1, 3, 5, 8, 10, 12, 15, 17 and 19.

E. Observation on 12:03 PM revealed NA-I, NA-J, and NA-K were lined up at the meal tray line at the kitchen area on the Cottonwood unit. NA-K was wearing a surgical mask and their face shield was flipped up and not covering their eyes or surgical mask. NA-K was not wearing any other eye protection. NA-K was observed pouring the drinks on the trays. At 12:08 PM all of the drinks were poured onto 22 trays. The drinks were not covered. At 12:11 PM the cook started plating the food then put the plates of food onto the trays. NA-I, NA-J, and NA-K covered the plates of food and took them down the hall to the residents. All of the trays had drinks on them and none of the drinks were covered. By 12:30 PM all 22 trays had gone out to the resident rooms without the drinks covered.

Review of the facility policy "Room-Tray Service-Food and Nutrition" date reviewed/revised 5/18/2020 revealed the following: Deliver room/tray service in a sanitary manner (covered during transport, plated at the proper serving temperature by employees who have washed their hands, etc.)

Interview with the facility Administrator on 6/18/2020 at 9:43 AM confirmed the whirlpool was used for more than 1 resident and the facility staff were expected to clean the whirlpool in

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285285	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GRAND ISLAND VILLAGE	4061 TIMBERLINE STREET & 4055 TIMBERLINE STREET GRAND ISLAND, NE 68803

(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 15	F 880		

between use of residents. The Administrator confirmed the lifts, including the STS lifts, were used for more than 1 resident and the staff were expected to clean them between residents. The Administrator revealed it was their expectation the facility staff changed gloves when they were contaminated and performed hand hygiene with both soap and water or hand sanitizer when hands were contaminated. The Administrator revealed the blue plastic gowns were disposable; however, based on need versus supply, the facility was utilizing conservation with gowns following the guidance. The Administrator revealed the room that had the PPE by the doors belonged to residents who had been outside of the facility for a medically necessary appointment within the last 14 days and as an extra precautionary measure, they were utilizing gowns for high contact cares. The Administrator revealed the expectation for staff was to deliver the meals covered to the residents' rooms. At 11:21 AM the Administrator revealed the facility staff were expected to follow the manufacturer's instruction for the contact or "wet set" time on the disinfectant for the whirlpool. The Administrator revealed facility staff were not allowed to hang the blue gowns touching each other or hanging over the hallway hand rails touching the floor. The Administrator revealed the facility staff were not allowed to hold clean resident clothing up against their smocks/scrub tops.

F.
Observation on 6/17/20 at 11:22 AM on the Ash Grove household revealed that Resident 8 had the resident's legs over the side of the bed. NA-D asked Resident 8 if they needed to use the bathroom. NA-C performed hand hygiene with alcohol based hand sanitizer (ABHR) and put on

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285285	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GRAND ISLAND VILLAGE	4061 TIMBERLINE STREET & 4055 TIMBERLINE STREET GRAND ISLAND, NE 68803

(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 16	F 880		

disposable gloves. NA-D performed hand hygiene with ABHR and put on disposable gloves. NA-D brought the sit to stand lift (a mechanical assistive device used to transfer a resident with difficulty standing up on their own from a seated position) from the hallway into the resident's room. NA-C and NA-D placed the sit to stand lift sling (a fabric device with straps that is placed around the back of a resident when a sit to stand lift is used to transfer a resident with difficulty or inability to stand up on their own from a seated position) around Resident 8 and connected the sling to the sit to stand lift. NA-C connected the leg strap around the resident's shins. NA-C instructed Resident 8 to hold onto the hand grips on the lift and to look up. NA-C operated the sit to stand lift and Resident 8 was transferred from a seated position on the bed to a standing position on the lift. NA-C and NA-D transferred Resident 8 from the bed into the bathroom with the sit to stand lift and lowered Resident 8 onto the toilet. NA-C and NA-D exited the bathroom and closed the bathroom door approximately half way. Resident 8 notified NA-C and NA-D that the resident was finished on the toilet. NA-C and NA-D reentered the resident's bathroom. NA-C and NA-D each performed hand hygiene with ABHR and each put on disposable gloves. NA-D assisted the resident with wiping the private areas of the resident. A new brief was placed on the resident. NA-D removed the disposable gloves and performed hand hygiene using soap and water. NA- C removed the disposable gloves and performed hand hygiene with soap and water. NA-C and NA-D transferred Resident 8 from the bathroom to the bed with the sit to stand lift. The resident was lowered to a sitting position on the edge of the bed and the lift sling was removed. Resident was assisted from a sitting

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285285	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GRAND ISLAND VILLAGE	4061 TIMBERLINE STREET & 4055 TIMBERLINE STREET GRAND ISLAND, NE 68803

(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 17	F 880		

position on the edge of the bed to lying on the bed by NA-C and NA-D. NA-C performed hand hygiene with ABHR as NA-C exited the resident's room. NA-D removed the sit to stand lift from the room of Resident 8 and parked the lift along the wall between the rooms of Resident 8 and the empty room across the hall from Resident 8. NA-D did not disinfect the sit to stand lift. NA-D walked to the kitchen area and performed hand hygiene with ABHR and placed cups on resident meal trays.

Record review of the facility policy titled SAFE RESIDENT HANDLING EQUIPMENT COMPETENCY VALIDATION CHECKLIST dated 4/20 revealed section D: Transfers Surface to Surface with Stand Aid Competency Validation Checklist step 15. Clean stand aid after use.

Interview on 6/18/20 at 3:15 PM with the facility administrator (FA) confirmed that the expectation for cleaning the lifts is that staff perform cleaning of the lift between resident use.

G.
Record review of the Nebraska Infection Control Assessment and Promotion Program (ICAP) document titled Cohorting (an imposed grouping of residents within a similar risk status) Plan For Long Term Care Facilities (LTCF) dated 4/17/20 revealed that facilities should plan to identify red, yellow and green zones where the residents can be cohorted based on their symptoms and exposure risks to COVID-19. Facilities are also recommended to establish a transitional zone (gray zone) for asymptomatic patients who are being transferred from other healthcare facility. Establishing Transitional (Gray) Zones:

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285285	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GRAND ISLAND VILLAGE	4061 TIMBERLINE STREET & 4055 TIMBERLINE STREET GRAND ISLAND, NE 68803

(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 18 -All nursing homes should consider establishing a transitional zone for new admissions, returning residents from the hospital or those who are travelling in and out of the nursing home (such as the residents who are on hemodialysis). Transitional zones/units are established to quarantine those residents who are at somewhat higher risk of getting exposed to COVID-19 but have no known exposure to COVID-19. -Facilities should also consider dedicating separate staff to take care of residents in transitional (gray) zone/unit. -Facilities should implement COVID-level precautions for the residents admitted to the transition unit. If PPE supply is inadequate, nursing homes can consider limiting COVID-level precautions to only high-contact resident care-activities or aerosol generating procedures within the transition zone. -These units should be established even when no COVID-case is identified at the facility and may consist dedicating a geographically distinct area/unit/rooms to returning residents. -The residents are usually kept in this zone for 14 days and if remains asymptomatic at the end of 14 day will be moved to the Green zone. Interview on 6/17/20 at 8:57 AM in the west parking lot of the facility with the Facility Administrator revealed that the Cedar Creek cottage is a gray zone for new residents to the facility. An Email received on 6/17/20 at 6:22 PM from the Facility Administrator (FA) confirmed that the facility is working with the Central District Health Department, ICAP, and the Department of Health and Human Services to perform covid testing for all staff and residents. The FA confirmed that the	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
	285285	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GRAND ISLAND VILLAGE	4061 TIMBERLINE STREET & 4055 TIMBERLINE STREET GRAND ISLAND, NE 68803

(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 19 facility began to isolate new admissions to the facility on 4/10/20. Record review of the Centers for Disease Control (CDC) guidance titled Preparing for COVID-19 in Nursing Homes updated 6/19/20 revealed the section Core Practices: Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown. oDepending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. Health Care Professionals (HCP) should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. Testing at the end of this period can be considered to increase certainty that the resident is not infected. Interview on 6/17/20 at 9:38 AM Licensed Practical Nurse-A (LPN-A) at the treatment cart outside of the nurse's station in the Cedar Creek cottage revealed that LPN-A was wearing a surgical mask (not an N95 mask) and face shield. LPN-A revealed that the residents in the Cedar Creek cottage are new admissions to the facility and that the residents are isolated for 14 days to monitor them for Covid-19. Interview 6/17/20 at 9:38 AM with Nursing Assistant (NA-B) outside of the nurse's station in	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
	285285	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GRAND ISLAND VILLAGE	4061 TIMBERLINE STREET & 4055 TIMBERLINE STREET GRAND ISLAND, NE 68803

(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 20	F 880		

the Cedar Creek cottage revealed that NA-B was wearing a surgical mask (not an N95 mask) and face shield. NA-B revealed that NA-B cares for the residents in this cottage.

Observation on 6/17/20 at 9:30 AM in the Cedar Creek cottage (the facility gray zone quarantine unit) revealed that the facility Social Services Director (SSD) was wearing a surgical mask (not an N95 mask) and a face shield. The SSD put on a gown and no gloves while outside of the room of Resident 1. SSD entered the room of Resident 1. The SSD sat on a chair in the resident's room and talked to the resident seated in the recliner. The facility Therapy Director (TD) was observed in Resident 1's room wearing a surgical mask (not an N95 mask), face shield, gown, and gloves. TD assisted Resident 1 to ambulate from the recliner to the room door and back to the recliner with a walker.

Observation on 6/17/20 at 11:05 AM in the Cedar Creek cottage revealed that Licensed Practical Nurse-A (LPN-A) wore a surgical mask (not an N95 mask) and face shield and put on a gown and gloves while outside of the room of Resident 5. LPN-A entered Resident 5's room with a [redacted] and supplies used for obtaining the resident [redacted] level. LPN-A pricked a finger on the resident's right hand and obtained a blood sample for the [redacted] LPN-A told the resident that the [redacted] today. Resident 5 stated that the resident had eaten some cookies. LPN-A carried the [redacted] to the treatment cart in the hall and sat the [redacted] on the top of the cart and removed

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285285	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GRAND ISLAND VILLAGE	4061 TIMBERLINE STREET & 4055 TIMBERLINE STREET GRAND ISLAND, NE 68803

(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 21 the disposable gloves. LPN-A 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) using ABHR. LPN-A removed the gown and hung the gown on the handrail in the hallway outside of the resident's room. LPN-A performed ABHR and put on disposable gloves. LPN-A wiped all surfaces of the [redacted] with a Sani Cloth (disinfectant) wipe. LPN-A placed a new Sani Cloth wipe on the top of the treatment cart and sat the [redacted] on the Sani Cloth wipe on the cart. Observation on 6/17/20 at 11:12 AM in the Cedar Creek cottage revealed that LPN-A pushed the treatment cart from the nurse's station to the doorway of the room of Resident 6. LPN-A had a surgical mask (not an N95 mask) and face shield on. LPN-A put on a gown that was hanging on the handrail beside the Personal Protective Equipment (PPE) cart (a storage container for equipment that includes gloves, masks, gowns, and eye protection worn to minimize exposure to infectious hazards) outside of the room of Resident 6 and then put disposable gloves on. LPN-A entered the resident's room with the [redacted] LPN-A obtained a blood drop sample from the resident's finger and placed it on the [redacted] The [redacted] for Resident 6. LPN-A exited the resident's room. LPN-A placed the [redacted] on the top of the treatment cart. LPN-A removed and discarded the disposable gloves. LPN-A removed the gown and hung the gown back on the handrail beside the PPE cart. LPN-A performed hand hygiene with ABHR. LPN-A put on disposable gloves and wiped all surfaces of the [redacted] with a Sani	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
	285285	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GRAND ISLAND VILLAGE	4061 TIMBERLINE STREET & 4055 TIMBERLINE STREET GRAND ISLAND, NE 68803

(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 22 Cloth wipe. LPN-A wiped the top of the treatment cart with a new Sani Cloth and placed the [redacted] on a new Sani Cloth wipe. Email received on 6/17/20 at 6:22 PM from the Facility Administrator (FA) revealed that the facility had not initiated baseline testing for staff for Covid-19 as of yet; however, numerous staff have been tested for either symptoms or to utilize Test Nebraska. Record review of the facility documentation titled Good Samaritan - Grand Island Staff Suspected or Confirmed Covid-19 received on 6/17/20 at 6:22 PM revealed that the facility Social Services Director (SSD) who was observed in the room of Resident 1 was tested for Covid-19 on 5/8/20 with a result of negative for Covid-19 infection. Nursing Assistant-B (NA-B) who assists residents in the Cedar Creek cottage was tested for Covid-19 on 5/18/20 with a result of negative for Covid-19 infection. Licensed Practical Nurse-A (LPN-A) who works in the Cedar Creek cottage and was observed in the rooms of Resident 5 and Resident 6 had not been tested for Covid-19. Record review of the medical record for Resident 25 (a resident in the Cedar Creek cottage) revealed that the resident was admitted to the facility on [redacted] On 6/15/20 at 3:44 PM Resident 25 was to be tested [redacted] Record review of the Centers for Disease Control (CDC) guidance titled Preparing for COVID-19 in Nursing Homes updated 6/19/20 revealed the section Core Practices: Evaluate and Manage Residents with Symptoms of COVID-19: -Actively monitor all residents upon admission	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
	285285	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GRAND ISLAND VILLAGE	4061 TIMBERLINE STREET & 4055 TIMBERLINE STREET GRAND ISLAND, NE 68803

(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 23 and at least daily for fever (temperature equal to or greater than 100.0 Fahrenheit). If COVID-19 is suspected, based on evaluation of the resident or prevalence of COVID-19 in the community: -Residents with known or suspected COVID-19 should be cared for using all recommended PPE, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face),gloves, and gown. Interview on 6/18/20 at 3:15 PM with the facility administrator (FA) confirmed that the facility supply of N-95 masks "are fine". The FA revealed that fit testing for the facility started with 3 on campus staff that did fit testing and certification to do fit testing last week and that the facility plans to begin doing fit testing next Thursday for additional staff. The administrator confirmed that facility staff are currently required to wear a face mask (surgical mask) and a face shield or goggles.	F 880		

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

MIDWEST DIVISION OF SURVEY AND CERTIFICATION

July 7, 2020

Dorin Vaipan, Administrator
Good Samaritan Society - Hastings Village
926 East E Street
Hastings, NE 68901-2149

CMS Certification Number: 285072

Dear Administrator:

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

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

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

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

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

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

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

Sincerely,

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

cc:
NE DHHS
Power/Grimes

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

MIDWEST DIVISION OF SURVEY AND CERTIFICATION

May 8, 2020

Aimee Middleton, Administrator
Good Samaritan Society - Millard
12856 Deauville Drive
Omaha, NE 68137

CMS Certification No: 285098

Dear Ms. Middleton:

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

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

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

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

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

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

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

Sincerely,

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

cc:
NE DHHS
Powers/Grimes

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285193	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - OSCEOLA	600 CENTER DRIVE OSCEOLA, NE 68651

(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 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations	F 838		7/17/20

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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285193	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - OSCEOLA	600 CENTER DRIVE OSCEOLA, NE 68651

(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 838	Continued From page 1 that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Licensure Reference Number 175 NAC According to CMS (Center for Medicare and Medicaid) 483.70(e) Facility Assessment "The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently	F 838	CORRECTION TO RESIDENT AFFECTED: Administrator updated Facility Assessment on 7-9-2020. SYSTEM CHANGES (IDENTIFICATION AND CORRECTION FOR OTHER	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285193	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - OSCEOLA	600 CENTER DRIVE OSCEOLA, NE 68651

(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 838	Continued From page 2 during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment". Record review of Facility Assessment not dated revealed the document was a planning tool with no facility specific information on it. An interview on 7/7/20 at 2:00PM with Administrator confirmed the document titled facility assessment Location was the only Facility Assessment available.	F 838	RESIDENTS POTENTIALLY AFFECTED): The administrator updated the facility assessment on 7-9-20 and will continue to use the facility assessment, the Contingent and Crisis staffing plan, the pandemic addendum with its checklist, and SNF cohorting zone instructions if there is a resident that is suspected or is positive with COVID-19. MONITORING PROCESS FOR THE SYSTEM CHANGE INCLUDING FREQUENCY AND PERSON RESPONSIBLE The Administrator will audit the facility assessment if the need to update the facility assessment was missed at any time on a weekly basis x 3 weeks then monthly x 3 months. Audit results will be taken to the QAPI Committee.	
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:	F 880		7/24/20

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285193	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - OSCEOLA	600 CENTER DRIVE OSCEOLA, NE 68651

(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 3 §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: (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	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
	285193	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - OSCEOLA	600 CENTER DRIVE OSCEOLA, NE 68651

(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 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 Licensure Reference Number 175 NAC 12-006.17B Based on record reviews, interviews and observations the facility failed to prevent potential for cross contamination of COVID-19 related to 1) the facility failure to appropriately remove PPE (Personal Protective Equipment) including gowns, face shields and 2) the facility failure to perform hand hygiene (hand washing using soap and water or an alcohol based hand rub (ABHR) when exciting an isolation room this affected 1 resident (Resident 1) of 3 residents sampled; and 3) the facility failed to develop a facility -wide IPCP (Infection Prevention Control Program) for undiagnosed respiratory illness and COVID-19. This had the potential to affect all resident in the facility. The facility census was 33. A. Record review of facility policy title Contact Precautions dated 12/19/20 revealed the following on page 14 section f. hand hygiene will	F 880	CORRECTION TO RESIDENT AFFECTED: 1) On 7-15-2020, DNS and IP educated NA-A on the removal of PPE per ICAP recommendations with emphasis of not touching the outside of the gown and proper sanitation of the face shield. 2) On 7-15-2020, DNS and IP educated NA-A on hand hygiene when exiting an isolation room. 3) On 7-16-20 education was provided to IP by nurse consultant RN regarding the IPCP identifies for undiagnosed respiratory illness and COVID 19 through the use of the daily COVID 19 user defined assessment (UDA) and on the use of the interventions required if a residents has an abnormal COVID-19 screen result. On 7-16-20 IP educated LPN-2 on the use of the COVID-19 UDA assessment and interventions required if a residents has an abnormal COVID-19 screen result. IDENTIFICATION AND CORRECTION FOR OTHER RESIDENTS HAVING THE	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285193	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - OSCEOLA	600 CENTER DRIVE OSCEOLA, NE 68651

(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 be performed, using a 60-90% ABHS, before and after all patient contact and before and after removal of PPE (Personal Protective equipment). Record review of facility policy titled Putting on and Taking Off Personal Protective Equipment (PPE) dated 2/2018 on page 5 section Gown revealed the front of the gown and sleeves are contaminated, unfasten gown ties, taking care that sleeves don't contact your body when reaching for ties, pull gown away from neck and should, touching inside of gown only. Recommendation from ICAP (Infection Control Assessment and Promotion Program) (A State and federally funded program that works with Department of Health and human services and Center for Disease Control to provide education about infection prevention) dated 6/18/20 revealed the following steps for removing face shield after contact with a non Covid positive resident. 1. Apply clean gloves or sanitize gloves 2. place wipe (barrier) on table 3. Remove eyewear and place on wipe 4. Sanitize gloves 5. Remove n95 place in storage bag 6. Sanitize gloves 7. Wipe front and back of shield 8. Wipe table 9. Place shield upside down to dry 10. Sanitize gloves 11. Remove gloves 12. Wash hands with soap and water or hand sanitizer Record review of facility policy titled Emerging Threats- Acute respiratory Syndrome-Coronavirus (COVID) dated 6/16/2020 revealed	F 880	POTENTIAL TO BE AFFECTED: 1) All nursing staff have been educated on proper PPE donning and doffing by IP and DNS per ICAP recommendations with emphasis of not touching the outside of the gown and sanitation of the face shields. 2) Nursing staff have been educated by the IP and DNS on using the face shield one time and then discarding when doffing. All nursing staff and housekeeping staff have been educated on hand hygiene when exiting an isolation room. All staff will watch the videos per DPOC 'Clean Hands, Closely Monitor Residents, Keep COVID-19 out and Lessons' per DHHS recommendation. 3) All RNs and LPNs education was provided by IP regarding the IPCP identifies for undiagnosed respiratory illness and COVID 19 through the use of the daily COVID 19 user defined assessment (UDA) and on the use of the interventions required if a residents has an abnormal COVID-19 screen result. Abnormal COVID-19 screening results interventions will be posted at each nurses station for reference. This education piece will be provided at daily huddle, Monday-Friday, for 2 weeks. System Changes: 1) For isolation rooms face shields will be worn once then discarded during the doffing process. Proper donning and doffing visual aides will be posted in the isolation rooms for staff reference. Donning and doffing visual aide will be posted at each nurse station. 2) Individual	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285193	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - OSCEOLA	600 CENTER DRIVE OSCEOLA, NE 68651

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6 one page 24 cleaning and disinfection of face shield- wear gloves, wipe inside of face shield, use new wipe for outside of face shield and use appropriate contact time, fully air dry, remove gloves and perform hand hygiene, store the face shields in a designated area to minimize cross contamination. Record review of Resident 1's Electronic Health Record revealed that resident was readmitted to facility on [redacted] after a recent hospital stay. Resident 1 tested negative for Covid-19 in hospital and was placed in Isolation room at facility for 14 day's to prevent spread of Covid-19. An observation on 7/7/20 at 11:30 AM revealed NA (Nursing Assistant) An applied hand sanitizer to hands and rubbed until hands were dry, reusable white gown was applied, followed by face shield and then gloves over gown cuffs. NA-A entered Resident 1's room, Resident 1 requested to use the restroom, a gait belt was applied to resident's waist, and resident was assisted to standing position and ambulated to restroom. Resident 1 preformed perineal care. Resident 1 was assisted back to recliner, alarm put in place and call light within reach. An observation on 7/7/20 at 11:35 AM revealed NA -A removed gloves, touched the outside of gown with bare hands, rolled gown against trunk of body, placed gown in laundry bin in resident room. NA then stepped outside of resident's room without performing hand hygiene, removed face shield, placed face shield on top of (dirty) work station, removed wipe from container washed	F 880	hand sanitizer is available for staff use. Proper hand sanitation visual aide will be placed in all utility rooms and nurse stations for staff reference. All staff will watch the videos per DPOC 'Clean Hands, Closely Monitor Residents, Keep COVID-19 out and Lessons' per DHHS recommendation. 3) Abnormal COVID-19 screening results interventions will be posted at each nurses station for reference. This education piece will be provided at daily huddle, Monday-Friday, for 2 weeks. MONITORING PROCESS FOR THE SYSTEM CHANGE INCLUDING FREQUENCY AND PERSON RESPONSIBLE 1) IP or designee will audit proper doffing before exiting an isolation room, to include monitoring of proper doffing and disposal of the face shield before leaving an isolation room weekly x 3 weeks then monthly x 3 months. Results will be taken to QAPI Committee. 2) IP or designee will audit proper hand sanitization before leaving an isolation room weekly x 3 weeks then monthly x 3 months. Results will be taken to QAPI Committee. 3) DNS or designee will audit 10% of nursing staff for his/her knowledge of the interventions for an abnormal COVID-19 screen result and how to implement those interventions weekly x 3 weeks then monthly x 3 months. Results will be taken to QAPI Committee.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285193	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - OSCEOLA	600 CENTER DRIVE OSCEOLA, NE 68651

(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	F 880		

shield with wipe and hung shield on hand sanitizer stand, NA-A then applied hand sanitizer to hands and wrists.

An interview on 7/7/20 at 11:40 AM with DON (Director of Nursing) confirmed NA -A should not have touched the outside of gown when removing gown or rolled gown against body during removal. DON also confirmed NA- A should have performed hand hygiene before leaving residents room; placed a clean barrier on work station for face shield to be cleaned, and apply clean gloves to sanitize reusable face shield.

B.

Record review of Facility Covid -19 Planning tool revealed no document was available.

An interview on 7/7/20 at 8:40 AM with Administrator revealed the Facility Covid -19 Policy procedure was the one titled Emerging Threats- Acute respiratory Syndrome- Coronavirus (COVID) dated 6/16/2020 was the only one available.

Record review of document Emerging Threats- Acute respiratory Syndrome- Coronavirus (COVID) dated 6/16/2020 revealed a section titled Long Term Care or Skilled Nursing Facility provided general guidelines for resident with acute febrile respiratory illness no facility specific information for treating presumptive or Covid positive residents.

An interview on 7/7/20 at 2:12 PM with LPN (Licensed Practical Nurse) 2 revealed that if a resident had an abnormal Covid screening result (gender) would call Director of Nursing or

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285193	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - OSCEOLA	600 CENTER DRIVE OSCEOLA, NE 68651

(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 8 Infection Preventionist for guidance, when asking if any document or computer document was available LPN-2 replied " no" I would just call IP or DON. During interview with LPN -2; IP (Infection Preventionist) walked into the room and LPN- 2 asked "what do we do if a resident has any of those Covid symptoms? Like temperature, cough and shortness of breathe?" IP responded "In computer- Electronic Health Record the Covid screening in the system prompts nurse to ask additional questions and to implement interventions; no policy or procedure for nursing staff is available for how to provide care for resident with abnormal Covid screening symptoms. LPN- 2 replied "I've never seen that feature but also have not answered "yes" to that question as the evening nurse does the daily Covid assessment". An interview on 7/7/20 at 1:00PM with IP Confirmed the facility does not have a policy for Covid-19 in relation to how staff are to care for resident with abnormal Covid screening results (fever greater than 100.0 chills, new or change in cough, shortness of breath, sore throat or new loss of taste or smell, sputum production, congestion, runny nose or fatigue, muscle or body aches, headache, nausea or vomiting, or diarrhea).	F 880		

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

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 14, 2020

Emily Triplett, Administrator
Good Samaritan Society - Osceola
600 Center Drive
Osceola, NE 68651-9601 **CMS Certification No. 285193**

Subject: **Survey Results**
Cycle Start Date: July 7, 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 7, 2020, a survey was completed at Good Samaritan Society - Osceola by the State Survey Agency to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the CMS 2567 and will be posted on the ePOC system.

PLAN OF CORRECTION

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

The PoC must contain the following:

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

ENFORCEMENT REMEDIES

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

- **Directed Plan of Correction:**

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

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

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

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

Connie Vogt, RN, BSN

dhhs.healthcarefacilities@Nebraska.gov

In the Subject Line please put: DPOC

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

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

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

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

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

WITHDRAWAL OF APPROVAL FOR NURSE AIDE TRAINING PROGRAM

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

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

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

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

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

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

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

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

APPEAL RIGHTS

If you disagree with the determination to impose remedies made on the basis of noncompliance identified at the July 7, 2020 survey, you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board (DAB). The appeal rights are set forth at 42 C.F.R. § 498.5 and the procedures for requesting a hearing are set forth at §498.40, et seq. You must file your hearing request electronically by using the DAB's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov/, unless you obtain a waiver from the DAB (*see* DAB Civil Remedies Division Procedures, § 6(a)(i)(1)). Your appeal must be filed no later than 60 days from the date of receipt of this letter.

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

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

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

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

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

CONTACT INFORMATION

If you have any questions please contact this office.

Sincerely,

Connie F Vogt RN,BSN

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

CV/kd

Enclosures: CMS 2567

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

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

Pete Ricketts, Governor

July 2, 2020

Jeff Achtenberg, Administrator
Good Samaritan Society - Ravenna
411 West Genoa
Ravenna, NE 68869-1213

CMS CERTIFICATION NUMBER: 285202

Dear Mr. Achtenberg:

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

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

Pete Ricketts, Governor

August 21, 2020

Jeff Achtenberg, Administrator
Good Samaritan Society - Ravenna
411 West Genoa
Ravenna, NE 68869-1213

CMS CERTIFICATION NUMBER: 285202

Dear Mr. Achtenberg:

This is to acknowledge the results of the Infection Control survey conducted at your facility on August 19, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

MIDWEST DIVISION OF SURVEY AND CERTIFICATION

June 21, 2020

Shawn Leach, Administrator
Good Samaritan Society - St Johns
3410 Central Avenue
Kearney, NE 68847-2992

CMS Certification No: 285189

Dear Mr. Leach:

SUBJECT: SURVEY RESULTS
Cycle Start Date: June 10, 2020

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

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

SURVEY RESULTS
On June 1, 2020, the Centers for Medicare & Medicaid Services (CMS) completed a COVID-19 Focused Survey at Good Samaritan Society – St. Johns to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was in substantial compliance with participation requirements and no deficiencies were cited. The findings from this survey are documented on the enclosed form CMS 2567.

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

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

be found at Locate Your QIO.

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

Sincerely,

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

cc:
NE DHHS
Allen/Grimes

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

Pete Ricketts, Governor

July 2, 2020

Dianna Epp, Administrator
Good Samaritan Society - Syracuse
P O Box F-1, 1622 Walnut Street
Syracuse, NE 68446-0646 CMS CERTIFICATION NUMBER: 285138

Dear Ms. Epp:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 22, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

Pete Ricketts, Governor

July 16, 2020

Heather Krzmarzick, Administrator
Good Samaritan Society - Valentine
601 West 4th Street
Valentine, NE 69201-0180

CMS CERTIFICATION NUMBER: 285176

Dear Ms. Krzmarzick:

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

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

Pete Ricketts, Governor

June 24, 2020

Andrew Bowman, Administrator
Good Samaritan Society - Arapahoe
P O Box 448, 601 Main Street
Arapahoe, NE 68922-0448

CMS CERTIFICATION NUMBER: 285175

Dear Mr. Bowman:

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

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

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 1, 2020

Cassandra Greene, Administrator
Good Samaritan Society - Auburn
1322 U Street
Auburn, NE 68305-9799 **CMS Certification No. 285112**

Subject: Survey Results
Cycle Start Date: June 22, 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 22, 2020, a survey was completed at Good Samaritan Society - Auburn 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 22, 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/ls

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
	285112	A. BUILDING _____ B. WING _____	06/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AUBURN	1322 U STREET AUBURN, NE 68305

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS References to Title 175 of the Nebraska Administrative Code, Chapter 12- "Regulations Governing Licensure of Skilled Nursing Facilities, Nursing Facilities, and Intermediate Care Facilities" have been included in survey report as they apply to deficient practices identified.	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		8/14/20

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

Electronically Signed | 07/02/2020

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
	285112	A. BUILDING _____ B. WING _____	06/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AUBURN	1322 U STREET AUBURN, NE 68305

(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	F 880 CORRECTION TO RESIDENT	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285112	A. BUILDING _____ B. WING _____	06/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AUBURN	1322 U STREET AUBURN, NE 68305

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observation, record review and interview; the facility failed to maintain a 6 foot distance between 8 residents during meals in the main dining area for residents that required assist with eating. This created the potential for exposure to COVID - 19 due to the reduced physical distancing between residents. The facility census was 58. Findings are: Record review of a Center for Medicare and Medicaid [CMS] Memo QSO-20-28-NH dated 4/24/20 revealed the following: 14. Communal Dining: Nursing homes should adhere to social distancing, such as being at separate tables at least 6 feet apart. Social distancing should be practiced at all times. Record review of a facility policy entitled " Food and Nutrition Services Considerations for Pandemic / Epidemic Outbreaks COVID-19 " dated March 19 2020 revealed that residents with choking / swallowing risk were to be assisted in a dining location. The policy called for 1 resident per table, 6 feet apart. Observation on 6/22/20 between 11:40 AM and 12:55 revealed a total of 9 tables set up for meal service. Four of the tables were set for 2 residents to be seated at a table. At 12:00 PM, 12 residents that required assist with eating were seated in the main dining room. Four of the tables had 2 residents at each table as they were assisted with eating for a total of 8 residents. The residents were seated across form each other at the tables while eating.	F 880	AFFECTED: All 4 residents were immediately moved to a 6 foot table sitting across from each other with areas marked to ensure 6 foot of distance. SYSTEM CHANGES (IDENTIFICATION AND CORRECTION FOR OTHER RESIDENTS POTENTIALLY AFFECTED): This deficiency has the potential to affect all residents. As a part of our system review, all residents will have 6 foot between them during meal times marked out or a Plexiglass barrier between them will be used on tables not at least 6 ft long. Education provided on 07/01/2020 to all staff regarding social distancing in dining room. Education provided with the following video Closely Monitor Residents - https://youtu.be/1ZbT1Njv6xA .Staff will be required to watch the videos by 08/14/2020 if it is not completed by then will be completed before the start of their next shift. MONITORING PROCESS FOR THE SYSTEM CHANGE INCLUDING FREQUENCY AND PERSON RESPONSIBLE: Administrator or Designee will conduct a focus audit of all dining room tables for appropriate distance and use of plexi-glass barrier. Will monitor, weekly x4 weeks and monthly x 4 months with results taken to QAPI committee for further review and recommendations.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285112	A. BUILDING _____ B. WING _____	06/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AUBURN	1322 U STREET AUBURN, NE 68305

(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 3 Observation on 6/22/20 at 12:50 PM with the facility Administrator confirmed that at 4 of the tables, the residents were seated 2 to a table across from each other. The facility administrator measured the width of the tables with a tape measurer. The width of the table measured 3 feet 5 inches. The Administrator then measured the width from wheelchair arm to wheelchair arm across the table. This measurement equally 4 feet and 5 inches. In an interview on 6/22/20 at 12:50 PM, the facility Administrator confirmed that 4 of the tables had 2 residents per table and that the residents seated across from each other at the tables were not 6 feet apart.	F 880		

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

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 1, 2020

Correne Adams, Administrator
Good Samaritan Society - Beatrice
401 S 22nd Street
Beatrice, NE 68310-4999 **CMS Certification No. 285203**

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 Good Samaritan Society - Beatrice 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 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: ROkcm
and to the CMS Regional Chief Counsel at:
OGCKansasCityGeneralInbox@hhs.gov

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

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

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

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

CONTACT INFORMATION

If you have any questions please contact this office.

Sincerely,



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

CV/kd

Enclosures: CMS 2567

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

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

Pete Ricketts, Governor

April 9, 2020

Kay Vanness, Administrator
Good Samaritan Society - Bloomfield
P O Box 307, 300 North Second St
Bloomfield, NE 68718-0307

CMS CERTIFICATION NUMBER: 285156

Dear Ms. Vanness:

SUSPENSION OF SURVEY ACTIVITIES AND ENFORCEMENT REMEDIES

CMS is taking action to help facilities prepare and respond to COVID-19. In accordance with *Memorandum QSO-20-20-All*, regarding the prioritization of survey activities, CMS has limited the performance of state and federal surveys and suspended all enforcement activity until the prioritization period has been lifted. As a result, providers may submit a POC or request an IDR within the typical 10 day timeframe, or delay the request until 10 days after the survey prioritization period has ended. If CMS receives an acceptable POC, we will authorize desk reviews as appropriate. If substantial compliance needs to be verified onsite, we will authorize a revisit once survey and enforcement activities have resumed.

The attached CMS-2567 documents the results of a complaint investigation which includes one or more findings of noncompliance with the Federal regulations for Nursing Homes and Skilled Nursing Facilities, Nursing Facilities and Intermediate Care Facilities. The report was prepared following the inspection at your facility completed on March 20, 2020 by representatives of the Nebraska Department of Health and Human Services, Division of Public Health. The facility may submit a POC or delay the submission of a POC until the prioritization period is over.

Informal Dispute Resolution

In accordance with §488.331, you have an opportunity to question cited deficiencies through an Informal Dispute Resolution (IDR) process. To be given such an opportunity, you are required to complete the attached form. This request may be sent within the typical 10 day timeframe, or 10 days after the prioritization period has ended.

We thank you and your staff for your cooperation and assistance at the time of the survey. If you have any questions regarding this correspondence, 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

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285156	A. BUILDING _____ B. WING _____	C 03/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BLOOMFIELD	P O BOX 307, 300 NORTH SECOND ST BLOOMFIELD, NE 68718

(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 the survey report as they apply to deficient practices identified.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		4/21/20

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

Electronically Signed | 04/17/2020

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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285156	A. BUILDING _____ B. WING _____	C 03/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BLOOMFIELD	P O BOX 307, 300 NORTH SECOND ST BLOOMFIELD, NE 68718

(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	Plan of Correction for Bloomfield	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285156	A. BUILDING _____ B. WING _____	C 03/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BLOOMFIELD	P O BOX 307, 300 NORTH SECOND ST BLOOMFIELD, NE 68718

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observation, interview, and record review; the facility failed to ensure infection control practices were followed to prevent potential cross-contamination related to active screening of visitors and interventions for Resident 6 who had symptoms of a respiratory illness. This had the ability to affect all residents. The total sample size was 38 and the facility census was 38. 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): -restriction of all visitors and non-essential healthcare personnel except for certain end of life situations: -cancel all group activities and communal dining; -implement active screening of residents for fever and respiratory symptoms; and -screen all staff at the beginning of their shift for fever and respiratory symptoms. Actively take their temperatures and document the absence of shortness of breath, new or change in cough and sore throat. If they are ill, have them put on a mask and then self-isolate at home. B. Review of the facility "COVID-19 Visitor Restrictions Overview" (undated) revealed: - Visitors were limited to only those who need entry, - All visitors would be directed to the main entrance, - Visitors who were not end-of-life-visit related or	F 880	Survey 3-20-2020 Preparation 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 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 7305 of the State Operations Manual. F-880 Infection Prevention & Control Corrected to Resident Affected: Corrective action to Resident 6-Facility did start non communal dining and no group activities on March 16th. Resident 6 was isolated to his room on March 16th. During the night on March 18th resident 6 had signs of coughing staff did wear mask when entering resident 6□s room. Medical director advised wearing a mask with his symptoms of coughing and low grade fever until respiratory panel test results were obtained. System Change (Identification and correction for other residents potentially affected):	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285156	A. BUILDING _____ B. WING _____	C 03/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BLOOMFIELD	P O BOX 307, 300 NORTH SECOND ST BLOOMFIELD, NE 68718

(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 3 medically or operationally necessary would not be permitted in the building, and - All individuals entering the building would be actively screened and entry would be restricted for those with respiratory symptoms or possible exposure to COVID-19. C. On 3/20/20 at approximately 12:30 PM, an individual was observed walking through the front doors of the facility and down the hallway towards the therapy room. The visitor stated they were there for outpatient therapy. Review of the facility "Visitor Screening Log" dated 3/11/20 through 3/22/20 revealed no evidence to indicate outpatient therapy patients were actively screened when entering the facility. D. Review of a facility document dated 3/20/20 revealed Medical Doctor (MD)-A was in the facility seeing residents on 3/16/20, 3/17/20, and 3/19/20. Review of the facility "Visitor Screening Log" dated 3/11/20 through 3/22/20 revealed no evidence to indicate (MD)-A was actively screened when entering the facility and seeing residents. E. Review of Resident 6's Progress Notes revealed: - On 3/17/20 MD-A had a visit and exam with the resident with orders for lab the next blood draw day. - On 3/18/20 the resident had [redacted] - On 3/19/20 at 7:50 AM, MD-A was called and	F 880	All Residents are screened twice a day with full sets of vitals/O2 stats and if any symptoms occur- residents will be placed on isolation precautions. Any new admissions to the facility will be screen on admission to the facility and twice daily with full sets of vitals/O2 stats and if any symptoms occur- resident will be placed on isolation precautions. Out-patient therapy clients are coming in utilizing the outside Therapy back door entrance. Therapy staff are screening all out- patient clients before entering the therapy department for (temp, fever, sore throat, cough, new shortness of breath & any travel within the last 14 days, or have been in contact with anyone with diagnosis of COVID 19) These screenings started on 3-16-2020 (Will email screening forms that were completed) (3-20-2020) Medical Director was educated on signing in on the visitor log as well as screening for (temp, fever, sore throat, cough, new shortness of breath & any travel within the last 14 days, or have been in contact with anyone diagnosis of COVID 19) when entering the facility. Completing all Staff education - Hand washing audits (started 3-12-2020), Online Infection Control Prevention (started 3-13-2020), PPE skills checklist (started 3-20-2020), Respiratory hygiene/Cough Etiquette & Return to work policy, Emerging Threats Acute Respiratory Syndromes Coronavirus	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285156	A. BUILDING _____ B. WING _____	C 03/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BLOOMFIELD	P O BOX 307, 300 NORTH SECOND ST BLOOMFIELD, NE 68718

(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 informed of the resident's condition. The resident voiced [redacted]. The resident was [redacted] - On 3/19/20 at 8:54 AM, MD-A came to the facility to examine the resident. Orders were given for blood work and the sample was sent back with MD-A for testing. - On 3/20/20 at 8:00 AM, MD-A called the facility to report the resident was [redacted] with no new orders given and to continue current treatment. F. Interviews with the Director of Nursing (DON) and the Administrator on 3/20/20 from 11:30 AM to 1:15 PM confirmed: - The facility didn't start screening staff and residents for potential COVID-19 symptoms or exposure until 3/16/20. - MD-A was not screened prior to seeing residents on 3/16/20, 3/17/20, or 3/19/20. - Visitors that presented for outpatient therapy were to enter the therapy room through a separate door. The outpatient therapy client today was coming for their first day and therefore they didn't know the process. - Outpatient therapy visitors were not actively screened for symptoms or potential exposure to COVID-19. -The DON confirmed Resident 6 had [redacted] and was seen by MD-A on 3/17/20. Further interview confirmed additional interventions were not put into place for Resident 6 while awaiting test results.	F 880	Policy, Steps to help prevent the spread of COVID 19 if you are sick, PPE Extended Use for COVID 19, Infection Control Droplet precautions (started 3-31-2020). RN completed Education for (Nurses & Medication Aide)- Vital Signs- Blood Pressure Clinical Skills Checklist, Oxygen Administration with Nasal Cannula/Face Mask Clinical Skill Checklist, & Monitoring Body Temperature. (Started 3-31-2020) RN Completed Education for (Nurses) Nebulizer Cleaning Clinical skill Checklist & Blood Glucose Monitoring Clinical Skill Checklist. (Started 4-1-2020) Monitor process for the system change including frequency and person responsible: Administrator or designee will complete random audits on ensuring staff, out-patient therapy, medical director & visitors are screening for any signs or symptoms of COVID 19 when entering the facility. Resident screening is completed and any respiratory symptoms will placed resident on isolation precautions. Audit will be completed for 2 x week for 4 weeks, 1 x for 4 weeks, and 1 x monthly for 3 months with all audits taken to QAPI monthly.	

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

Pete Ricketts, Governor

April 9, 2020

Kay Vanness, Administrator
Good Samaritan Society - Bloomfield
P O Box 307, 300 North Second St
Bloomfield, NE 68718-0307

Dear Ms. Vanness:

An unannounced visit was conducted to investigate a complaint at Good Samaritan Society - Bloomfield on March 20, 2020, by representatives of the Department of Health and Human Services Division of Public Health. To complete this investigation, a representative sample of the residents who reside in the facility or had resided in the facility was selected. The investigative process included review of resident records; observation of the provision of care and services; and interviews with residents, family members and staff.

ALLEGATION:
The facility fails to follow infection control guidelines for illnesses.

FINDINGS:
The facility failed to follow infection control guidelines for illnesses. To make this determination, records were reviewed which included staff schedules, cleaning/disinfection protocols, staff and resident screening documentation and facility policies. In addition, staff interviews were conducted and interviews confirmed concerns with implementation of infection control guidelines. It was determined the facility was in violation of federal regulation F880 and licensure reference number 175 NAC 12-006.17.

Please see the enclosed letter for instructions on completion and submission of the plan of correction for the deficiency(ies) found during the complaint investigation.

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

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

Pete Ricketts, Governor

July 27, 2020

Kay Vanness, Administrator
Good Samaritan Society - Bloomfield
P O Box 307, 300 North Second St
Bloomfield, NE 68718-0307

CMS CERTIFICATION NUMBER: 285156

Dear Ms. Vanness:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 23, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 14, 2020

Stacy Neubauer, Administrator
Good Samaritan Society - Colonial Villa
719 North Brown Street
Alma, NE 68920 **CMS Certification No. 285185**

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

Dear Administrator,

UNANNOUNCED COVID-19 SURVEY

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

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

SURVEY RESULTS

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

PLAN OF CORRECTION

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

in the imposition of additional remedies.

The PoC must contain the following:

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

ENFORCEMENT REMEDIES

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

- **Directed Plan of Correction:**

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

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

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

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

Connie Vogt, RN, BSN

Email: dhhs.healthcarefacilities@Nebraska.gov

In the Subject Line please put: DPOC

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

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

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

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

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

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

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

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

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

APPEAL RIGHTS

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

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

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

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

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

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

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

CONTACT INFORMATION

If you have any questions please contact this office.

Sincerely,



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

CV/kd

Enclosures: CMS 2567

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285185	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COLONIAL VILLA	719 NORTH BROWN STREET ALMA, NE 68920

(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 the 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		7/15/20

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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285185	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COLONIAL VILLA	719 NORTH BROWN STREET ALMA, NE 68920

(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 175NAC 12-006.17D	F 880	F880 CORRECTION TO RESIDENTS	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285185	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COLONIAL VILLA	719 NORTH BROWN STREET ALMA, NE 68920

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Licensure Reference Number 175NAC 12-006.18C1 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) between resident room contacts during the delivery of laundered clothes and linens for 17 residents (Residents 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 20, 18, and 19) to prevent the potential for cross contamination and Covid-19 and failed to ensure that staff handled clean linens to prevent the potential for cross contamination for 1 resident (Resident 19). The facility census was 36. Findings are: A. Observation on 6/29/20 at 12:41 revealed that Laundry Assistant-A (LA-A) exited the room of Resident 4 carrying used empty hangers from the resident's room. LA-A hung the used hangers on the rod on the laundry cart. LA-A did not perform hand hygiene. LA-A took laundered clothes from the laundry cart into the companion room of Residents 5 and 6. LA-A hung the clothes on the rod (a piece of furniture in the resident environment to hang clothes hangers on) in the resident closet. LA-A brought used empty hangers from the resident closet out of the resident room and hung them on the rod on the laundry cart. LA-A did not perform hand hygiene. LA-A removed laundered clothes from the rod on the laundry cart and took the clothes into the companion room of Residents 7 and 8. LA-A	F 880	AFFECTED: The Administrator and the Environmental Service Director provided verbal education immediately to laundry assistant-A about the importance of hand hygiene between resident rooms when delivering laundered clothing and linens for residents 4,5,6,7,8,9,10,11,12,13,14,15,16, 17,18 , 19 & 20. On 7/2/2020, education was provided to Medication Aide-B on handling clean linens (hand hygiene and the handling of clean linens, when to wash hands, handling of clean linens and clean versus dirty) for resident 19. On 7/2/2020, education was provided to all staff on hand hygiene and the handling of clean linens by the administrator. SYSTEM CHANGES: This deficiency has the potential to affect all residents. As part of our system review, hand sanitizer was placed on the laundry carts for laundry staff, so that they are able to perform hand hygiene between rooms when delivering laundered clothing and linens. Continued education, monitoring and review will take place on hand hygiene and the handling of clean linens, when to wash hands, handling of clean linens and clean versus dirty. This facility will also require staff to complete additional training; Clean Hands - https://youtu.be/xmYMUly7qiE, by 7/24/2020 and all staff have completed this. MONITORING PROCESS FOR THE SYSTEM CHANGE INCLUDING FREQUENCY AND PERSON	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285185	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COLONIAL VILLA	719 NORTH BROWN STREET ALMA, NE 68920

(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 3 hung the clothes on the rod in the resident closet. LA-A brought used empty hangers from the resident closet out of the resident room and hung them on the rod on the laundry cart. LA-A did not perform hand hygiene. LA-A pushed the laundry cart into the facility laundry room. LA-A put additional laundered clothes in the laundry cart. LA-A exited the laundry room with the laundry cart and pushed the cart to the doorway of Resident 9. LA-A took laundered clothes from the laundry cart into the room of Resident 9. LA-A hung the clothes on the rod in the resident's closet. LA-A removed used empty hangers from the resident's closet and exited the resident's room and hung them on the rod on the laundry cart. LA-A did not perform hand hygiene. LA-A took laundered clothes into the room of Resident 10. LA-A hung the clothes on the rod in the resident's closet. LA-A removed used empty hangers from the resident's closet and exited the resident's room and hung them on the rod on the laundry cart. LA-A did not perform hand hygiene. LA-A took laundered clothes from the laundry cart into the companion room of Residents 11 and 12. LA-A hung the laundered clothes on the rod in the resident closet. LA-A removed used empty hangers from the resident closet. LA-A exited the room and hung them on the rod on the laundry cart. LA-A did not perform hand hygiene. LA-A took laundered clothes from the laundry cart into the room of Resident 13. LA-A hung the clothes on the rod in the resident's closet. LA-A exited the resident's room and returned to the laundry cart. LA-A did not perform hand hygiene. LA-A took laundered clothes from the laundry cart into the companion room of Residents 14 and 15 and hung the clothes on the rod in the resident closet. LA-A removed used empty hangers from the resident closet and exited the resident's room and	F 880	RESPONSIBLE: To monitor our performance to ensure that solutions are sustained for all residents, the QPAI Coordinator or designee will do a focus audits on all of the laundry staff and 25% of the nursing staff every week x3 and then monthly x 3 and then quarterly x 3, ensuring that hand hygiene is being performed between resident rooms while delivering laundered clothing, linens and while handling clean linens. The results of these audits will be reviewed and reported at the monthly Quality Committee meeting to ensure effectiveness of added education and interventions. Date of completion, 7/15/2020.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285185	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COLONIAL VILLA	719 NORTH BROWN STREET ALMA, NE 68920

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

hung the hangers on the rod on the laundry cart. LA-A did not perform hand hygiene. LA-A took laundered clothes from the laundry cart into the room of Resident 16. LA-A hung the clothes on the rod in the resident's closet. LA-A removed used empty hangers from the resident's closet and exited the room and hung them on the rod on the laundry cart. LA-A did not perform hand hygiene. LA-A took laundered clothes from the laundry cart into the room of Resident 17. LA-A hung the clothes on the rod in the resident's closet. LA-A exited the resident's room and did not perform hard hygiene. LA-A took laundered clothes from the laundry cart into the room of Resident 20. LA-A hung the clothes on the rod in the resident's closet. LA-A exited the resident's room and did not perform hand hygiene. LA-A took laundered clothes from the laundry cart into the room of Resident 18. LA-A hung the clothes on the rod in the resident's closet. LA-A removed used empty hangers from the resident's closet and exited the room and hung them on the rod on the laundry cart. LA-A did not perform hand hygiene.

Observation on 6/29/20 at 2:18 PM revealed that Medication Aide-B (MA-B) entered the room of Resident 20 and delivered clean linens from the laundry cart into the resident's room. MA-B exited the resident's room and performed hand hygiene with ABHR. MA-B delivered clean linens from the laundry cart into the room of Resident 16. MA-B exited the resident's room and did not perform hand hygiene. MA-B walked to the utility room area on the Liberty Lane Hallway. MA-B was observed with the back against the medication cart outside of the utility room as MA-B visited with an unknown staff member. MA-B returned to the laundry cart and picked up some clean wash

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285185	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COLONIAL VILLA	719 NORTH BROWN STREET ALMA, NE 68920

(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		

cloths and towels from the laundry cart and delivered them into the room of Resident 20. MA-B exited the resident's room with a cup and took the cup into the utility room. MA-B did not perform hand hygiene. MA-B carried laundered towels from the laundry cart into the room of Resident 19. MA-B exited the resident's room and walked to the clean linen closet on the Liberty Lane hallway. MA-B did not perform hand hygiene. MA-B opened the door to the closet, looked at the contents, and then closed the closet door. MA-B left the Liberty Lane hallway and then returned carrying several laundered cloth gowns while holding the gowns against MA-B's uniform. MA-B took the gowns into the room of Resident 19. MA-B exited the resident's room. MA-B did not perform hand hygiene. MA-B walked into the room of Resident 18. MA-B exited the resident's room and performed hand hygiene with ABHR.

Record review of the facility policy titled Hand Hygiene And Handwashing dated 4/14/20 revealed the section titled Background:
Regular handwashing with soap and warm not hot water is one of the best ways to remove germs, avoid getting sick and prevent the spread of germs to others.
Patient Care: The goal is to prevent the spread of infection between residents. Handwashing and changing gloves occurs after care is delivered to prevent the spread of organisms to other residents. Sanitizers are used in patient care areas.
Procedure: During Patient Care
Step 2. If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based hand rub for routinely cleaning hands:
a. Before having direct contact with residents,

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285185	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COLONIAL VILLA	719 NORTH BROWN STREET ALMA, NE 68920

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6 patients and children b. After having direct contact with another person's skin c. After having contact with body fluids, wounds, or broke skin d. After touching equipment or furniture near the resident/patient e. After removing gloves Record review of the Centers for Disease Control undated document titled Hand Hygiene in Healthcare Settings revealed the section titled: When should your healthcare providers clean their hands. -Every time they enter your room and when they remove gloves. Interview response by email from the Facility Administrator (FA) dated 6/30/20 at 4:19 PM to the question: The policy titled Hand Hygiene And Handwashing has guidance on handwashing and glove use for patient care and food service. Is there a hand washing policy specific to laundry staff? The FA confirmed that there is no specific handwashing policy/procedure for laundry department staff. Record review of the facility provided copy of the Hand Hygiene and Handwashing Clinical Skill Checklist for Laundry Assistant-A (LA-A) confirmed that LA-A completed the competency for hand hygiene on 3/31/20 with the facility Infection Control Nurse signing the competency verifying completion of the hand hygiene competency. The Hand Hygiene and Handwashing Clinical Skill Checklist completed for LA-A is the Hand Hygiene and Handwashing Clinical Skill Checklist from the facility policy titled	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
	285185	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COLONIAL VILLA	719 NORTH BROWN STREET ALMA, NE 68920

(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 Hand Hygiene And Handwashing dated 4/14/20. Interview on 7/1/20 at 3:00PM with the facility Infection Control Nurse (ICN) confirmed that staff are to use hand sanitizer or wash with soap and water when they leave a resident room if they have touched anything. If they just walk into the room and don't touch anything hand hygiene would not be required. B. Observation on 6/29/20 at 2:30 PM revealed that Medication Aide-B (MA-B) MA-B carried laundered towels from the laundry cart into the room of Resident 19. MA-B exited the resident's room and walked to the clean linen closet on the Liberty Lane hallway. MA-B did not perform hand hygiene. MA-B opened the door to the closet, looked at the contents, and then closed the closet door. MA-B left the Liberty Lane hallway and then returned carrying several laundered cloth gowns while holding the gowns against MA-B's uniform. MA-B took the gowns into the room of Resident 19. MA-B exited the resident's room. MA-B did not perform hand hygiene. MA-B walked into the room of Resident 18. MA-B exited the resident's room and performed hand hygiene with ABHR. Record review of the facility policy titled Laundering and Drying Clothes and Linens dated 1/18 revealed that Proper laundering and drying practices will be followed to prevent the spread of potential infectious disease, to ensure proper cleaning, to prevent damage and promote maximum useful life of the clothes and linens being laundered, to maximize the useful life of laundry equipment, to minimize utility costs and to protect the health and well-being of residents,	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
	285185	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COLONIAL VILLA	719 NORTH BROWN STREET ALMA, NE 68920

(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 8 patients, employees and visitors. Interview on 7/1/20 at 3:00PM with the facility Infection Control Nurse (ICN) confirmed that the staff uniform is a potentially contaminated surface and that dirty laundry and clean laundry should not be held against the uniform when carried by staff. The ICN went on to reveal that the facility does not have a policy with anything specific on how to deliver laundry. The supervisor trains the laundry staff on common sense and the concept of clean and dirty. The ICN revealed that with the Covid pandemic, the facility has done intense training on clean to dirty and on staff being cognizant of what they are touching and performing hand hygiene.	F 880		

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

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 14, 2020

Karen Glesinger, Administrator
Good Samaritan Society - Albion
P O Box 271, 1222 South 7th Street
Albion, NE 68620-0271 **CMS Certification No. 285197**

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

Dear Administrator,

UNANNOUNCED COVID-19 SURVEY

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

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

SURVEY RESULTS

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

PLAN OF CORRECTION

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

The PoC must contain the following:

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

ENFORCEMENT REMEDIES

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

- **Directed Plan of Correction:**

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

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

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

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

Connie Vogt, RN, BSN

dhhs.healthcarefacilities@Nebraska.gov

In the Subject Line please put: DPOC

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

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

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

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

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

WITHDRAWAL OF APPROVAL FOR NURSE AIDE TRAINING PROGRAM

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

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

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

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

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

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

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

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

APPEAL RIGHTS

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

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

OGCKansasCityGeneralInbox@hhs.gov

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

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

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

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

CONTACT INFORMATION

If you have any questions please contact this office.

Sincerely,



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

CV/kd

Enclosures: CMS 2567

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

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285197	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBION	P O BOX 271, 1222 SOUTH 7TH STREET ALBION, NE 68620

(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 the survey report as they apply to deficient practices identified.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		7/31/20

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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285197	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBION	P O BOX 271, 1222 SOUTH 7TH STREET ALBION, NE 68620

(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: License Reference Number: 175 NAC 12-006.17B	F 880	Preparation and execution of this response and plan of correction does not	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285197	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBION	P O BOX 271, 1222 SOUTH 7TH STREET ALBION, NE 68620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observations, record reviews and interviews; the facility failed to implement infection control precautions to prevent the spread of COVID-19 as 1) staff failed to follow transmission based precautions for 4 (Residents 1, 2, 6 and 7) of 7 sampled residents; and 2) staff failed to ensure forms were completed for staff screening. This had the ability to affect all of the facility residents. The total sample size was 7 and the census was 54. Findings are: A. Review of the facility policy for Transmission Based Precautions (undated) revealed staff were to wear a mask, face shield, isolation gown, and gloves when entering the room of a resident on isolation precautions. The following sequence for placing on Personal Protective Equipment (PPE) was identified: -complete hand hygiene; -put on a gown ensuring torso is fully covered from neck to knees, arms to end of wrists and wrapped around the back. The gown should then be fastened in back of the neck and waist; -put on mask with ties or elastic bands at middle of head and neck, fit flexible band to nose-bridge and ensure a snug fit to face and below chin; -place goggles or face shield over face and eyes and adjust to fit; and -put on gloves ensuring the gloves extend to cover wrist of isolation gown. The following instructions were identified for removal of PPE: -remove gloves; -remove gown; -exit the resident's room; -perform hand hygiene;	F 880	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 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 7305 of the State Operations Manual. F880 □ Infection Prevention and Control 1) Staff failed to follow transmission based precautions for 4 of 7 sampled residents (Residents 1, 2, 6 & 7) How will corrective action be accomplished for those residents found to have been affected by the deficient practice? Director of Nursing or designee had educated nursing team members on correct transmission based precautions prior to survey. For residents 1, 2, 6 & 7, who were affected by the practice of NA-C, corrective action taken is NA-C re-educated on correct transmission based precautions. How will the facility identify other residents having the potential to be affected by the same deficient practice? Director of Nursing or designee will identify residents that will be placed on	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285197	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBION	P O BOX 271, 1222 SOUTH 7TH STREET ALBION, NE 68620

(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 3 -remove the face shield/goggles; and -perform hand hygiene. B. Review of a the facility form titled "COVID-19 Unit-Outside the patient's room" with a revision date of 4/14/20 revealed the following procedure for re-use of a face shield: -sanitize hands; -put on a pair of clean gloves; -place a disinfectant wipe on table as a barrier; -remove face shield and position on barrier; -use a disinfectant wipe to cleanse the front and the back of the shield, the elastic band and the foam band; -place shield upside down to dry; -remove gloves; and -hand sanitize. C. Observations on 6/29/20 of the 100 corridor during the noon meal revealed the following: -12:20 PM Nursing Assistant (NA)-C positioned a cart with room trays outside of Resident 6's room. Signs posted outside of the room indicated the resident was in the Gray Zone and was on isolation. NA-C was wearing a surgical mask and a face shield. Without performing hand hygiene, NA-C placed on a pair of clean gloves. NA-C removed the face shield and placed the shield directly on the shelf of a cabinet located outside of the residents' room. NA-C donned an isolation gown and placed the face shield back on. NA-C entered the resident's room and delivered the meal tray. After completion of task, NA-C removed gloves and isolation gown before leaving the resident's room. NA-C failed to cleanse the face shield or to complete hand hygiene; -12:22 PM NA-C propelled the room tray cart to Resident 1's room. A sign outside of the room	F 880	transmission based precautions based on each resident□s assessed care needs. Any residents placed on transmission based precautions because of their assessed care needs, have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Director of Nursing or designee will educate team members on measures to ensure that this practice does not recur, including: Re-education of all staff on properly following transmission based precautions will be conducted and documented by the completion date. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? QAPI Coordinator and QAPI Committee will monitor corrective actions to ensure the effectiveness of these actions, including: Quality assurance audits of staff performing transmission based precautions for affected residents (if we have residents on transmission based precautions during the audit period) will be conducted three times per week for four (4) weeks, then one time per week for four (4) weeks, then bi-weekly times two (2), to ensure compliance. If any non-compliance is identified, staff counseling and re-education will be conducted and documented. Completed quality assurance audits and any related documentation of staff counseling and education will be brought to the QAPI	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285197	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBION	P O BOX 271, 1222 SOUTH 7TH STREET ALBION, NE 68620

(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 indicated the resident was in the Gray Zone and was on isolation. Without completing hand hygiene, NA-C entered the resident's room and placed on an isolation gown then, stepped out of the room and placed on a clean pair of gloves from an isolation cart. NA-C brought a meal tray into the room and positioned the tray on a bedside table. The bedside table contained various items including a television remote, a covered thermal cup, a Kleenex box and a can of soda. NA-C attempted to move items to accommodate the meal tray and dropped the remote on the floor then proceeded to pick up. Items on the table were rearranged so that food was within the resident's reach. NA-C assisted the resident with meal set-up and with putting on a clothing protector. Upon leaving the resident's room, NA-C removed gloves and gown and completed hand hygiene. NA-C failed to cleanse the face shield; -12:25 PM NA-C positioned the room tray cart outside of Resident 7's room. Signs outside of the resident's room indicated the resident was on isolation as the resident was in a Gray Zone. NA-C removed face shield and placed directly on the top shelf of the isolation cart outside of the room without benefit of a barrier. NA-C placed on an isolation gown and secured, then replaced the face shield. Without any hand hygiene, NA-C put on clean gloves. After delivery of the meal tray to the room, NA-C removed gown and gloves and performed hand hygiene but failed to clean the shield; and -12:28 PM NA-C propelled the room tray cart to Resident 2's room. Signs outside of the room indicated the resident was in the Gray Zone and was on isolation. NA-C donned an isolation gown and gloves. NA-C delivered the room tray and removed gown and gloves before leaving the	F 880	Committee monthly for review and action, as needed. Completion Date: 07/31/2020 2) Staff failed to ensure forms were completed for staff screening. This had the ability to affect all of the facility residents. The total sample size was 7 and the census was 54. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? Administrator or designee had, previous to survey date, implemented corrective actions for all residents affected by the deficient practice, including: On May 12, 2020, a new screening process was implemented wherein anyone entering the facility is actively screened by a person referenced as screener. The screening is documented electronically for employees and contractors, and on paper for essential visitors. There is a back-up paper screening process for employees in the event the electronic application is unavailable. Job aids for use of the screening application and thermometer are available at the screening location. There were no instances of missing documentation found during survey since the new screening process was implemented on May 12, 2020.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285197	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBION	P O BOX 271, 1222 SOUTH 7TH STREET ALBION, NE 68620

(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 resident's room. NA-C removed the face shield and placed on the top of the isolation cart without benefit of a barrier. NA-C proceeded to cleanse the shield with disinfectant wipes, placed the shield back on, performed hand hygiene and returned to the dining room. During an interview with the Director of Nursing (DON) on 6/30/20 at 2:20 PM, the DON verified the following regarding NA-C: -hand hygiene should have been completed before placing on PPE and entering the resident's rooms; -NA-C's face shield should have been placed on a clean barrier and cleansed with a disinfectant wipe. This task should have been completed each time NA-C exited a resident room; and -hand hygiene should have been performed after removal of PPE to prevent the potential for cross contamination. D. An observation on 6/29/20 at 10:15 AM showed an area located at the facility entrance for screening with a sign stating, "Upon arriving to work: sanitize your hands, put on your mask, social distance while you are waiting to be screened and get screened (temp taken, answer questions)." Review of the facility's Employee Screening Logs from 3/11/20 - 5/11/20 revealed the logs were documented on paper. The logs were to include the date, the names of the employee being screened and the employee's temperature. In addition, employee responses to screening questions to determine potential COVID-19 symptoms and risks of exposure were included. Further review of the screening logs revealed the	F 880	How will the facility identify other residents having the potential to be affected the same deficient practice? Every resident of the facility had the potential to be affected by this practice, however, on May 12, 2020, which is prior to the survey date, an audit process was put into place. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Administrator already implemented the system change on May 12, 2020, to ensure the deficient practice will not recur, including: There were no instances of missing documentation found during survey since the new screening process was implemented on May 12, 2020. Screeners were trained at implementation on the screening process and what actions to take depending on the outcome of the screening. Audits of 100% of all employee and visitor screening documentation are conducted no more than daily and no less than two times per week to ensure compliance. If any non-compliance is identified, staff counseling and re-education will be conducted and documented. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? QAPI Coordinator and QAPI Committee will monitor corrective actions to ensure the effectiveness of these actions, including:	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285197	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBION	P O BOX 271, 1222 SOUTH 7TH STREET ALBION, NE 68620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6 following: -3/25/20 no temperatures were documented on 2 line entries; -1 temperature was not documented on 3/30/20, 4/3/20, 4/6/20, 4/13/20, 4/16/20, 4/28/20 and 5/1/20; and -4/18/20 no temperature and no responses to symptoms were documented on 1 line entry. Review of the facility's Dietary Deliveries Log dated 3/12/20 - 4/10/20, had 20 line entries without temperatures documented but had the word "no" written under the column "Do you have a fever?" Review of 2 forms titled "COVID-19/Coronavirus Disease 2019 Employee Screening Documentation updated 3/12/20" showed the forms did not include the date screening was completed. An interview on 6/30/20 at 3:00 PM with the DON and Administrator confirmed the screening logs were missing documentation.	F 880	At survey exit it was discussed all screening logs have been audited to date since May 12th prior to survey date. If an issue is identified in the screening audits, we will conduct staff counseling and education and any related documentation of that will continue to be brought to the QAPI Committee monthly for review and action, as needed. Completion Date: 07/31/2020	

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

Pete Ricketts, Governor

September 8, 2020

Ms. Karen Glesinger, Administrator
Good Samaritan Society - Albion
P O Box 271, 1222 South 7th Street
Albion, NE 68620-0271

Dear Ms. Glesinger:

We would like to place your facility back into compliance for the June 30, 2020 survey, however, in order to do that we need you to provide written evidence that shows that you have completed all corrective actions outlined in your Plan of Correction (POC). These examples could be, but are not limited to, new policies and procedures, attendance sign in sheets for education, invoices showing supplies ordered or completed, audits as outlined in the POC, etc. Failure to provide this information may impact your provider agreement with CMS.

Please email the requested information to **dhhs.healthcarefacilities@nebraska.gov** by September 13, 2020.

If you have any questions, please contact this office at the number listed below.

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

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

Pete Ricketts, Governor

July 2, 2020

Jessica Eby, Administrator
Good Samaritan Society - Atkinson
409 Neely Street
Atkinson, NE 68713-5225

CMS CERTIFICATION NUMBER: 285177

Dear Ms. Eby:

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

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

Pete Ricketts, Governor

June 24, 2020

Sharon Colling, Administrator
Good Shepherd Lutheran Home
2242 Wright Street
Blair, NE 68008

CMS CERTIFICATION NUMBER: 285148

Dear Ms. Colling:

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

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

Pete Ricketts, Governor

July 10, 2020

Cathy Snyder, Administrator
Gordon Countryside Care
500 East 10th Street
Gordon, NE 69343

CMS CERTIFICATION NUMBER: 28E257

Dear Ms. Snyder:

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

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

Pete Ricketts, Governor

July 7, 2020

Dorene Spies, Administrator
Greeley Care Home
201 E O'Connor Avenue
Greeley, NE 68842-0190

CMS CERTIFICATION NUMBER: 285286

Dear Ms. Spies:

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

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

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 20, 2020

Ruth Sands-Jerke, Administrator
Harvard Rest Haven
400 East 7th Street
Harvard, NE 68944-2117 **CMS Certification No. 285272**

Subject: Survey Results
Cycle Start Date: July 7, 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 7, 2020, a survey was completed at Harvard Rest Haven 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 30, 2020**, to the State Survey Agency Contact. **Failure to submit an acceptable PoC by July 30, 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, September 3, 2020 in accordance with the statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal regulations at 42 CFR §488.417. Your Medicare Administrative Contractor will be notified of the date the denial of payment begins. DPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated.

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 7, 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
	285272	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARVARD REST HAVEN	400 EAST 7TH STREET HARVARD, NE 68944

(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		8/3/20

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

Electronically Signed | 07/29/2020

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
	285272	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARVARD REST HAVEN	400 EAST 7TH STREET HARVARD, NE 68944

(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	F880 Corrective taken will potentially protect all	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285272	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARVARD REST HAVEN	400 EAST 7TH STREET HARVARD, NE 68944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observation, interview and record review, the facility failed to implement infection control practices and Centers for Medicare and Medicaid Services (CMS) guidelines to prevent potential cross contamination including the spread of COVID-19 (a mild to severe respiratory illness that is caused by a coronavirus) related to failing to verify screening results for facility employees, failure to ensure the screening sheets contained full staff identifying information including first and last names and titles, failure to ensure follow up of symptoms indicated on screening sheets and failure to prevent self screening. The facility failure had the potential to affect all residents in the building. The facility identified a census of 30. Findings are: A. A record review of the Covid-19 Start of Shift Employee Screening log sheet (SSESL, a screening tool for Covid-19 symptoms and exposure) dated 07/06/20 for Employee A revealed a temperature above the stated facility guidelines was documented prior to allowing Employee A to work. Further review of the SSESL for Employee A revealed there was no evidence of a follow up evaluation prior to allowing Employee A to work. B. A record review of the SSESL dated 07/02/20 for Employee B revealed the SSESL had been left blank regarding Covid-19 symptoms. Further review of the SSESL for Employee B revealed there was no evidence of a follow up evaluation prior to allowing Employee B to work. C. A record review of the SSESL dated 07/02/20 for Employee C revealed the SSESL had no	F 880	residents as the deficiency has the potential to affect all residents. The systemic change includes: Staff self screening is now prohibited. Designated screeners will complete a modified staff sign in sheet that includes individual screening sheets for each employee-Full name and Title, Temperature, Systems, and Signature and Title of Screener. A comment section on the back side of the sheet will be used to document immediate follow up of any symptoms noted by the charge nurse and/or Director of Nursing to prevent any symptomatic staff member from entering the facility. This change is to be implemented on 07/29/2020 QAPI monitors will include 3 times weekly unannounced observation of the screening process by DON. Will do a daily monitor of all screening sheets by DON and/or by the Charge Nurse on the weekends. DPOC was sent under separate cover to Connie Vogt at dhhs.healthcarefacilities@Nebraska.gov. In the subject line it was designated as DPOC	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285272	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARVARD REST HAVEN	**400 EAST 7TH STREET HARVARD, NE 68944**

(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 3 temperature documented. Further review of the SSESL for Employee C revealed there was no evidence of a follow up evaluation prior to allowing Employee C to work. D. A record review of the SSESL dated 06/25/20 for Employee D revealed the SSESL had no temperature documented. Further review of the SSESL for Employee D revealed there was no evidence of a follow up evaluation prior to allowing Employee D to work. E. An interview with the facility Administrator, D.O.N. A and D.O.N. B was conducted on 7/7/20 at 09:05 A.M. The interview revealed that the SSESL sheets were reviewed daily by the D.O.N.'s. During the interview with the facility Administrator, DON A and DON B the SSESL sheets for Employee A, B, C, and D were reviewed. The interview confirmed that there was no evidence of a follow up evaluation being completed prior to Employees A, B, C, and D being allowed to work.	F 880		

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

Pete Ricketts, Governor

July 9, 2020

Cathy Snyder, Administrator
Hemingford Community Care Center
P O Box 307, 605 Donald Avenue
Hemingford, NE 69348-0307

CMS CERTIFICATION NUMBER: 28E301

Dear Ms. Snyder:

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

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

Pete Ricketts, Governor

July 6, 2020

Katie Frederick, Administrator
Heritage Of Bel Air
1203 North 13th Street
Norfolk, NE 68702-0429

CMS CERTIFICATION NUMBER: 285089

Dear Ms. Frederick:

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

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

Pete Ricketts, Governor

July 7, 2020

Harriet Lambrecht, Administrator
Heritage Care Center
P O Box 667, 909 17th Street
Fairbury, NE 68352-0667

CMS CERTIFICATION NUMBER: 285262

Dear Ms. Lambrecht:

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

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

Pete Ricketts, Governor

July 9, 2020

Cory Morris, Administrator
Heritage Estates
2325 Lodge Drive
Gering, NE 69341

CMS CERTIFICATION NUMBER: 285071

Dear Mr. Morris:

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

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

Pete Ricketts, Governor

August 12, 2020

Shellee Huggenberger, Administrator
Heritage Of Emerson
607 Nebraska Street
Emerson, NE 68733-3627

CMS CERTIFICATION NUMBER: 285222

Dear Ms. Huggenberger:

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

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

Pete Ricketts, Governor

July 22, 2020

Kim Grams, Administrator
Heritage Of Red Cloud
636 North Locust Street
Red Cloud, NE 68970

CMS CERTIFICATION NUMBER: 285225

Dear Ms. Grams:

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

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

Pete Ricketts, Governor

June 29, 2020

Alice Smith, Administrator
Highland Park Care Center
P O Box 950, 1633 Sweetwater
Alliance, NE 69301-0950

CMS CERTIFICATION NUMBER: 285063

Dear Ms. Smith:

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

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 8, 2020

Virginia Lundahl, Administrator
Hillcrest Care Center
702 Cedar Avenue
Laurel, NE 68745 **CMS Certification No. 285178**

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

PLAN OF CORRECTION

A Plan of Correction (PoC) for the deficiencies must be submitted **by July 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 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
	285178	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE CENTER	702 CEDAR AVENUE LAUREL, NE 68745

(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		7/24/20

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

Electronically Signed | 07/18/2020

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

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285178	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE CENTER	702 CEDAR AVENUE LAUREL, NE 68745

(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	F880 Infection Prevention & Control	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285178	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE CENTER	702 CEDAR AVENUE LAUREL, NE 68745

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observation, interview, and record view; the facility failed to 1) ensure visitors were screened for signs/symptoms of COVID-19 (A highly contagious virus primarily spread from person to person through respiratory droplets, which can lead to serious illness and even death); 2) ensure transmission-based precautions (the second tier of basic infection control and are to be used in addition to Standard Precautions for patients who may be infected with certain infectious agents for which additional precautions are needed to prevent infection) were implemented for 2 (Residents 1 and 5) of 5 sampled residents; and 3) failed to complete routine screening of the residents for signs and symptoms of COVID-19. 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 (Center for Disease Control) website for information and resources. Per the CDC, prompt detection, triage, and isolation of potentially infectious residents are essential to prevent unnecessary exposures among residents and healthcare personnel; -implement active screening of residents for fever and respiratory symptoms; -screen all staff at the beginning of their shift for fever and respiratory symptoms. Actively take	F 880	Based on the allegation that Hillcrest Care Center failed to implement transmission-based precautions for resident #1 and resident #5, the facility has taken the following steps: 1. Resident #1 has been in and out of Hillcrest Care Center for various necessary medical appointments since the Nebraska State of Emergency was declared on March 13, 2020. Isolation-based precautions are a necessary step for keeping residents safe from COVID-19 and to keep other residents and staff from potentially contracting COVID-19. 2. Resident #5 was out of the facility for an emergency on April 12, 2020. This resident has since passed away. 3. In order to protect Resident #1 and all residents, the following policy has been enacted: COVID-19 INFECTION PREVENTION POLICY In order to protect the residents from the COVID-19 virus, it is the policy of Hillcrest Care Center & Assisted Living that the following actions will be taken: 1. All residents will be screened daily for symptoms of COVID-19. This screening will involve measuring temperature, oxygen status, visual assessment, verbal assessment and charting results. Further medical interventions will be taken as symptoms warrant. Nursing staff will monitor the results of resident screening and take all appropriate action. Adherence to this policy will be overseen	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285178	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE CENTER	702 CEDAR AVENUE LAUREL, NE 68745

(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 3 their temperatures and document the absence of shortness of breath, new or change in cough and sore throat; and -if possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital where they would remain for 14 days with no symptoms. B. Review of the CMS Center for Clinical Standards and Quality, Safety and Oversight Group dated 4/24/20 revealed the following guidance for infection control and prevention of Coronavirus Disease 2019 (COVID-19): -the facility should consider the necessity of appointments outside of the facility to the resident's health, whether it is critical for the resident to attend; -if attending the appointment is necessary, the facility should help arrange for the resident to attend the appointment by taking precautions to minimize the risk of transmission of COVID-19; and -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 the observation of asymptomatic residents). C. Review of the COVID-19 staff/visitor screening logs dated 6/1/20 through 6/15/20 revealed visitors and staff were to be screened prior to admission to the facility to determine if they had any signs or symptoms of a respiratory infection, and if they had contact with someone who had or was under investigation for COVID-19. Further review of the screening logs revealed no evidence the staff and/or visitors had been screened before entering the facility on 6/4/20, 6/10/20 and on 6/11/20.	F 880	at monthly QA meetings. 2. During Phase I and Phase II of Nebraska's COVID-19 response, all residents who leave Hillcrest for medical or other appointments will be placed on isolation-based precautions for 14 days to prevent the potential spread of the COVID-19 virus. Isolation-based precautions will include the use of PPE for all staff entering the resident's room, the use of disposable dietary supplies, and the isolation of linens and trash. Residents will be removed from isolation-based precautions when 14 days have passed and no COVID-19 symptoms are noted. 3. During Phase III of Nebraska's COVID-19 response, all residents who leave the building for appointments will be placed under observation on their return, unless conditions warrant otherwise. Residents who come to Hillcrest from an acute care facility will be placed under 14-day isolation-based precautions. 4. Residents who are on isolation-based precautions will not be taken out of their rooms for any reason except for additional appointments outside of the building. Residents on isolation-based precautions will wear a mask while being transported from their room to the exit for appointments and returning to their room from an outside appointment. 5. All department heads will be notified by the nursing department when a resident is placed in isolation. Department heads are required to inform their staff about isolation precautions and how their department can assist in preventing the	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285178	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE CENTER	702 CEDAR AVENUE LAUREL, NE 68745

(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 D. Review of Resident 1's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 5/12/20 revealed diagnoses of cancer, anemia, heart failure, peripheral vascular disease and diabetes. Review of Resident 1's Nursing Progress Notes revealed the following: -4/22/20 at 2:14 PM a new order was received for the resident to be seen for [redacted] he resident was to wear a mask to the appointment and was to be screened upon return from the appointment for COVID-19. The resident was to then be placed in isolation; -4/22/20 at 4:25 PM the resident "continues to be at the Nurse's Station making phone calls to friends"; -4/23/20 at 4:26 PM the resident returned from a [redacted] appointment and was placed on isolation as the resident was "out of the building"; -4/30/20 at 11:07 PM the resident was out on the patio after the evening meal with staff and 2 other residents; -5/3/20 at 2:35 PM the resident "enjoyed watching Dean Martin show in the commons area this afternoon"; -5/6/20 at 8:11 AM the resident left the facility for an appointment at the [redacted]; and -5/6/20 at 4:48 PM the resident was out in the dining room and visited with staff. Review of Resident 1's medical record revealed no evidence the resident had been actively screened for fever or for respiratory symptoms after appointments or on a routine basis to monitor for signs and symptoms of COVID-19.	F 880	spread of potentially infectious agents. 6. Residents who are placed on isolation-based precautions will have that intervention noted on their electronic medical record. 7. All staff and visitors will undergo screening for COVID-19 symptoms upon entry into the building. At all entrances, a screening form will be filled out and an initial temperature taken. If that temperature is 100F or higher the staff or visitor will not be allowed past the entry point. If the temperature is lower than 100F and all other COVID-19 symptoms are NOT present, a second temperature check will be performed by a member of the nursing staff. If that temperature is less than 100F then the screening form will be left at a designated point for review and filing. 8. Staff will be trained yearly and as needed on infection prevention procedures and policies. Training materials will be used that include the most recent science-based findings. 9. New employees will receive COVID-19 training. This policy will ensure that resident #1 and all residents are protected from the potential transmission of COVID-19. This policy will ensure that residents who present with COVID-19 symptoms are: 1) identified and given the proper care and treatment; and 2) isolated from the rest of the resident population so as to prevent the potential spread of COVID-19. This policy makes isolation procedures a part of the electronic medical administration	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285178	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE CENTER	702 CEDAR AVENUE LAUREL, NE 68745

(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 E. Interview with the Administrator on 6/15/20 at 10:30 AM confirmed the following: -no evidence the staff and/or visitors had been screened prior to admission to the facility on 6/4/20, 6/10/20 and on 6/11/20; -Resident 1 was placed on transmission-based precautions 4/22/20 due to [redacted] The resident should not have been out of the resident's room on 4/22/20, 4/23/20, 4/30/20, 5/3/20 and on 5/6/20; and -no active screening for fever and/or respiratory symptoms had been implemented for any of the facility residents. F. Review of Resident 5's MDS dated 3/24/20 revealed the following diagnoses: [redacted] Review of Resident 5's Progress Notes revealed the following: -4/12/20 at 4:30 AM the resident was transferred to the [redacted] via ambulance after [redacted] at 3:40 AM; and -4/12/20 at 9:50 AM the resident returned [redacted] and had [redacted]. During an interview on 6/16/20 at 10:00 AM, the Administrator confirmed Resident 5 had never been placed in transmission-based precautions upon return [redacted] and had not been actively screened for COVID-19 symptoms, thereby putting the resident and others at an increased risk for exposure to the virus.	F 880	record (eMAR) and improves communication throughout the facility with regard to isolation interventions. All-staff in-services were held the week of July 20-24. These in-services provided staff with the following videos regarding best practices for COVID-19 prevention in long-term care: 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 Donning N95 - https://www.youtube.com/watch?v=CoSb-HJJ5tk This intervention will be completed on July 24, 2020. Based on the allegation that Hillcrest Care Center failed to ensure visitors were screened for signs and symptoms of COVID-19, the facility has taken the following steps: To protect Resident #1 and all residents, the following steps have been taken: 1. A new screening tool has been implemented at all entries to the building. The new tool will require a more thorough	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285178	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE CENTER	702 CEDAR AVENUE LAUREL, NE 68745

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6	F 880	screening of entrants to the facility for signs and symptoms of COVID-19. Besides expecting entrants to answer questions regarding their health symptoms, the new tool will require a second temperature check by nursing staff. This screening will help Hillcrest to immediately assess staff and visitors for COVID-19 symptoms and immediately deny access as symptoms warrant. All screening paperwork will be monitored, collected by designated staff members and filed by the infection control preventionist. Any irregularities will be reported to the administrator and referred for medical evaluation. 2. A new COVID-19 INFECTION PREVENTION POLICY has been put into effect. The new policy states: 10. All staff and visitors will undergo screening for COVID-19 symptoms upon entry into the building. At all entrances, a screening form will be filled out and an initial temperature taken. If that temperature is 100F or higher the staff or visitor will not be allowed past the entry point. If the temperature is lower than 100F and all other COVID-19 symptoms are NOT present, a second temperature check will be performed by a member of the nursing staff. If that temperature is less than 100F then the screening form will be left at a designated point for review and filing. This intervention was completed on July 20, 2020.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285178	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE CENTER	702 CEDAR AVENUE LAUREL, NE 68745

(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	F 880	Based on the allegation that Hillcrest Care Center failed to screen residents daily for fever and/or respiratory symptoms of COVID-19, the facility has taken the following steps: Each resident now has COVID-19 symptom checks as part of the daily electronic medical administration record (eMAR). Nurses check temperature and oxygen status and visually and verbally assess each resident daily for signs and symptoms of COVID-19. Results of the screening are part of the permanent eMAR record and are available for review and referral as needed. The new COVID-19 Infection Control Policy states: 11. All residents will be screened daily for symptoms of COVID-19. This screening will involve measuring temperature, oxygen status, visual assessment, verbal assessment and charting results. Further medical interventions will be taken as symptoms warrant. Nursing staff will monitor the results of resident screening and take all appropriate action. Adherence to this policy will be overseen at monthly QA meetings. This policy will help protect all residents from the potential spread of COVID-19 in the facility. This intervention will: 1) identify residents who present with COVID-19 symptoms; 2) help medical professionals provide appropriate care to	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285178	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CARE CENTER	702 CEDAR AVENUE LAUREL, NE 68745

(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 8	F 880	affected residents; and 3) help protect other residents from potentially contracting COVID-19. This intervention was implemented on June 17, 2020 and is ongoing. To monitor the performance of this plan of correction, to protect resident #1, and to protect all residents, the infection preventionist will monitor adherence to these interventions and the facility will monitor compliance with this plan of correction at monthly QA meetings. The QA team will continue to identify potential areas of improvement, implement appropriate plans of improvement, and review and revise the effectiveness of the performance improvement plans.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285293	A. BUILDING _____ B. WING _____	06/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST COUNTRY ESTATES-COTTAGES	6082 GRAND LODGE AVENUE PAPILLION, NE 68133

(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		7/24/20

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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285293	A. BUILDING _____ B. WING _____	06/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST COUNTRY ESTATES-COTTAGES	6082 GRAND LODGE AVENUE PAPILLION, NE 68133

(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	F-880 SS=D	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285293	A. BUILDING _____ B. WING _____	06/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST COUNTRY ESTATES-COTTAGES	6082 GRAND LODGE AVENUE PAPILLION, NE 68133

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observation, interview and record review, the facility failed to implement infection Control Practices and Center for Medicare and Medicaid Services (CMS) guidelines to prevent the potential for cross contamination including the spread of Covid-19 related to failure of staff to wear approved eye protection in resident room for 1 Resident (Resident 1) of 3 residents reviewed. The facility Census was 34. Findings are: Interview on 6/22/2020 at 8:25 AM with the Assistant Administrator revealed the facility is working with Infection Control Assessment and Promotion Program (ICAP- a CDC-funded efforts with the primary objective to prevent health care-associated infections) . All resident rooms are private rooms and signs on nameplates denote gray zone (area for residents that are being quarantined to assess for Covid-19) residents. Observation on 6/22/2020 at 10:00 AM revealed Resident 1 had a gray sign on the door indicating Resident 1 was in a gray zone. Review of Gray Zone sign on Resident 1's door revealed Team members PPE to include surgical mask, gloves, gown and goggles (if available) Interview on 6/22/2020 at 1:30 PM with the administrator revealed the facility had an adequate supply of Personal Protective Equipment (PPE) including eye protection.	F 880	Tag Description: Infection Prevention and Control Summary of Statement of Deficiency: The facility failed to ensure staff followed transmission based standards of precaution per the droplet standard of practice. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Team members were re-educated on wearing the correct PPE when entering all zones, (see Attachment A & C) this includes the wearing of goggles or a face shield in the Transitional Zone. Resident 1, was in admitted into the Rehab Cottage (short stay) and remained in the transitional zone. The team members wore the appropriate PPE (including goggles) when entering the guests room. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents admitting or readmitting to facility will continue to enter the facility in a Transitional Zone for 14 day period of quarantine while the facility remains in Phase 1 and 2 of facility reopening plan. All team members providing high contact care during Phase 1 and 2 of facility reopening plan will utilize PPE as indicated on Attachment A - Facility Zoning/PPE Grid. The DCS/designee will re-educated team members on the proper PPE to be worn and the importance of doing so for each of these zones. The	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285293	A. BUILDING _____ B. WING _____	06/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST COUNTRY ESTATES-COTTAGES	6082 GRAND LODGE AVENUE PAPILLION, NE 68133

(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 3 Observation on 6/22/2020 at 12:40 PM revealed Certified Occupational Therapy Assistant (COTA) A in Resident 1's room working with Resident 1. COTA A was within 3 feet of Resident 1 and was not wearing eye protection only prescription glasses. Interview on 6/22/2020 at 12:40 PM with Clinical Consultant revealed COTA A was wearing only prescription glasses with no eye protection in Resident 1's room. Review of the facilities Covid-19 Cohorting plan dated 5/6/2020 revealed that in the gray zone eye protection is required. Review of the Center for Disease Control article Titled: Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (Covid-19) Healthcare Setting dated June 19, 2020 revealed "personal eyeglasses and contact lenses are NOT considered eye protection"	F 880	Directed Plan of Correction (DPOC) will be the following: team members will be re-educated no later than July 24, 2020 regarding proper use of PPE to prevent the spread of COVID 19 using the video training: Use Personal Protective Equipment Correctly for COVID 19 https://www.youtube.com/watch?v=YYTATw9yav4 . What measures will be put in place or what systematic changes will you make to ensure that the deficient practice does not recur: PPE Audits of the Zones will be conducted to ensure proper PPE is being worn for the established Zone(s). These audits will be conducted at randomly 10x/week X 4 weeks, then 5x/week X 4 weeks, then weekly X 4 weeks. These audits will be conducted by the Infection Control Preventionist/designee. How will the corrective action(s) be monitored to ensure the deficient practice will not recur: Data from these audits will be collected and brought to QAPI monthly for review and monitoring. Process Owner: DCS/ICP/Designee Target Date: July 24, 2020	

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

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 8, 2020

Tara Gabel, Administrator
Hillcrest Country Estates-Cottages
6082 Grand Lodge Avenue
Papillion, NE 68133 **CMS Certification No. 285293**

Subject: **Survey Results**
Cycle Start Date: June 22, 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 22, 2020, a survey was completed at Hillcrest Country Estates-Cottages by the State Survey Agency to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the CMS 2567 and will be posted on the ePOC system.

PLAN OF CORRECTION

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

The PoC must contain the following:

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

ENFORCEMENT REMEDIES

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

- **Directed Plan of Correction:**

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

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

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

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

Connie Vogt, RN, BSN

Email: dhhs.healthcarefacilities@Nebraska.gov

In the Subject Line please put: DPOC

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

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

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

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

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

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

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

An IDR, including any face-to-face meetings, constitutes an informal administrative process that

in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

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

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

APPEAL RIGHTS

If you disagree with the determination to impose remedies made on the basis of noncompliance identified at the June 22, 2020 survey, you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board (DAB). The appeal rights are set forth at 42 C.F.R. § 498.5 and the procedures for requesting a hearing are set forth at §498.40, et seq. You must file your hearing request electronically by using the DAB's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov/, unless you obtain a waiver from the DAB (*see* DAB Civil Remedies Division Procedures, § 6(a)(i)(1)). Your appeal must be filed no later than 60 days from the date of receipt of this letter.

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

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

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

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

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

CONTACT INFORMATION

If you have any questions please contact this office.

Sincerely,



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

CV/kd

Enclosures: CMS 2567

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

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

Pete Ricketts, Governor

July 27, 2020

Tara Gabel, Administrator
Hillcrest Country Estates-Cottages
6082 Grand Lodge Avenue
Papillion, NE 68133

CMS CERTIFICATION NUMBER: 285293

Dear Ms. Gabel:

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

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

MIDWEST DIVISION OF SURVEY AND CERTIFICATION

May 18, 2020

Rebecca Smith, Administrator
Hillcrest Firethorn
8601 Firethorn Lane
Lincoln, NE 68520

CMS Certification No: 285300

Dear Ms. Smith:

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

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

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

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

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

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

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

Sincerely,

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

cc:
NE DHHS
Powers/Grimes

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285133	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST HEALTH & REHAB	1702 HILLCREST DRIVE BELLEVUE, NE 68005

(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		7/21/20

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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285133	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST HEALTH & REHAB	1702 HILLCREST DRIVE BELLEVUE, NE 68005

(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	What corrective action(s) will be accomplished for those residents found to	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285133	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST HEALTH & REHAB	1702 HILLCREST DRIVE BELLEVUE, NE 68005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observation, interview and record review; the facility failed to implement infection control practices and Centers for Medicare and Medicaid Services (CMS) guidelines to prevent potential cross contamination including the spread of COVID-19 related to failing to verify screening results for facility employees and failure to ensure use of Personal Protective Equipment (PPE) in isolation rooms which had the potential to effect all residents. The facility identified a census of 118. Findings are: A A record review of a Team Member Fitness For Duty Screen (TMFFDS, a screening tool for Covid-19 exposure) sheet dated 6/14/20 revealed that Employee A had symptoms of cough, sore throat or shortness of breath. Further review of Employee A's TMFFDS sheet revealed there was no evidence Employee A's symptoms were evaluated prior to allowing Employee A to work. B. A record review of the TMFFDS sheets dated 6/12/20 and 6/14/20 revealed that Employee B had symptoms of cough, sore throat or shortness of breath. Further review of Employee B's TMFFDS sheet revealed there was no evidence Employee B's symptoms were evaluated prior to allowing Employee B to work. C. A record review of the TMFFDS sheet dated 6/14/20 revealed that Employee C had symptoms of cough, sore throat or shortness of breath. Further review of Employee C's TMFFDS sheet revealed there was no evidence Employee C's symptoms were evaluated prior to allowing Employee 3 to work.	F 880	have been affected by the deficient practice: No affected residents as noted by no cases of COVID-19. Team members, including employee F, were re-educated on wearing the correct PPE when entering all zones, (see Attachment A) this includes the wearing of goggles or a face shield in the Transitional Zone. Employee A, B, C, D and E's symptoms were d/t allergies and not of new onset. The Team Member Fitness for Duty Screen (TMFFDS, a screening tool forCovid-19 exposure) has been updated to reflect that the Administrator/Designee must be contacted if Yes to any question or if temperature is 99.1 or higher. (See Attachment B- TMFFDS form) The designated screener has been educated to this new addition and that there must be documentation as to why the team member is allowed to work. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents admitting or readmitting to facility will continue to enter the facility in a Transitional Zone for 14 day period of quarantine while the facility remains in Phase 1 and 2 of facility reopening plan. All team members providing high contact care during Phase 1 and 2 of facility reopening plan will utilize PPE as indicated on Attachment A - Facility Zoning/PPE Grid. Team members will be	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285133	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST HEALTH & REHAB	1702 HILLCREST DRIVE BELLEVUE, NE 68005

(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 3 D. A record review of the TMFFDS sheets dated 6/12/20, 6/15/20 and 6/21/20 revealed that Employee D had symptoms of cough, sore throat or shortness of breath. Further review of Employee D's TMFFDS sheet revealed there was no evidence Employee D's symptoms were evaluated prior to allowing Employee D to work. E. A record review of the TMFFDS sheet dated 6/15/20 revealed that Employee E had symptoms of cough, sore throat or shortness of breath. Further review of Employee E's TMFFDS sheet revealed there was no evidence Employee E's symptoms were evaluated prior to allowing Employee E to work. F. On 6/22/20 at 3:11 P.M. an interview was conducted with the facility Administrator. During the interview, a review of the TMFFDS sheets for Employees A, B, C, D and E dated 6/12/20, 6/15/20 and 6/21/20 was completed. The facility Administrator confirmed there should have been follow up regarding Employee A, B, C, D and E's symptoms and was not. G. On 6/22/20 at 10:25 A.M. an observation revealed Employee F to be exiting a gray zone room, room 136, with a bag in hand which was being taken to the dirty utility room. Employee F was observed to have a surgical mask in place with no face shield or eye protection. H. On 6/22/20 at 1:55 P.M an interview with Employee L revealed that face shields were not available for use on the gray zone and that the goggles which the facility had available did not fit over eye glasses, so their eye glasses were considered their protection device.	F 880	re-educated by the DCS/designee on the proper PPE to be worn and the importance of doing so. Team members will be educated regarding proper use of PPE to prevent the spread of Covid-19 using the video training: CDC-Keep Covid-19 out. Team members will be re-educated regarding proper use of PPE to prevent the spread of COVID-19. What measures will be put in place or what systematic changes will you make to ensure that the deficient practice does not recur: 1) Audits (Attachment C) will be conducted by the Administrator/designee on the TMFFDS to ensure that the facility remains in compliance and that there is documentation to support a question marked as a yes. These audits will be completed 3x/week X 4 weeks; and then weekly X 4 weeks and monthly x 2 months. 2) PPE Audits of the Zones will be conducted to ensure proper PPE is being worn for the established Zone(s). These audits will be conducted 3x per week X 4 weeks, then weekly X 4 weeks and monthly x 2 months. These audits will be conducted by the Infection Control Preventionist/designee. How will the corrective action(s) be monitored to ensure the deficient practice will not recur: Data from these audits will be collected and brought to QAPI monthly for review and monitoring.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285133	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST HEALTH & REHAB	1702 HILLCREST DRIVE BELLEVUE, NE 68005

(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 Record review of a CDC Coronavirus Disease 2019 (COVID 19) sheet dated 6-19-2020 revealed the following information: -Eye Protection: -"Personal eyeglasses's and contact lenses are NOT considered adequate eye protection".	F 880	Process Owner: Administrator/DCS/Designee	

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

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 1, 2020

Tammy Weston, Administrator
Hillcrest Health & Rehab
1702 Hillcrest Drive
Bellevue, NE 68005 **CMS Certification No. 285133**

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 Hillcrest Health & Rehab 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 at 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 45 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)

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 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 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
DPOC

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

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

MIDWEST DIVISION OF SURVEY AND CERTIFICATION

May 8, 2020

David Deemer, Administrator
Hillcrest Millard
13225 Westwood Lane
Omaha, NE 68144

CMS Certification No: 285302

Dear Mr. Deemer:

SUBJECT: SURVEY RESULTS
Cycle Start Date: April 29, 2020

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

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

SURVEY RESULTS
On April 29, 2020, the Centers for Medicare & Medicaid Services (CMS) completed a COVID-19 Focused Survey at Hillcrest Millard to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was in substantial compliance with participation requirements and no deficiencies were cited. The findings from this survey are documented on the enclosed form CMS 2567.

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

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

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

Sincerely,

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

cc:
NE DHHS
Powers/Grimes

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

Pete Ricketts, Governor

July 9, 2020

David Deemer, Administrator
Hillcrest Millard
13225 Westwood Lane
Omaha, NE 68144

CMS CERTIFICATION NUMBER: 285302

Dear Mr.. Deemer:

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

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

MIDWEST DIVISION OF SURVEY AND CERTIFICATION

July 7, 2020

Shane Filipi, Administrator
Hillcrest Nursing Home
P O Box 1087, 309 West 7th Street
McCook, NE 69001

CMS Certification Number: 285080

Dear Administrator:

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

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

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

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

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

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

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

Sincerely,

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

cc:
NE DHHS
Power/Grimes

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28E299	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST SHADOW LAKE	1507 E GOLD COAST ROAD PAPILLION, NE 68046

(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 | 07/09/2020

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
	28E299	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST SHADOW LAKE	1507 E GOLD COAST ROAD PAPILLION, NE 68046

(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	Summary of Statement of Deficiency: F880 - The facility failed to ensure staff	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28E299	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST SHADOW LAKE	1507 E GOLD COAST ROAD PAPILLION, NE 68046

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on interview, observation, and record review, the facility failed to ensure staff followed transmission based precautions per the droplet standard of practice by staff failure to don eye protection in the faciltiy GREY ZONE for 1 [Resident 2] of 3 sampled residents. The facility census was 91. Findings are: A. Observation at 10:00 AM for resident 2 revealed a NA B [Nurse Aide] donned PPE (personal protective equipment] on which included long sleeved gown that snapped in the back, had a surgical mask on and put gloves on. The NA B did not don on a face shield or googles during answering of this residents call light. NA B assisted the resident to the bathroom with wheelchair and assisted resident 2 by pivoting to the toilet, waited while the resident finished and assisted resident 2 from bathroom back to wheelchair, assisted resident 2 with hand washing; and NA B doffed PPE and put dirty gown and gloves in waste baskets and laundry baskets, then NA B used hand sanitizer for hands. Interview on 6/22/2020 at 10:15 AM with Resident 2 confirmed the resident 2 was a new admission and had been there [redacted], the quarantine was extended as resident 2 went to [redacted] out of the facility, did wear mask, but the staff that provided cares for this resident did not use any PPE (face shield or googles) to assist this resident with any activities of daily living. B. Interview on 6/20/2020 at 11:00 AM with Director of Nursing revealed the facility was in	F 880	followed transmission based standards of precaution per the droplet standard of practice. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Team members were re-educated on wearing the correct PPE when entering all zones, (see Attachment A) this includes the wearing of goggles or a face shield in the Transitional Zone. Resident 2 was transitioned out of the Transitional Zone on 06.24.2020 and continues to be asymptomatic. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents admitting or readmitting to facility will continue to enter the facility in a Transitional Zone for 14 day period of quarantine while the facility remains in Phase 1 and 2 of facility reopening plan. All team members providing high contact care during Phase 1 and 2 of facility reopening plan will utilize PPE as indicated on Attachment A - Facility Zoning/PPE Grid. The DCS/designee will re-educated team members on the proper PPE to be worn and the importance of doing so for each of these zones. Team members will be re-educated no later than July 10, 2020 regarding proper use of PPE to prevent the spread of COVID 19	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28E299	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST SHADOW LAKE	1507 E GOLD COAST ROAD PAPILLION, NE 68046

(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 3 Phase 1 of reopening and Resident 2 was new admission and in the GREY ZONE, but resident 3 had left the nursing home for a [redacted] so the quarantine lasted a few days longer. The Director of Nursing stated Resident 2 did not have any signs or symptoms of covid-19 and the medical director of the facility stated they did not need to wear eye protection. C. A review of facility policy titled Hillcrest Health Services Coronavirus Disease 2019 (COVID-19) SNF Policy V.8 up-dated 6/8/20 exhibit 2 revealed the following Personal Protective Equipment is required for Team Members in the grey zone: -Surgical Mask -Gown -gloves -goggles D. A review of CDC website updated 6/22/20 revealed the following for guidance for managing new admission and readmissions whose COVID-19 status is unknown: -"HCP [Health Care Professional] should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves and gown when caring for theses residents."	F 880	using the video training: Use Personal Protective Equipment Correctly for COVID 19 https://www.youtube.com/watch?v=YYTATw9yav4 . See Attachment B - Zoning PPE and YouTube PPE Course Completion. What measures will be put in place or what systematic changes will you make to ensure that the deficient practice does not recur: PPE Audits of the Zones will be conducted to ensure proper PPE is being worn for the established Zone(s). These audits will be conducted at randomly 10x/week X 2 weeks, then 3x/week X 2 weeks, then weekly X 4 weeks. These audits will be conducted by the Infection Control Preventionist/designee. See Attachment C - PPE Audit Tool How will the corrective action(s) be monitored to ensure the deficient practice will not recur: Data from these audits will be collected and brought to QAPI monthly for review and monitoring. Process Owner: DCS/ICP/Designee	

IMPORTANT NOTICE – PLEASE READ CAREFULLY

June 30, 2020

Kevin Sauberzweig, Administrator
Hillcrest Shadow Lake
1507 E Gold Coast Road
Papillion, NE 68046 **CMS Certification No. 28E299**

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 Hillcrest Shadow Lake 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 10, 2020**, to the State Survey Agency Contact. **Failure to submit an acceptable PoC by July 10, 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: (*Please see the attached guidance)***

  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 at 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 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 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

Enclosures
CMS 2567

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

Pete Ricketts, Governor

July 27, 2020

Scott Bahe, Administrator
Hilltop Estates
P O Box 429, 2520 Avenue M
Gothenburg, NE 69138

CMS CERTIFICATION NUMBER: 285163

Dear Mr. Bahe:

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

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

MIDWEST DIVISION OF SURVEY AND CERTIFICATION

May 19, 2020

Lavonne Harrom, Administrator
Holmes Lake Rehabilitation & Care Center
6101 Normal Blvd
Lincoln, NE 68506

CMS Certification No: 285164

Dear Ms. Harrom:

SUBJECT: SURVEY RESULTS
Cycle Start Date: May 13, 2020

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

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

SURVEY RESULTS
On May 13, 2020, the Centers for Medicare & Medicaid Services (CMS) completed a COVID-19 Focused Survey at Holmes Lake Rehabilitation & Care Center to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was in substantial compliance with participation requirements and no deficiencies were cited. The findings from this survey are documented on the enclosed form CMS 2567.

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

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

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

Sincerely,

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

cc:
NE DHHS
Powers/Grimes

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

MIDWEST DIVISION OF SURVEY AND CERTIFICATION

May 18, 2020

Taylor Schommer, Administrator
Homestead Nursing & Rehabilitation Center
4735 South 54th Street
Lincoln, NE 68516

CMS Certification No: 285049

Dear Ms. Schommer:

SUBJECT: SURVEY RESULTS
Cycle Start Date: May 14, 2020

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

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

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

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

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

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

Sincerely,

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

cc:
NE DHHS
Powers/Grimes

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

Pete Ricketts, Governor

July 7, 2020

Diane Villwok, Administrator
Hooper Care Center
400 East Birchwood Drive
Hooper, NE 68031

CMS CERTIFICATION NUMBER: 285229

Dear Ms. Villwok:

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

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

MIDWEST DIVISION OF SURVEY AND CERTIFICATION

July 15, 2020

Patrick Fairbanks, Administrator
Immanuel Fontenelle
6809 N 68th Plaza
Omaha, NE 68152-2117

CMS Certification No: 285085

Dear Mr. Fairbanks:

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

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

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

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

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

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

https://qioprogram.org/locate-your-qio.

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

Sincerely,

Lisa Hauptman

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

cc:
NE DHHS
Power/Grimes

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

July 17, 2020

Eric Haider, Administrator
Imperial Manor Nursing Home
P O Box 757, 933 Grant Street
Imperial, NE 69033

CMS Certification No: 285252

Dear Mr. Haider:

SUBJECT: SURVEY RESULTS
Cycle Start Date: July 15, 2020

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

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

SURVEY RESULTS
On July 15, 2020, the Centers for Medicare & Medicaid Services (CMS) completed a COVID-19 Focused Survey at Imperial Manor Nursing Home to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was in substantial compliance with participation requirements and no deficiencies were cited. The findings from this survey are documented on the enclosed form CMS 2567.

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

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

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

CONTACT INFORMATION

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

Sincerely,

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

cc:
NE DHHS
Powers/Grimes

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

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 1, 2020

Margaret Rogers, Administrator
Indian Hills Manor
1720 North Spruce
Ogallala, NE 69153 **CMS Certification No. 285091**

Subject: **Survey Results**
Cycle Start Date: June 17, 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 17, 2020, a survey was completed at Indian Hills 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

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

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 17, 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
	285091	A. BUILDING _____ B. WING _____	06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN HILLS MANOR	**1720 NORTH SPRUCE OGALLALA, NE 69153**

(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		7/16/20

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
	285091	A. BUILDING _____ B. WING _____	06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN HILLS MANOR	**1720 NORTH SPRUCE OGALLALA, NE 69153**

(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 12-006.17B	F 880	F880 1. Effective 06/18/20 all residents,	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285091	A. BUILDING _____ B. WING _____	06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN HILLS MANOR	1720 NORTH SPRUCE OGALLALA, NE 69153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observations, interviews and record review, the facility failed to place seven residents (Residents 1, 2, 4, 5, 8, 9, and 10) in droplet precautions for two weeks following admission to the facility to prevent the potential spread of COVID-19. Facility census was 38. Sample size was 10. Findings are: On 6/17/2020 at 10:50 AM, an interview with the facility's Administrator and DON (Director of Nursing) revealed that between 3/13/2020 and 6/1/2020 Residents 1, 2, 4, 5, 8, 9, and 10 were admitted to the facility from [redacted] They reported that these residents were all placed in private rooms, but droplet precautions for 14 days of quarantine were not put in place per CMS (Centers for Medicare and Medicaid Services) memo QSO-20-14-NH which was dated 3/13/2020 although the facility did have a copy of that document in their COVID-19 manual. The Administrator stated that because there was no COVID-19 in the local area and because all residents were being isolated in their rooms or wearing face masks when out of their rooms, they did not believe that droplet precautions were necessary. The Administrator also verified that of this group only Resident 1 had been tested for COVID-19 before admission to the facility, and Resident 1 was only tested once and had a negative result. The Administrator did provide a list of both staff and residents who had been tested for COVID-19, and all results were negative. Two residents who were admitted to the facility in June had two negative tests for COVID-19 either before being admitted to the	F 880	including residents #1, 2, 5, and 9 have been placed in appropriate isolation with droplet precautions per CMS recommendation and facility policy. Residents #4, 8, and 10 were all discharged prior to 06/18/2020. All residents who use the dinning room for meals will utilize face masks if possible. During the quarantine period all therapy will be conducted in the resident's room. And residents will not be allowed to move freely about the facility unless supervised. Upon admission residents will be placed in a private room for the duration of the quarantine period. Residents and families will be educated on the regulations regarding leaving the facility and that the quarantine period will be restarted for 14 days upon return, this includes physician visits and dialysis. 2. Facility will follow CMS guidelines as well as facility policy for all admits, readmits and residents traveling outside the facility. Facility policy is inline with all guidelines provided by CMS. Responsible party; Administrator/DON 3. All staff, including non-nursing staff will be re-educated on the facility policy for admissions and physician visits as well as a review of basic infection control protocols including droplet precautions. In addition, all staff will view the videos; "Closely Monitor Residents", and "Keep COVID Out". Responsible party; Administrator/DON 4. An audit will be completed daily for 2 weeks, then weekly until the facility enters Phase 3, by the administrator, to monitor that all residents are in compliance with	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285091	A. BUILDING _____ B. WING _____	06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN HILLS MANOR	**1720 NORTH SPRUCE OGALLALA, NE 69153**

(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 3 facility or before being taken out of droplet precautions. On 6/17/2020 at 12:00 PM observations by surveyor P. Ramirez showed some residents eating lunch in their rooms while those in the dining room were seated one person to a table with the tables positioned to keep residents 6 feet apart. Residents in dining room waiting for the meal were not wearing masks. Review of the "Progress Notes" for Resident 5 from 3/13/2020 to 3/27/2020 showed that the resident was admitted for skilled nursing care following [redacted] A note on 3/18/ 2020 by therapy indicated the resident was receiving [redacted] everal times per week but did not specify if this was being done only in the resident's room. A note on 3/19/2020 at 11:15 AM revealed that the resident had been left in the wheelchair in their room since being pushed back to the room after breakfast indicating that the resident was not being kept in a private room at all times to avoid possibly exposing others to COVID-19. None of the "Progress Notes" during that time period indicated any effort to isolate this resident to their private room or to use droplet precautions to prevent the possible spread of COVID-19. Review of the "Progress Notes" for Resident 8 from [redacted] showed that the resident was admitted [redacted] "Progress Notes" on 3/15, 16, and 17/2020 all stated "eating meals at own table and keeping 6 feet distance from other	F 880	the COVID regulations. This audit will be reviewed daily at the stand-up meeting and reported monthly to the QA committee. 5. Completion date; 7/16/20	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285091	A. BUILDING _____ B. WING _____	06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN HILLS MANOR	**1720 NORTH SPRUCE OGALLALA, NE 69153**

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

residents." This demonstrated that the resident was not kept in isolation in a private room for 14 days after admission. A "Progress Note" on 3/18/2020 showed that the resident had been going to the dining room for meals." Notes on 3/20 and 22/2020 showed staff assist to and from dining room. Notes on 3/24, 25, 26, and 27/2020 also indicated that the resident had gone to the dining room for meals. None of the "Progress Notes" during that time period indicated any effort to confine this resident to the private room or to use droplet precautions to prevent the possible spread of COVID-19.

Review of the "Progress Notes" for Resident 2 from 3/20/2020 to 4/3/2020 showed that the resident was admitted [redacted] A "Progress Note" on 3/22/2020 revealed the resident was brought to the lobby yesterday to call a family member and although the resident had a cell phone it was difficult to hear. The note also indicated that when the resident's spouse called staff brought the resident to the phone. A "Progress Note" on 3/25/2020 indicated that the resident was working [redacted] but did not specify whether this was being done only in the resident's room. A "Progress Note" on 3/27/2020 revealed that the resident had breakfast in their room and lunch in the dining room. None of the "Progress Notes" during that time period indicated that this resident was confined to a private room, and no mention of the use of droplet precautions to prevent the possible spread of COVID-19 was seen.

Review of the "Progress Notes" for Resident 10 from 3/25/2020 to 4/9/2020 showed that this

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285091	A. BUILDING _____ B. WING _____	06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN HILLS MANOR	1720 NORTH SPRUCE OGALLALA, NE 69153

(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 resident arrived at the facility via family car with a family member on [redacted] for unspecified injury of the [redacted] following a fall. Two "Progress Notes" on 3/27/2020 at 12:19 PM and 12:21 PM related to medication administration revealed that while on an outing with family, the resident's family decided to take them to Kearney to get a [redacted] before returning to the facility. A "Progress Note" at 6:45 PM on 3/27/2020 showed that the resident had returned from an outing with family with a [redacted] in place. A "Progress Note" on 3/30/2020 stated that the resident was encouraged to come to the dining room as they ate better there. A "Progress Note" on 4/1/2020 indicated that the resident was working [redacted] multiple times per week with no mention of whether this was done only in the resident's room. A "Progress Note" on 4/4/2020 revealed that the resident had their morning meal in the dining room. None of the "Progress Notes" during that time period indicated the use of droplet precautions or isolation in a private room to prevent the possible spread of COVID-19. Review of the "Progress Notes" for Resident 4 from 4/8/2020 to 4/22/2020 showed that the resident was admitted to the facility on [redacted] for a [redacted] A "Progress Note" on 4/10/2020 revealed that the resident's spouse brought them back to the facility after being seen in the Emergency Room that day for a fall. "Progress Notes" on 4/14 and 15/2020 showed that the resident was moved to the dining room for meals and did seem to eat better there. A "Progress Note" on 4/15/2020 indicated the resident was working [redacted]	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
	285091	A. BUILDING _____ B. WING _____	06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN HILLS MANOR	**1720 NORTH SPRUCE OGALLALA, NE 69153**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6 multiple times per week but did not state whether this was done only in the resident's room. None of the "Progress Notes" during that time period indicated that the resident remained in a private room or that droplet precautions were used to prevent the possible spread of COVID-19. Review of the "Progress Notes" for Resident 9 from 5/6/2020 to 5/17/2020 showed that the resident came to the facility on [redacted] accompanied by a family member. A "Progress Note" at 3:42 PM on that date revealed that the resident was going up and down the hall in a wheelchair looking at the names on the doors to see if they knew anyone. Another note at 5:14 PM of the same day indicated that the resident was staying by the nurse's side to keep the resident safe as the resident was attempting to stand up and walk unassisted. "Progress Notes" on 5/7, 8, 11, 14 and 15/2020 revealed the resident was sitting in a wheelchair by the nurses station. A "Progress Note" on 5/14/2020 at 10:16 PM showed that the resident got up and ambulated in the hall 8 times before settling down. A "Progress Note" on 5/15/2020 revealed that the resident was moved to another room on that date but the note did not state whether this was a private room or whether transmission precautions were being used either before or after this move. A "Progress Note" by the dietician on 5/18/2020 stated that the resident dined at a verbal cue/assist table to encourage to consume maximum quantity of meals. None of the "Progress Notes" during this time period indicated that the resident was placed in transmission based precautions or confined in a private room to prevent the possible spread of COVID-19. Review of the "Progress Notes" for Resident 1	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
	285091	A. BUILDING _____ B. WING _____	06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN HILLS MANOR	1720 NORTH SPRUCE OGALLALA, NE 69153

(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 from 5/27/2020 to 6/8/2020 showed that this resident returned to the facility on 5/27/2020 after being hospitalized for [redacted] The list of residents tested for COVID-19 showed that Resident 1 had a negative test on 5/23/2020 but had not had a second negative test done before returning to the facility. A "Progress Note" on 6/8/2020 indicated that the resident had returned at 6:00 PM that day from an appointment to have [redacted] During the interview with the Administrator and DON at 10:50 AM on 6/17/2020, the DON clarified that this resident was placed in transmission based precautions following a visit to the [redacted] which was out of the local area. Observations on 6/17/2020 at 2:50 PM showed staff using gown, gloves, mask, and goggles when entering this resident's room for droplet precautions. The resident was in a private room. None of the "Progress Notes" reviewed between 5/27/2020 and 6/8/2020 indicated the use of droplet precautions or isolation in a private room to prevent the possible spread of COVID-19. A "Progress Note" on 6/9/2020 indicated that the resident had refused to get dressed that morning due to not wanting to wait while staff "get all gowned up" before entering the room. None of the previous "Progress Notes" indicated the use of transmission based precaution or the need for the resident to remain in a private room. These concerns were reviewed during an exit conference on 6/17/2020 at 5:25 PM, and at 5:45 PM the Administrator provided a written note of the facility's plan to continue to place all residents into isolation for 14 days when admitted or upon return to the facility from any appointment.	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
	285282	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COMMUNITY HEALTH & LIFE GARDENSIDE	**P O BOX 277, 2200 NORTH H STREET FAIRBURY, NE 68352**

(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		8/12/20

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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285282	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COMMUNITY HEALTH & LIFE GARDENSIDE	P O BOX 277, 2200 NORTH H STREET FAIRBURY, NE 68352

(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 Numbers 12-006.17A and 12-006.17B	F 880	Concern was noted during our Infection Control survey with the utilization of	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285282	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COMMUNITY HEALTH & LIFE GARDENSIDE	P O BOX 277, 2200 NORTH H STREET FAIRBURY, NE 68352

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observation, interview, and record review; the facility failed to implement appropriate transmission-based precautions related to the potential spread of COVID-19 for new admissions for 1 (Resident 1) of 3 residents reviewed and failed to ensure staff did not screen themselves for signs and symptoms of COVID-19. This had the potential to affect all residents residing in the facility. The facility had a total census of 34 residents. The findings are: Transmission-Based Precautions/Resident Cohorting A. A review of the facility's Novel Coronavirus Policy, last revised 5/2020 revealed the following: "Resident Cohorting: -Preference is to establish red, yellow and green zones in geographically distinct areas with the facility, however with the limited space within [Facility Name], staff will work with NE ICAP (Nebraska Infection Control Assessment and Promotion Program - supported by the Nebraska Department of Health and Human Services Healthcare Associated Infections Program via a CDC grant) in determining cohorting plan." -Extended use of PPE (Personal Protective Equipment) may be considered within zones, but may not be used between color zones. Definitions: -Yellow Zone - asymptomatic residents who may have been exposed to COVID-19. Goal: separating people who are, or may have been, exposed to a pathogen, but are not showing signs of illness. -Red Zone - Light Red-symptoms present or	F 880	JCH&L as an Alternate Care Site for Gardenside LTC. While "preference" is to establish red, yellow and green zones in geographically distinct areas within the facility it is not possible in our facility as we are limited with our physical layout, our small size and with our current census we are unable to define a distinguished "distinct area". For this reason and the in the interest of safety for all of our residents, we have entered into a transfer agreement with JCH&L to act as an Alternate Care Site for our facility. We have planned to transfer any residents requiring a red or gray zone to JCH&L for care. While our facility was in Phase 2 on the date of survey we successfully tested 100% of our staff on that same date,June 30, 2020. We received all staff results on July 2nd, and all staff tested negative. We contacted Public Health Solutions on July 2nd and offically moved to Phase 3. Our facility has had no staff nor residents with COVID-19 and our community has remained low for transmission of COVID-19 throughout. Additionally our Critical Access Hospital (CAH) has had no COVID-19 positive inpatients. Our nursing home and CAH utilize the same Infection Preventionist (IP) which enables us to establish policies & procedures that are consistent throughout our campus. It also gives us unique insight into any potential transmission concerns within our community enabling us to make the most accurate and individualized decisions on actions we need to take to keep our staff	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285282	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COMMUNITY HEALTH & LIFE GARDENSIDE	P O BOX 277, 2200 NORTH H STREET FAIRBURY, NE 68352

(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 3 high-risk exposure and awaiting test results, Dark Red-symptoms present with confirmed positive test results. Goal: to separate people who are sick from those who are not sick. -Green Zone - no significant exposure and asymptomatic residents. -Gray Zone asymptomatic: New admissions or readmission and is asymptomatic and no known exposure. Goal: to prevent inadvertent exposure, residents who are not ill to possible asymptomatic individual. -Gray Zone symptomatic: Possible symptoms but tests negative upon admission/readmission. Goal: to prevent inadvertent exposure, residents who are not ill to possible positive individual. PPE: -Work in cooperation with ICAP and local Public Health District in determining appropriate interventions/precautions and in establishing proper zones." B. An interview with the Administrator on 6/30/20 at 7:30 AM revealed the facility considered themselves in "Phase 2" of their reopening plan. A review of the facility's undated Reopening Plan revealed the following related to resident cohorting in Phase 2: -"Two private rooms have been established as dedicated space for new admissions or readmissions to establish a gray zone where the new admission/readmission will quarantine for 14 days." C. A review of Resident 1's medical record revealed an admission date of [redacted] Resident 1 was admitted from the [redacted] where Resident 1 had been since [redacted]	F 880	and residents as safe as possible. Our IP also works closely with our Public Health District to monitor any potential outbreaks. Because of our unique postion and affiliation with our CAH we will continue with our plan to care for our residents requiring red or gray zones at JCH&L as needed. We feel we have been diligent and have taken appropriate measures to keep our residents safe rather than being "lucky" as stated by our survey team. While our written policy had not yet been updated at the time of survey, we were taking important steps to keep our staff & residents safe. Survey staff had indicated that procedure masks could not be worn between zones, however we have confirmed information provided by NE ICAP in a webinar on June 25th (@14:05) that masks can be worn between zones as the preferred Infection Control practice to reduce staff touching their face/masks/eye protection as much as possible. ICAP indicated that masks and eye protection do not come into contact with residents and therefore staff can and are recommended to extend the use of masks and eye protection. Our policy states staff will extend the use of masks and eye protection however, if gowns or gloves are required PPE, they will be changed after each use, prior to leaving a resident's room. This was also confirmed with a phone call to ICAP on 7/22/2020. On 7/22/2020 our policy was updated to	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285282	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COMMUNITY HEALTH & LIFE GARDENSIDE	P O BOX 277, 2200 NORTH H STREET FAIRBURY, NE 68352

(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 [redacted] In an interview on [redacted] at 9:15 AM, Resident 1 reported being admitted to the facility the day before. Resident 1 stated Resident 1 was receiving meals in the room and only came out for a bath last evening. An observation at this time revealed a sign outside Resident 1's door stated, "Observation Zone. Standard Precautions with Procedure Mask." The sign indicated Resident 1 started observation on 6/21/20 and would end observation on 7/5/20. There was a box of gloves and a bottle of hand sanitizer outside of Resident 1's room on the handrail. In an interview on [redacted] at 8:20 AM, LPN (Licensed Practical Nurse)-C reported Resident 1 was admitted the day before [redacted]. LPN-C stated PPE required in Resident 1's room was a mask and gloves only. LPN-C reported it was the same procedure facemask staff wore in other resident rooms and throughout the building. In interviews on [redacted] between 9:30 AM and 10:07 AM, the DON (Director of Nursing) and Administrator reported Resident 1 was in the "gray" zone at the attached hospital for 8 days and was finishing the 14-day isolation period at the facility. The DON stated after 6 days in isolation at the facility, Resident 1 would move to a semi-private room with a roommate. The DON and Administrator also reported the hospital generally quarantines the facility's new admissions for 14 days prior to them moving to the facility. The Administrator stated the facility used to have a "gray" zone, but now call it an "observation" zone as of 6/25/20. An observation on 6/30/20 at 11:20 AM revealed LPN-A exited Resident 1's room wearing a	F 880	reflect the addition of our transfer agreement with JCH&L as an ACS for red and gray zones (as determined necessary by our Infection Control team for potential exposure)as well as to include our procedures for observation and monitoring. We will continue to extend the use of our face masks as recommended by NE ICAP. Resident #1 was discharged to home on [redacted] after completing skilled rehab. In our routine follow-up post discharge call Resident #1 revealed that this resident was doing well at home and had not developed any S&S of COVID-19. Staff screening was also noted as a concern during survey. We have great confidence that our staff understand the importance of screening and not reporting to work if they are ill or screen positive. Staff were instructed to report any temperature >99.5 initially then moved that threshold to 99.9 as outdoor temperatures have increased. Staff were also instructed to screen for and report any of the COVID-19 symptoms before entering Gardenside. Our facility also took an additional precautionary step requiring staff to check their temperature and screen a second time mid-shift to assure the safety of our residents. Staff have been compliant with this screening and the documentation of their screening. This same staff are responsible for the screening of our residents and have demonstrated competency and understanding of the importance of this	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285282	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COMMUNITY HEALTH & LIFE GARDENSIDE	P O BOX 277, 2200 NORTH H STREET FAIRBURY, NE 68352

(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 procedure mask and entered another resident room across the hall wearing the same procedure mask. The resident in the second room did not have any signage to indicate they were in transmission-based precautions. An observation and interview on 6/30/20 at 11:38 PM with OT (Occupational Therapist)-B revealed OT-B was exiting Resident 1's room wearing a procedure mask. OT-B stated the only PPE required when working with Resident 1 was a procedure mask and gloves if there was contact with Resident 1. OT-B reported the same procedure mask was worn when working with other residents in the facility. D. A review of recommendations from Nebraska ICAP related to resident cohorting and zones revealed the following PPE should be worn in the gray zone: gown, gloves, eye protection and N95 mask (N95 preferred, if no N95, then surgical mask with face shield). E. In an interview on 7/01/20 at 9:15 AM, the Administrator confirmed the facility was not following the guidelines that had been recommended by Nebraska ICAP related to resident cohorting for Phase 2. Staff Screening F. An observation and interview on 6/30/20 at 7:10 AM revealed the ADON (Assistant Director of Nursing) entered the locked front door of the facility and took (gender) own temperature in the lobby. The ADON reported that staff can screen each other when they come to work or can screen themselves.	F 880	process. While it is not in regulation, nor is there written guidance prohibiting staff from self screening, our DHHS has made the interpretation that staff are not be allowed to self screen. We disagree with this interpretation and feel that if we allow our staff to screen our vulnerable residents, they should be considered competent and reliable to perform self screening. In spite of our disagreement with this interpretation, to meet the expectation of DHHS, as of 07/15/2020 we initiated a change to our screening process. We now require staff to have another staff person witness and initial their screening prior to entering the nursing home and are now screening only once prior to their shift. This is documented on a screening log with initials of staff confirming the screening and maintained and reviewed by our IP. Additionally, all Gardenside staff have been assigned training on proper screening protocol, this training has been assigned through RELIAS and will be completed by 8/07/2020. We are also exploring the purchase of screening kiosks that would be used to electronically screen staff. We will be evaluating, the nanonation system on 07/28/2020. These kiosks would be accessed through staff key fobs to identify staff, would take the staff's temperature, electronically record it then prompt staff to answer the screening questions. This data would be stored electronically. To meet compliance with our Directed Plan of Correction all Gardenside staff	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285282	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COMMUNITY HEALTH & LIFE GARDENSIDE	P O BOX 277, 2200 NORTH H STREET FAIRBURY, NE 68352

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6 In an interview on 6/30/20 at 7:28 AM, the Administrator reported staff were responsible for screening themselves when they arrive to work and the DON and IP (Infection Preventionist) review the screenings. The Administrator reported staff had to call the Charge Nurse if they have a temperature greater than 99.5. In an interview on 6/30/20 at 8:05 AM, the IP reported staff screen themselves in the facility lobby when they arrive to work for symptoms of COVID-19 and take their own temperatures. The staff were to call the Charge Nurse if they had a temperature greater than 100.0 and the Charge Nurse would assess the staff member further. In an interview on 6/30/20 at 8:30 AM, LPN-C (also the Charge Nurse) reported staff screen themselves for symptoms when they arrive to work and take their own temperatures. LPN-C stated if staff have symptoms or a temperature greater than 100.0, they were to call the DON. In an interview on 6/30/20 at 10:55 AM the IP reported dietary staff screen themselves for signs and symptoms of COVID-19 and increased temperature. The IP also stated the DON is responsible for making sure staff are doing the screening and temperature checks at the start of their shift. A review of the facility's Novel Coronavirus Policy, last revised 5/2020 revealed the following information about staff screening: -"All staff will be screened upon coming to work and when leaving work for symptoms of COVID-19 and temperature." G. Interview on 6/30/20 at 7:50 AM with Nursing Assistant [NA] D and NA E on 6/30/20 at 8:03 AM	F 880	have been assigned to watch Keep COVID-19 Out! - https://youtu.be/7srwrF9MGdw, Staff will document they have completed watching this video and this will be completed by 08/07/2020. Our Infection Control Team, in cooperation with Public Health Solutions, will be responsible for determining proper cohorting and PPE use for our residents.The Director of Nursing Services and/or designee will be responsible to monitor staff compliance in following the guidance for cohorting and PPE use,as established by this team. She will review with new admissions or changes in COVID-19 status among existing residents. Our Infection Preventionist and/or Director of Nursing Services will monitor staff screening logs for complaince and will initial logs when reviewed. The logs will be maintained by our IP. The agenda for our QAPI meeting on 8/12/2020 will include review of our facility's current phasing, community transmission, COVID-19 status for staff & residents as well as a report from the IP on compliance with staff screening and from the DON for compliance with Infection Control standards for cohorting and appropriate PPE use. The DON will also present confirmation that staff education is completed at this meeting.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285282	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COMMUNITY HEALTH & LIFE GARDENSIDE	**P O BOX 277, 2200 NORTH H STREET FAIRBURY, NE 68352**

(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 revealed that the staff wear surgical masks and gloves only when going into Room 105 "the isolation" room. NA D and NA E confirmed that staff do not wear gowns, eye protection or an N 95 mask and they do not discard their surgical mask after being in the isolation room. NA D stated they receive one mask when they come on duty and wear it all day. Interview on 6/30/20 at 8:32 AM with LPN A confirmed that staff wear gloves and surgical masks when going into Room 105, the isolation room. They do not wear gowns, goggles or N 95 masks and do not change their surgical masks after being in the isolation room.	F 880		

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

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 14, 2020

Debra Sutton, Administrator
Jefferson Community Health & Life Gardenside
P O Box 277, 2200 North H Street
Fairbury, NE 68352 **CMS Certification No. 285282**

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

Dear Administrator,

UNANNOUNCED COVID-19 SURVEY

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

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

SURVEY RESULTS

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

PLAN OF CORRECTION

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

in the imposition of additional remedies.

The PoC must contain the following:

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

ENFORCEMENT REMEDIES

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

- **Directed Plan of Correction:**

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

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

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

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

Connie Vogt, RN, BSN

dhhs.healthcarefacilities@Nebraska.gov

In the Subject Line please put: DPOC

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

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

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

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

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

WITHDRAWAL OF APPROVAL FOR NURSE AIDE TRAINING PROGRAM

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

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

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

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

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

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

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

APPEAL RIGHTS

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

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

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

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

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

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

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

CONTACT INFORMATION

If you have any questions please contact this office.

Sincerely,

Connie F Vogt RN,BSN

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

CV/kd

Enclosures: CMS 2567

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

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

MIDWEST DIVISION OF SURVEY AND CERTIFICATION

May 28, 2020

Tara Helenthal, Administrator
Keystone Ridge Post Acute Nursing and Rehab
7501 Keystone Drive
Omaha, NE 68134-3335

CMS Certification No: 285238

Dear Ms. Helenthal:

SUBJECT: SURVEY RESULTS
Cycle Start Date: May 22, 2020

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

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

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

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

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

CONTACT INFORMATION

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

Sincerely,

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

cc:
NE DHHS
Hauptman/Grimes

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

Pete Ricketts, Governor

July 2, 2020

Shannon Monheiser, Administrator
Kimball County Manor
810 East 7th Street
Kimball, NE 69145

CMS CERTIFICATION NUMBER: 285256

Dear Ms. Monheiser:

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

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

MIDWEST DIVISION OF SURVEY AND CERTIFICATION

May 18, 2020

Amy Fish, Administrator
Lancaster Rehabilitation Center, LLC
1001 South Street
Lincoln, NE 68502

CMS Certification No: 285275

Dear Ms. Fish:

SUBJECT: SURVEY RESULTS
Cycle Start Date: January 23, 2020

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

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

SURVEY RESULTS
On May 11, 2020, the Centers for Medicare & Medicaid Services (CMS) completed a COVID-19 Focused Survey at Lancaster Rehabilitation Center, LLC to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was in substantial compliance with participation requirements and no deficiencies were cited. The findings from this survey are documented on the enclosed form CMS 2567.

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

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

be found at Locate Your QIO.

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

Sincerely,

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

cc:
NE DHHS
Powers/Grimes

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

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 14, 2020

Shari Dorsey, Administrator
Legacy Garden Rehabilitation & Living Center
200 Valley View Drive
Pender, NE 68047 **CMS Certification No. 285186**

Subject: Survey Results
Cycle Start Date: July 7, 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 7, 2020, a survey was completed at Legacy Garden Rehabilitation & Living Center by the State Survey Agency to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the CMS 2567 and will be posted on the ePOC system.

PLAN OF CORRECTION

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

in the imposition of additional remedies.

The PoC must contain the following:

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

ENFORCEMENT REMEDIES

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

- **Directed Plan of Correction:**

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

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

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

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

Connie Vogt, RN, BSN

dhhs.healthcarefacilities@Nebraska.gov

In the Subject Line please put: DPOC

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

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

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

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

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

WITHDRAWAL OF APPROVAL FOR NURSE AIDE TRAINING PROGRAM

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

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

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

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

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

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

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

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

APPEAL RIGHTS

If you disagree with the determination to impose remedies made on the basis of noncompliance identified at the July 7, 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
	285186	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY GARDEN REHABILITATION & LIVING CENTER	**200 VALLEY VIEW DRIVE PENDER, NE 68047**

(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		7/31/20

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/22/2020

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
	285186	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY GARDEN REHABILITATION & LIVING CENTER	200 VALLEY VIEW DRIVE PENDER, NE 68047

(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: 175 NAC 12-006.17	F 880	Resident 1 was readmitted to Legacy Garden on 7/2/20 from Pender	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285186	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY GARDEN REHABILITATION & LIVING CENTER	200 VALLEY VIEW DRIVE PENDER, NE 68047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observation, interview, and record review, the facility failed to quarantine 1 [Resident 1] of 3 sampled residents following readmission to facility from the hospital, failed to follow up on an employee's response to screening criteria for COVID-19 recorded on staff screening form, and failed to have residents wear face masks when out of room to protect residents from potential exposure to COVID 19. The facility had a total of census of 34 residents that could be affected by the practice. Findings are: -A review of Resident 1's Progress Notes revealed Resident 1 was admitted to [redacted] and readmitted to the facility on [redacted]. Observations on 7/6/20 between 10:35-10:56 AM revealed Resident 1 was transferred from bed to bathroom and bathroom to wheelchair by Nurse Aide A and Nurse Aide B. Nurse Aide A and B wore surgical masks and donned gloves for the transfer. Resident 1's room was not identified as requiring isolation precautions and personal protective equipment was not available outside of Resident 1's room door. In interviews on 7/6/20 at 9:55 AM and 11:06 AM, the Administrator confirmed Resident 1 had readmitted to the facility [redacted] and had tested [redacted]. The Administrator reported that Resident 1 had not been placed in isolation as Resident 1 was a readmission and not a new admission to the facility. The Administrator reported the facility was in stage 1 of reopening and would not move to stage II until	F 880	Community Hospital. Resident was not readmitted to a "gray zone" as the "quarantine" time period had already passed. The Covid Response Plan was updated on 7/17/20 to reflect that all admits/readmits be admitted to a "gray zone" for 14 days, nursing staff were educated on this process 7/21/20. The administrator will complete a process improvement plan by 7/24/20. The director of nursing/assistant director of nursing will report quarterly to the QAPI committee on their findings of the compliance with the admission/readmission of residents to the facility "gray zone" at the facility's next QAPI meeting. The QAPI committee will determine when the audit can be discontinued. The facility is unable to follow up on Registered Nurse C for an elevated temperature on 7/3/20 as the time has already lapsed. The facility did modify the facility staff monitoring log to include "if your temp is 100.4 or higher you need to return to your car for 20 minutes and then be rechecked. If your temp is 100.4 or higher after recheck you will be asked to go home. If you are symptomatic but no fever, you will need to have your temp rechecked mid shift, if your temp is 100.4 at that time you will be send home. The	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285186	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY GARDEN REHABILITATION & LIVING CENTER	200 VALLEY VIEW DRIVE PENDER, NE 68047

(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 3 baseline testing had been completed. A review of facility policy titled Long Term Care Guidance to Covid-19 dated 6/22/20 revealed the following guidance under Phase 1: -"New admissions or readmissions from a hospital setting must quarantine for 14 days." -A review of Staff Monitoring report dated 7/3/20 revealed Registered Nurse C had recorded a temperature of 100 F at the beginning of the shift. The Staff Monitoring report did not include any documentation of follow up regarding temperature of 100 F [Fahrenheit]. Staff Monitoring report stated that supervisor should be notified immediately of a temperature greater than 99.9 F. The Staff Monitoring report has includes columns for taking temperatures and oxygen saturation levels at the beginning and end of each shift. In an interview on 7/6/20 at 12:59 PM, Acting Director of Nurses reported receiving a report from Registered Nurse C regarding temperature of 100 F. The Acting Director of Nurses reported that Registered Nurse C had been told to retake temperature and if it was under 100 F it was ok for Registered nurse C to work. In an interview on 7/6/20 at 1:17 PM, Registered Nurse C reported informing Acting Director of Nursing about temperature of 100 F but not being told to retake temperature. Registered Nurse C reported temperature was retaken temperature at end of shift and it was ok. Registered Nurse C reported always runs a higher temperature. In interviews on 7/5/20 at 11:05 AM and 2:15 PM,	F 880	facility nurse/CMA is expected to monitor staff temperatures and oxygen levels. Staff were educated on new procedure on 7/8/20 during shift huddles. The facility nurse also reviews the staff monitoring log twice a day. The director of nursing/assistant director of nursing will report quarterly to the QAPI committee on their findings of the compliance with the staff monitoring log at the facility's next QAPI meeting. The QAPI committee will determine when the audit can be discontinued. The facility educated residents and staff on 7/8/20 on the importance of wearing cloth mask when residents are outside of their rooms. Cloth face mask are available for residents at all times The charge nurse and/or leadership team will monitor residents periodically throughout the day to ensure residents are wearing their face mask. DPOC: All facility staff have been directed to view the following videos: Clean hands, Closely monitor residents, Keep Covid 19 out and Lessons by 7/31/20. Staff are also being audited by 7/31/20 for proper donning/doffing and handwashing by Pender Community Hospital's	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285186	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY GARDEN REHABILITATION & LIVING CENTER	**200 VALLEY VIEW DRIVE PENDER, NE 68047**

(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 the Administrator reported that staff members are on the honor system for screening. The Administrator reported expecting staff to recheck their temperature if greater than 99.9F. According to the Administrator, staff with a temperature greater than 100.4 F, a low oxygen saturation level or sign/symptoms of COVID 19 would be sent home and told to call their provider. A review of undated facility policy titled Employee Self-Monitoring Guide revealed the following directions: -"Starting immediately, we are going to be temperature and oxygen level checking on ALL employees prior to the start of your shift and at the end of your shift. You will be required to go to the nurses station to monitor you own temp and oxygen level." -"Please document your temp and oxygen level on the spreadsheet on the clipboard" -"If your temperature is above 100.4, you will be asked to return to your car for 20 minutes and then will be rechecked." -"If your temperature is above 100.4 on recheck, you will be asked to go home. A provider will contact you for further direction." -"If you are symptomatic with a cough, sore throat, or shortness of breath, but no fever, you will be asked to wear a surgical mask during your shift. You will need to check your temperature mid-shift if you have any symptoms other than a fever." -Observations on 7/6/20 at 3:07 PM revealed 7 residents seated in a common area of the building not wearing masks. In an interview on 7/6/20 at 9:34 AM, Nurse Aide D reported that staff try to keep residents apart	F 880	emergency management coordinator	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285186	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY GARDEN REHABILITATION & LIVING CENTER	200 VALLEY VIEW DRIVE PENDER, NE 68047

(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 when they are out of their rooms. In an interview on 7/6/20 at 11:06 AM and 3:11 PM, the Administrator reported that residents are not required to wear masks when out of their rooms. The Administrator reported resident have been wearing masks for activities and facility had just received a number of masks for residents. The Administrator reported the facility was in stage 1 of reopening and would not move to stage II until baseline testing had been completed. A review of facility policy titled Long Term Care Guidance to Covid-19 dated 6/22/20 revealed the following guidance under Phase 1: -"Universal Source Control and PPE" -"Universal source control for everyone in the facility. Residents and visitors wear cloth face covering or facemask, if able to tolerate and wear safely."	F 880		

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

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 21, 2020

Cheryl Brown, Administrator
Legacy Square
1621 Front Street
Henderson, NE 68371 **CMS Certification No. 28E173**

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

Dear Administrator,

UNANNOUNCED COVID-19 SURVEY

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

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

SURVEY RESULTS

On July 9, 2020, a survey was completed at Legacy Square 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 31, 2020**, to the State Survey Agency Contact. **Failure to submit an acceptable PoC by July 31, 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, September 4, 2020 in accordance with the statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal regulations at 42 CFR §488.417. Your Medicare Administrative Contractor will be notified of the date the denial of payment begins. DPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated.

WITHDRAWAL OF APPROVAL FOR NURSE AIDE TRAINING PROGRAM

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

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

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

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

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

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

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

APPEAL RIGHTS

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

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

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

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

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

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

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

CONTACT INFORMATION

If you have any questions please contact this office.

Sincerely,

Connie F Vogt RN,BSN

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

CV/kd

Enclosures: CMS 2567

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

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

Pete Ricketts, Governor

August 6, 2020

Michelle Yosick, Administrator
Life Care Center Of Elkhorn
20275 Hopper Street
Elkhorn, NE 68022-1434

CMS CERTIFICATION NUMBER: 285134

Dear Ms. Yosick:

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

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

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

Sincerely,

Connie E Vogt RN,BSN

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

CV/kd

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

Pete Ricketts, Governor

July 29, 2020

Michelle Yosick, Administrator
Life Care Center Of Elkhorn
20275 Hopper Street
Elkhorn, NE 68022-1434

CMS CERTIFICATION NUMBER: 285134

Dear Ms. Yosick:

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

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

Pete Ricketts, Governor

July 16, 2020

Nolan Gurnsey, Administrator
Linden Court
4000 West Philip Avenue
North Platte, NE 69101

CMS CERTIFICATION NUMBER: 285083

Dear Mr. Gurnsey:

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

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

Pete Ricketts, Governor

July 23, 2020

Emily Triplett, Administrator
Litzenberg Memorial County Hospital
1715 26th Street
Central City, NE 68826

CMS CERTIFICATION NUMBER: 285292

Dear Ms. Triplett:

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

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

Pete Ricketts, Governor

August 6, 2020

Kari Wockenfuss, Administrator
Louisville Care Center
410 West 5th Street
Louisville, NE 68037

CMS CERTIFICATION NUMBER: 285267

Dear Ms. Wockenfuss:

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

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

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

Sincerely,

Connie E. Vogt RN,BSN

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

CV/kd

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 1, 2020

Eugenie Ahounou, Administrator
Maple Crest Health Center
2824 North 66th Avenue
Omaha, NE 68104-3996 **CMS Certification No. 285149**

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

Dear Administrator,

UNANNOUNCED COVID-19 SURVEY

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

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

SURVEY RESULTS

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

PLAN OF CORRECTION

A Plan of Correction (PoC) for the deficiencies must be submitted **by July 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 at 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 45 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)

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

We request that you provide an electronic copy of the request for appeal to ROkcmSCB@cms.hhs.gov and to the CMS Regional Chief Counsel 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
	285149	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE CREST HEALTH CENTER	2824 NORTH 66TH AVENUE OMAHA, NE 68104

(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		7/11/20

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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285149	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE CREST HEALTH CENTER	2824 NORTH 66TH AVENUE OMAHA, NE 68104

(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 # 175NAC 12-006.17	F 880	A)The facility did have screening in place and the surveyor was screened at the	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285149	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE CREST HEALTH CENTER	2824 NORTH 66TH AVENUE OMAHA, NE 68104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observation and interview, the facility staff failed to implement screening procedures to prevent the potential spread of infections and failed to ensure staff wore mask throughout the facility for COVID 19 precautions and failed to change gloves during the provision of care for 1 (Resident 2) of 3 sampled residents. The facility staff identified a census of 128. Findings are: A). On 6/8/20 at 2:23 P.M. during entry to the Red Unit (isolation unit) revealed a staff member allowed entry onto Red Unit without prescreening. Facility staff did not question presence on unit until reaching nursing station. On 6/8/20 at 2:55 P.M. an interview with the Director of Nursing (D.O.N.) confirmed that the expectation of the facility is everyone entering the building or the Red Unit complete a screening process which includes a questionnaire related to travel, illness symptoms and also a temperature check. B) Observation on 6/8/20 at 1234 P.M. the Staffing Coordinator was observed walking in the hallway from the staff dining room without having a mask in place. On 6/8/20 at 12:34 P.M. an interview was conducted with the Staffing Coordinator. During the interview the Staffing Coordinator reported having completing lunch and a new mask was in the office down the hall. C) On 6/8/20 at 1:05 P.M. an observation of housekeeping staff B was observed leaving the staff dining area without wearing a mask.	F 880	facility main entrance prior to entering the red zone and had full PPE on. Staff was notified that the surveyor was entering the red zone and the surveyor was let in. The surveyor also checked the screening log for the red zone and there was no discrepancy. Because the surveyor was screened at the main entrance prior to entering the red zone, there was no adverse reactions on the residents or staff. However, the facility reviewed the screening process with the staff involved to ensure whoever enters the red zone regardless if the person has been screened or not, to screen the person again. The red zone has been disbanded since then and the facility went all green except for one unit that the facility is using as a gray zone per the ICAP guidelines as the facility no longer has any COVID-19 positive residents. The DON and the Clinical manager have reviewed the screening logs for the red zone 2 weeks prior to the survey date of 6/8/2020 to ensure all the staff members that entered the red zone during that time frame were screened appropriately prior to entering the red zone to prevent the spread of COVID-19 to other residents and the facility was found to be in compliance. Review was completed on 6/16/2020. Furthermore during that time period, the facility also developed a COVID-19 team of licensed nurses, CNA's and medication aides to avoid staff sharing and therefore cross contamination throughout the facility. the COVID-19 team was not allowed to use the facility	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285149	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE CREST HEALTH CENTER	**2824 NORTH 66TH AVENUE OMAHA, NE 68104**

(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 3 On 6/8/20 at 1:20 P.M. an interview with D.O.N. revealed that the staff have been educated to place their masks on a paper towel next to them as they eat and that all staff are to wear a surgical mask in the non-patient care areas and an respirator mask (N95) with patient cares. D. Observation on 6-08-2020 at 12:50 PM revealed Nursing Assistant (NA) A donned a gown, face mask, face shield and gloves to assist Resident 2 from the commode. NA A using wipe cleaned Resident 2's buttocks area. NA A without changing the soiled gloves pulled up an adult brief, Resident 2's pants, touch Resident 2's walker,call light and bed controls with the soiled gloves. On 6-08-2020 at 1:45 PM an interview was conducted with NA A. During the interview NA A confirmed the soiled gloves had not been changed.	F 880	main entrance and timeclock and their hours worked were reported to the staffing coordinator to decrease a chance of cross contamination of other staff and consequently to other residents throughout the facility. The red zone was disbanded on 6/18/2020. All staff will also be required to watch (Keeping COVID-19 out) as well as (closely monitoring residents) video by July 11. Any staff member unable to watch the videos by 7/11/2020, will do so on their 1st scheduled day upon return. Closely Monitoring Residents: https://youtu.be/1ZbT1Njv6xA Keep COVID-19 out! https://youtu.be/7srwrF9MGdw In an effort to ensure ongoing compliance, DON and Administrator reviewed and revised the policy and procedure related to general infection control guidelines including the staff screening during pandemic and/or outbreak of communicable disease and an addendum was added to ensure screening is done regardless of the staff being screen at the facility main entrance prior to entering the red zone during outbreak or pandemic. Education will be provided to all nursing staff related to the revised policy and procedure to ensure everybody is screened if the facility were to have a red zone again where screening would be required to ensure screening was completed prior to entering the areas. Education will be completed by 7/11/2020. Any nursing staff unable to complete the education the end of the completion of the	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285149	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE CREST HEALTH CENTER	**2824 NORTH 66TH AVENUE OMAHA, NE 68104**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 4	F 880	POC, will fulfill this requirement on their first scheduled day upon return. B)Both staff members in question have been educated to ensure they put their mask back on right after eating and it stays on for the duration of their shift and while they remain at the facility. Because there was no residents in the break room area, no resident was exposed so there was no adverse reaction to any resident and both staff complied and put their mask back on right after the surveyor observation. Signs have been posted as 6/10/2020 to all areas including the hallways and break areas within the facility to remind staff that mask must remain on when they are in the hallways and mask must be put back on right after eating to protect all other residents within the facility they may come in contact with. All staff must watch (PPE lessons) and (Demonstration of doffing PPE) videos by 7/11/2020. Any staff member unable to watch the video's, will do so on their 1st scheduled date upon return. PPE Lessons: https://youtu.be/YYTATw9yav4 Demonstration of doffing (Taking off) PPE: youtube.com/watch?v=of73FN086E8 In an effort to ensure ongoing compliance, DON and Administrator reviewed and revised the general infection control guidelines including the wearing of mask during an outbreak or pandemic and it	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285149	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE CREST HEALTH CENTER	**2824 NORTH 66TH AVENUE OMAHA, NE 68104**

(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	was deemed to be appropriate. In-service education will be provided to all staff to ensure the mask is kept on for the duration of their shift and while they remain at the facility to avoid the transmission of communicable disease by 07/11/2020. Any staff unable to complete the in-service education by the end of the POC completion date, will fulfill this requirement on their first scheduled date upon return C)For the resident 2 in question, his/her room was cleaned and everything wiped down the same day the facility was made aware by the state surveyor on 6/9/2020 and the room has been deep cleaned since then including the walker, call light and bed controls (See work order 6/25/2020). The resident has not displayed any signs or symptoms of infection since the incident. The staff in question had resigned her position as of 6/11/2020. Staff development coordinator, clinical managers and Infection preventionist will conduct 100% pericare competency to all nursing staff to ensure gloves are removed and hands are washed before any clean surface and/or item is touched in any resident's room to avoid cross contamination when providing care. Competency will be completed by 7/11/2020. Any staff member unable to complete the competency prior to the end of the POC, will fulfill this requirement on their first scheduled day upon return. In	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285149	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE CREST HEALTH CENTER	**2824 NORTH 66TH AVENUE OMAHA, NE 68104**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6	F 880	addition to the competency, nursing staff must watch the videos of (clean hands) and (sparkling surfaces)by 7/11/2020. Any nursing staff unable to watch the videos by 7/11/2020, will do so on their 1st scheduled day upon return. Notes: nursing staff includes Licensed nurses, Medication aides and certified nursing assistants. Sparkling Surfaces: https://youtu.be/t7OH8ORr5Ig Clean Hands: https://youtu.be/xmYMUIy7qiE In an effort to ensure ongoing compliance, DON and Administrator reviewed the policy and procedure related to the infection control general guidelines including the donning and doffing of gloves during cares and it was deemed to be appropriate. In-service education will be provided to the nursing staff related to the facility infection control general guidelines to ensure, hands are washed and gloves are changed at the end of care and prior to touching any clean surface or items in the resident's rooms to avoid cross contamination by 07/11/2020. Any staff unable to attend the in-service education session by the end of POC completion date, will fulfill that requirement on their first scheduled day upon return. As a mean of quality assurance, staff development coordinator in collaboration with the Infection Preventitionist and/or designee shall conduct random audit of: A)5 staff members weekly before they	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285149	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE CREST HEALTH CENTER	**2824 NORTH 66TH AVENUE OMAHA, NE 68104**

(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	F 880	enter the red zone for a period of 3 months or until substantial compliance is achieved. Because the facility no longer has red zone and we are still in pandemic, audit will be completed only if the facility were to have a red zone again. B)10 staff members weekly throughout the facility including after breaks to ensure that their mask remains on for the duration of their shift as long as they are still in the building for a period of 3 months or until substantial compliance is achieved. C)5 staff members weekly and per unit during provision of care to ensure gloves are changed at the end of the care before touching any clean surface or item to avoid cross contamination for a period of 3 months or until substantial compliance is achieved. All audits will be presented at the facility bi-monthly QAPI meeting.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285149	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE CREST HEALTH CENTER	**2824 NORTH 66TH AVENUE OMAHA, NE 68104**

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

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

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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28E191	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL COMMUNITY CARE	**1423 SEVENTH STREET AURORA, NE 68818**

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

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

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

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28E191	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL COMMUNITY CARE	**1423 SEVENTH STREET AURORA, NE 68818**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 1 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		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28E191	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL COMMUNITY CARE	**1423 SEVENTH STREET AURORA, NE 68818**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observation, interview, and record review; the facility failed to prevent the potential spread of Covid-19 by failing to perform hand hygiene between residents for Residents 9, 3, 10, 11, 12, 15, and 13; failing to transport food trays to prevent potential cross contamination for Resident 14, and failing to carry soiled items in a manner to prevent potential cross contamination which had the potential to affect all of the facility residents. The facility identified a census of 40 at the time of survey. Findings are: Interview with the facility Administrator on 6/22/2020 at 10:30 AM revealed the facility was following Covid-19 prevention protocol and residents were eating their meals in their rooms. Facility staff were to follow precautions to protect the residents by wearing masks at all times and other PPE (Personal Protective Equipment) when indicated. A. Observation on 6/22/2020 at 11:00 AM revealed HK-F (Housekeeper) with a bag of trash tucked up under their arm touching the front and side of their smock, while walking down the hall on 300. HK-F discarded the trash then went back down to the housekeeping cart which was at the other end of the 300 hall. Observation of HK-F on 6/22/2020 at 11:36 AM revealed HK-F was standing outside a resident room door on the 300 unit. HK-F was then observed going in and out of resident rooms on the unit. Interview with the DON on 6/23/2020 at 7:57 AM	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
	28E191	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL COMMUNITY CARE	1423 SEVENTH STREET AURORA, NE 68818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 3	F 880		

revealed the housekeepers were assigned to a hallway, but did float (go to other hallways) and help each other out as needed.

Interview with the DON on 6/23/2020 at 2:14 PM revealed the expectation was that no one should be carrying anything up against their uniform top at any time.

B. Observation of NA-G (Nursing Assistant) on 6/22/2020 at 11:40 AM revealed NA-G went into Resident 9's room with a tray of food, set up their food on their tray table, touched the items on their tray (plate cover, drinks, silverware, salad, dessert) and the tray table, left their room, put the plate cover on the cart, then did a 2 second hand scrub with the HS (Hand Sanitizer) foam from the dispenser outside the room door. NA-G then picked up a tray of food from a cart in the hall, went into Resident 3's room, put their plate of food down on a tray table, took the cover off the plate of food and set up their tray touching the items on the tray in the process. NA-G then left their room, put the plate cover on the cart and did a 2 second scrub with the HS. NA-G did not rub it in. Their hands were still wet with the foam. Resident 3 was observed feeding themselves and handling the items on the tray. At 11:43 AM NA-G took a tray of food off the cart in the hall into Resident 10's room. NA-G placed the tray on the resident's personal tray table. NA-G walked out of the room with the plate cover after setting up their food tray by touching the items on the tray then did a 2 second hand scrub with the HS. Resident 10 was observed feeding themselves and handling the items on the tray. NA-G then picked up a wrapper off the floor in the hall, walked into the dining room, discarded the wrapper in the trash can, and put the plate cover

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28E191	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL COMMUNITY CARE	**1423 SEVENTH STREET AURORA, NE 68818**

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

on a cart in the dining room where 2 staff were observed plating food then putting the plates a ledge in front of the steam table. NA-G did not do any hand hygiene after NA-G picked the wrapper up off the floor. NA-G then grabbed a cart with trays of food on it and wheeled it down the hall. NA-G then took a tray of food into Resident 11. NA-G touched their tray table and moved it to where they were sitting, took the plate cover off the food, then put salt and pepper on Resident 11's food. NA-G then opened their bag of chips by handling the bag and put them back down on the tray. NA-G then took the plastic off Resident 11's dessert by picking up the plate then put the plate back on the tray; NA-G then picked up the plate cover and walked out of Resident 11's room. NA-G then did a 4 second hand scrub with HS. Resident 11 was observed feeding themselves and handling the items on the tray. NA-G then picked up another tray of food and took it into Resident 12's room. NA-G set up Resident 12's plate as well touching the items on their tray. NA-G then walked out of Resident 12's room and did a 3 second scrub with the HS. Resident 12 was observed feeding themselves and handling the items on the tray. NA-G then took a tray of food in to Resident 15. NA-G opened their hand sanitizer then opened their carton of milk. After setting up Resident 15's tray, NA-G walked out of Resident 15's room and did a 2 second hand rub with the HS. Resident 15 was observed feeding themselves and handling the items on the tray. NA-G then picked up another tray of food and took it in to Resident 13. NA-G moved the blanket off Resident 13's lap after putting their tray on the bed side table and wheeling it to where they were sitting. NA-G then took the cover off the food. NA-G then helped Resident 13 with their with hand sanitizer by opening the package. NA-G

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28E191	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL COMMUNITY CARE	1423 SEVENTH STREET AURORA, NE 68818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 5	F 880		

picked up the cup of salad dressing, took the lid off of it and on poured it on their salad. NA-G handled the salad container while they were putting the salad dressing on it. NA-G then opened their chocolate milk and poured it in the glass by picking up the glass. Resident 13 was observed feeding themselves and handling the items on the tray. At 11:52 AM after NA-G left Resident 13's room, NA-G did a 2 second hand rub with the HS then went into the dining room. At 11:53 AM, NA-G picked up a tray of food from the ledge in front of the steam table and carried it up against their smock across the dining room then left the dining room and took the tray of food to Resident 14. NA-G then put the tray down in front of Resident 14. NA-G opened the items on the tray and took the lid off the plate of food. NA-G pulled up a chair next to Resident 14 then proceeded to feed Resident 14 the food that was on the tray.

Review of the facility policy Hand Hygiene Policy revised 9/13/2018 revealed the following: Hand hygiene is the single most effective means of preventing the spread of infection. Skin surfaces, especially of the hands, are excellent carriers of organisms and contaminates. Hand hygiene must be performed before entering and leaving patient/resident room, before and after touching a patient/resident, before a clean/aseptic procedure, after body fluid exposure risk and after touching the patient/resident environment. Below are some examples of specific opportunities when hand hygiene must be performed. Before and after assisting a patient/resident with meals (hand washing with soap and water). The following hand cleansing procedure will be used when utilizing a waterless alcohol-based sanitizer. Hand sanitizer is

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28E191	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL COMMUNITY CARE	1423 SEVENTH STREET AURORA, NE 68818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6	F 880		

preferred over hand washing for hands that are not visibility soiled. Apply appropriate amount to palms. (Hand foam amount is about the size of an English walnut.) Rub all surfaces vigorously, between fingers, around nails, wrists, and back of hands until hands are dry, about 15 seconds.

Review of the Addendum A for the Hand Hygiene Policy revised 9/13/2018 revealed the following: Unique hand hygiene situation: There are some circumstances when the hand hygiene rule (clean hands on entry and exit) must be adapted for a task when being completed by staff while maintaining patient safety. Food Tray Delivery (clean trays): Clean hands. Pick up tray. Walk into patient room/environment. Place tray on over-bed table or as directed by patient/visitor or staff. Clean hands upon exit and in route to tray cart. Pick up the next tray. Repeat until all trays are delivered.
Review of the Ecolab Quick-Care Aerosol Foam Hand Sanitizer label provided by the facility and identified as the hand sanitizer the staff use in the facility revealed the following instructions for use: Directions: apply product onto hands, spread thoroughly and rub until dry.

Interview with the DON on 6/23/2020 at 2:14 PM revealed the expectation was that no one should be carrying anything up against their uniform top at any time.

Interview with the DON on 6/23/2020 at 3:09 PM revealed the following expectations:
Hand hygiene must be performed before entering and leaving patient/resident room, before and after touching a patient/resident, before a clean/aseptic procedure, after body fluid exposure risk and after touching the

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28E191	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL COMMUNITY CARE	**1423 SEVENTH STREET AURORA, NE 68818**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 7 patient/resident environment. Below are some examples of specific opportunities when hand hygiene must be performed coming on duty hands are visibly soiled (hand washing with soap and water); Before and after direct patient/resident contact (for which hand hygiene is indicated by acceptable professional practice).3. Before and after performing any invasive procedure (e.g., fingerstick, blood sampling).4. Before and after entering isolation precaution settings. 5. Before and after eating or handling food (hand washing with soap and water).6. Before and after assisting a patient/resident with meals (hand washing with soap and water).7. Before and after assisting a patient/resident with personal care (e.g., oral care, bathing).8. Before and after peripheral vascular catheters and other invasive devices. 9. Before and after inserting indwelling catheters. 10. Before and after changing a dressing. 11. Upon and after coming in contact with a patient/resident's intact skin (e.g., when taking a pulse or blood pressure, and lifting a patient/resident).12. After personal use of the toilet (hand washing with soap and water).13. Before and after assisting a patient/resident with toileting (hand washing with soap and water).14. After contact with a patient/resident with infectious diarrhea including, but not limited to infections caused by norovirus, salmonella, shigella, and C. difficile (hand washing with soap and water)15. After blowing or wiping nose. 16. After contact with a patient/resident's mucous membranes and body fluids or excretions. 17. After handing soiled or used linens, dressings, bedpans, catheters and urinals. 18. After handling soiled equipment or utensils. 19. After performing your personal hygiene (hand washing with soap and water).20. After removing gloves or aprons.	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
	28E191	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL COMMUNITY CARE	1423 SEVENTH STREET AURORA, NE 68818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 8 21. After completing duty. The following hand cleansing procedure will be used when utilizing a waterless alcohol-based sanitizer. Hand sanitizer is preferred over hand washing for hands that are not visibly soiled. 1. Apply appropriate amount to palms. (Hand foam amount is about the size of an English walnut.)2. Rub all surfaces vigorously, between fingers, around nails, wrists, and back of hands until hands are dry, about 15 seconds. Everyone should be following this policy. If something is picked up off of the floor, hand hygiene should be performed. Nothing should be carried up against their uniform tops. Interview with the DON on 6/23/2020 at 3:13 PM revealed the following expectations: Food Tray Delivery (clean trays):1. Clean hands. 2. Pick up tray. 3. Walk into patient room/environment. 4. Place tray on over-bed table or as directed by patient/visitor or staff. 5. Clean hands upon exit and in route to tray cart. 6. Pick up the next tray. 7. Repeat until all trays are delivered. Food tray Pick-up (dirty trays):1. Clean hands upon entry to patient room/environment. 2. Pick up used tray. 3. Place tray in the cart. 4. Clean hands and repeat until all the trays have been collected. Glove use: Assess the need to wear gloves before picking up the tray. 1. Clean hands. 2. Don gloves if the tray is visibly soiled. 3. Pick up tray and place in cart. 4. Remove gloves and clean hands upon entering next room. If the tray is visibly soiled with blood or body fluids, report incident to nursing staff. Nursing staff will remove the blood or body fluids from the tray. Do not throw away flatware, china etc. 1. Clean hands. 2. Don gloves. 3. Pick-up tray and place in cart. 4.	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
	28E191	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL COMMUNITY CARE	**1423 SEVENTH STREET AURORA, NE 68818**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 9 Remove gloves and clean hands. They should not carry the tray next to their uniform.	F 880		

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

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 1, 2020

Diane Keller, Administrator
Memorial Community Care
1423 Seventh Street
Aurora, NE 68818 **CMS Certification No. 28E191**

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 Memorial Community Care 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 at 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 45 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)

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 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 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

DPOC

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
	28E191	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL COMMUNITY CARE	**1423 SEVENTH STREET AURORA, NE 68818**

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

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

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

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

Pete Ricketts, Governor

July 9, 2020

Angela Caubarrus, Administrator
Mid-Nebraska Lutheran Home
109 North 2nd Street
Newman Grove, NE 68758

CMS CERTIFICATION NUMBER: 285213

Dear Ms. Caubarrus:

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

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

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

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285062	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST COVENANT HOME	**P O BOX 367, 615 EAST 9TH STREET STROMSBURG, NE 68666**

(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 Centers for Medicare & Medicaid Services (CMS) on 6/26/20. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6).	E 000		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/24/2020

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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285062	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST COVENANT HOME	**P O BOX 367, 615 EAST 9TH STREET STROMSBURG, NE 68666**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted by the Centers for Medicaid and Medicare Services (CMS) on 6/26/20. The facility was found not to be in substancial compliance with 42 CFR 483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. A determination was made that the facility's noncompliance with one or more of the requirements of participation placed all residents in immediate jeopardy. On 6/25/20 at 4:05pm, the Administrator was informed of the immediate jeopardy at F880 Infection Prevention and Control. Survey Dates: June 25 to June 26, 2020 The facility census was: 30	F 000		
F 880 SS=L	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:	F 880		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285062	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST COVENANT HOME	**P O BOX 367, 615 EAST 9TH STREET STROMSBURG, NE 68666**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 1 §483.80(a)(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: (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.	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
	285062	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST COVENANT HOME	**P O BOX 367, 615 EAST 9TH STREET STROMSBURG, NE 68666**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 §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: Based on observation, interview and record review, the facility failed to protect all residents in the facility by not following acceptable infection control practice recommendations for COVID-19 from the Centers for Disease Control (CDC) and the Centers for Medicare and Medicaid (CMS) Services. The facility failed to have a screening system in place to ensure all staff and visitors were screened for signs and symptoms of COVID-19 prior to having contact or providing care to the residents. The facility allowed staff to enter the facility and pass multiple resident rooms prior to being screened for signs and symptoms of COVID-19. The facility failed to follow up on employee documented signs and symptoms of COVID-19 and allowed staff to care for the residents after reporting signs and symptoms of COVID-19. The facility failed to screen visitors for signs and symptoms of COVID-19 when entering the facility and having contact with residents. This deficient practice placed all 30 residents at risk for contracting COVID-19 and resulted in Immediate Jeopardy (IJ). As a result of the identified non-compliance, the	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
	285062	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST COVENANT HOME	**P O BOX 367, 615 EAST 9TH STREET STROMSBURG, NE 68666**

(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 3 Administrator was notified on 6/25/20 at 4:05pm of the Immediate Jeopardy. Review of CMS, Center for Clinical Standards and Quality, Safety and Oversight (QSO) Memo 20-14-NH, dated 3/13/20, provided guidance to long term care facilities which included screening 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 ill, have them self-isolate at home. Review of the CDC's Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings, dated 3/13/20, showed the following: -Screen all healthcare professionals (HCP) at the beginning of their shift for fever and symptoms consistent with COVID-19. If they are ill, have them keep their facemask on and leave the workplace. -Fever is either measured temperature >100.0 degrees Fahrenheit or subjective fever. Respiratory symptoms consistent with COVID-19 are cough, shortness of breath and sore throat. Findings include: During a tour of the facility on 6/25/20 at, the DON identified that staff entered the facility through the employee break room door. She stated the employee's clock in, use hand sanitizer, put a mask on and proceed to the nurse's station to be screened for signs and symptoms of COVID-19. Observation on 6/25/20 at 9:52am, showed once staff entered the building from the employee	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
	285062	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST COVENANT HOME	**P O BOX 367, 615 EAST 9TH STREET STROMSBURG, NE 68666**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 4	F 880		

break room, they would pass by multiple resident rooms (1,2,3,4,5,6, and 7) on the West hall prior to entering the nurses station to be screened for signs and symptoms of COVID-19.

During an interview on 6/25/20 at 10am, Housekeeper (HK1) stated she enters the facility through the employee break room entrance, clocks in and goes to the nurse's station checks her temperature and completes the screening form.

During an interview on 6/25/20 at 10:15am, Nurse Aide (NA2) stated when she arrives at work she clocks in, uses hand sanitizer, puts on a mask and goes to the nurses station. She said the nurse usually watches her take her own temperature and complete the screening form.

During an interview on 6/25/20 at 1:20pm, Nurse Aide NA1 stated she enters the facility through the employee break room, uses hand sanitizer, puts a mask on and walks past resident rooms 1, 2, 3, 4, 5, 6, and 7 and then enters the nurse's station. She stated she screens herself but the charge nurse is usually close by and verifies what she has written down.

Review of the COVID-19 employee symptom evaluation log forms on 6/25/20 revealed on:

-4/27/20: Agency Staff/Nurse Aide (AS/NA1) entered the facility, no temperature assessed. Review of information provided by the administrator on 7/7/20 showed AS/NA1 was in orientation from 1:30pm to 2:25pm.

-4/30/20: facility Administrator entered facility, no screening completed for signs and symptoms of

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285062	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST COVENANT HOME	**P O BOX 367, 615 EAST 9TH STREET STROMSBURG, NE 68666**

(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 COVID-19. -5/4/20: AS/NA2 entered the facility and documented intermittent cough and shortness of breath. Sore throat. Review of information provided by the administrator on 7/7/20 showed AS/NA2 worked and provided care to the residents from 2pm until 11pm on 5/4/20. -5/16/20: Dietary Aide (DA1) entered facility, no screening completed for signs and symptoms of COVID-19. Review of information provided by the administrator on 7/7/20 showed DA1 worked from 5:28am to 2:14pm on 5/16/20. -5/12/20: AS/NA2 entered facility and documented having a sore throat. Review of information provided by the administrator on 7/7/20 showed AS/NA2 worked and provided care to the residents on from 2pm until 11pm on 5/12/20. -5/11/20: Registered Nurse (RN1) entered facility and documented having a sore throat. Review of information provided by the administrator on 7/7/20 showed RN1 worked and provided care to residents from 6:27am until 2:45pm on 5/11/20. -5/11/20: Social Services Director (SSD) entered facility and documented slight cough and sore throat. Review of information provided by the administrator on 7/7/20 shows the SSD worked from 8:06am until 5:00pm on 5/11/20. During an interview on 6/25/20 at 2:30pm, the	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
	285062	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST COVENANT HOME	**P O BOX 367, 615 EAST 9TH STREET STROMSBURG, NE 68666**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6 Infection Control Nurse stated that she tried to look over the employee screening logs to see if any staff had documented any signs or symptoms of COVID-19. She stated that staff had been educated to talk to herself, the DON or the Administrator if they documented any signs or symptoms of COVID-19 in the employee screening log forms. She stated she would expect any staff who reported any signs or symptoms of COVID-19 on the employee screening form to contact her. Review of the facility's document titled "COVID-19 Timeline" on 6/25/20 showed the following: -3/13/20: Non-essential personnel restricted from entering building. -3/15/20: Calls made to families to ask them to limit visitors. -3/16/20: Started no visitors except for those people on hospice or palliative care. Review of the facility's visitor COVID-19 symptom evaluation form on 6/25/20 revealed the following: -3/29/20: Visitor (V14) entered facility, "err" documented under temperature. -4/10/20: V2 entered the facility, no temperature documented. -4/17/20: V3 entered the facility, no screening completed for signs and symptoms of COVID-19. -4/28/20: V4 entered facility, no temperature assessed. -5/12, 5/14, 5/19, 5/26, 6/12/20: V5 entered the facility, no temperature assessed. -6/9/20: V6 entered facility, no screening completed for signs and symptoms of COVID-19. -6/19/20: V7 entered facility, no screening completed for signs and symptoms of COVID-19. -6/12/20: V8 entered facility, no screening	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
	285062	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST COVENANT HOME	**P O BOX 367, 615 EAST 9TH STREET STROMSBURG, NE 68666**

(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 completed for signs and symptoms of COVID-19. -6/12/20: V9 entered facility, no screening completed for signs and symptoms of COVID-19. -6/12/20: V10 entered facility, no screening completed for signs and symptoms of COVID-19. -6/12/20: V11 entered facility, no screening completed for signs and symptoms of COVID-19. -undated: V12 entered facility, no screening completed for signs and symptoms of COVID-19. -undated: V13 entered facility, no screening completed for signs and symptoms of COVID-19. During an interview on 6/25/20 at 12:05pm, the DON stated a screening station was set up at the front entrance of the building and the receptionist who worked Monday through Friday 8am to 4:30pm was responsible to ensure that anyone that entered the facility was screened for signs and symptoms of COVID-19. She stated anyone who entered the front door beyond the time that the receptionist was working, was responsible to screen themselves before proceeding to resident care areas. She stated about a week ago, the facility realized visitors were entering the facility through the front door and not conducting the screening for signs and symptoms of COVID-19 on themselves. She said the facility was not able to lock the front door related to fire codes but there was a sign at the front entrance letting anyone who entered the facility know that they were not allowing any visitors into the facility. She stated at that time (about a week ago), the facility initiated a new procedure that required anyone who entered the facility through the front door to interact with a staff member via telephone prior to entering resident care areas and to ensure the individual did not have a temperature or any signs or symptoms of COVID-19 before proceeding into the resident care areas of the facility.	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
	285062	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST COVENANT HOME	**P O BOX 367, 615 EAST 9TH STREET STROMSBURG, NE 68666**

(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 8 Review of the facility's COVID-19 visitor symptom evaluation form on 6/25/20 revealed on: -6/24/20: Dietician (D1) entered the facility and was not screened for signs and symptoms of COVID-19. -6/24/20: Visitor (V1) entered the facility and documented having shortness of breath. During an interview on 6/25/20 at 2:30pm, the Infection Control Nurse stated she would have expected all family and visitors who entered the facility to complete the COVID-19 screening log form prior to having any contact with any residents in the facility. She stated the facility had made a change to the screening process about a week ago for anyone who entered through the front door. She stated they had to communicate with staff via telephone and staff would ensure that they were screened prior to entering resident care areas. She stated prior to making the change that anyone who entered through the front entrance of the facility were kind of screening themselves. The facility submitted an acceptable plan and the IJ was removed and deficient practice corrected on 6/26/20 after verification of implementation of the removal plan.	F 880		

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
CMS Kansas City - Survey & Operations Group
601 East 12th Street, Room 355
Kansas City, Missouri 64106

IMPORTANT NOTICE – PLEASE READ CAREFULLY

Ju1y 15, 2020

Sheila Bjerrum, Administrator
Midwest Covenant Home
P O Box 367, 615 East 9th Street
Stromsburg, NE 68666-0367

CMS Certification Number: 285062

Subject: Survey Results
Cycle Start Date: June 25, 2020

Dear Ms. Bjerrum,

COVID-19 FOCUSED INFECTION CONTROL SURVEY

The Secretary of the U.S. Department of Health and Human Services (DHHS) has the duty and responsibility to protect the health, safety, welfare and rights of Medicare/Medicaid beneficiaries. The Secretary has delegated authority to administer and provide oversight of the Medicare program to Centers for Medicare & Medicaid Services (CMS).
The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-31-All, CMS and the State Survey Agency are conducting unannounced onsite surveys at certain Medicare certified provider and supplier types.
SURVEY RESULTS
On June 25, 2020, a survey was completed at Midwest Covenant Home by CMS to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the enclosed form CMS 2567.
PLAN OF CORRECTION

A Plan of Correction (PoC) for the deficiencies must be submitted within ten (10) calendar days of your receipt of this notice. Use the space provided to the right of each item of deficiency to type your PoC and the expected date of completion. A PoC must be entered for each item clearly identifying HOW, WHAT, WHEN, AND WHERE it was or will be corrected. The plan should also include provisions instituted to prevent reoccurrence. The PoC must contain the following:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be

affected by the same deficient practice;

- Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of the quality assurance being implemented, the earliest correction date will be the date of the revisit; and
- Include dates when corrective action will be completed. The corrective action completion dates must be written in the completion date column within acceptable time frames. If the PoC is unacceptable for any reason, you will be notified in writing by this office. If the PoC is acceptable, you will be notified via telephone, e-mail, etc. Please note that the facility is ultimately accountable for compliance, and that responsibility is not alleviated in cases where notification regarding the acceptability of the facility's PoC is not made timely. The PoC will serve as the facility's allegation of compliance.

You must send this office the original, signed and dated Statement of Deficiencies (SoD) with the PoC to:

Marilyn Mihalovich, Nurse Consultant

Marilyn.Mihalovich@cms.hhs.gov

ENFORCEMENT REMEDIES

Based on the Statement of Deficiencies (Form CMS-2567), the following remedies are imposed:

Directed Plan of Correction:

In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction (DPOC) is imposed on the facility. In accordance with 42 CFR § 488.402(f), this remedy is effective July 31, 2020. The DPOC may be completed before or after that date. The effective date is not a deadline for completion of the DPOC. However, CMS will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice.

The DPOC requires that your plan of correction include the following:

- The Infection Preventionist and Director of Nursing, in conjunction with the Medical Director, and senior leadership/Governing Body concurrence, shall complete the following:

o Develop and implement procedures to utilize an at-the-door symptom check for all visitors, vendors and others before entering the facility.

o Develop and implement procedures for screening all staff at the beginning of their shift for fever and respiratory symptoms before they enter areas accessible to residents. This will include actively measuring and recording staff temperatures and assessment of shortness of breath, new or changed cough, and sore throat. Screening logs will be maintained and signed by the staff member who conducts the screening.

- A Root Cause Analysis (RCA) of the deficient practices cited, conducted with assistance from the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee and Governing Body. The RCA should be incorporated into the intervention plan. Information regarding RCAs can be found at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies, within 10 days after receipt of the Form CMS 2567. Please send all documentation to CMS at the following:
Marilyn Mihalovich, Nurse Consultant
Email: Marilyn.Mihalovich@cms.hhs.gov

Please note, if documentation includes any resident personal identifiable information (PII) or personal health information (PHI) it must be sent encrypted.
Imposition of Denial of Payment for New Admissions (DPNA):
Payment will be denied for all NEW Medicare and Medicaid admissions, beginning July 31, 2020, in accordance with the statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal regulations at 42 CFR §488.417. Your Medicare Administrative Contractor will be notified of the date the denial of payment begins. DPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated.
INFORMAL DISPUTE RESOLUTION (IDR)
You have one opportunity to dispute the deficiencies cited on the survey date through (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Marsophia R. Powers, Long Term Care Branch Manager

Email: Marsophia.Powers@cms.hhs.gov

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

This request must be submitted within 10 days from the date of the enforcement letter. An incomplete Informal Dispute Resolution process will not delay the effective date of any enforcement action.

Informal Dispute Resolution is in no way to be construed as a formal evidentiary hearing. It is an informal internal process to review additional information submitted by the facility. You will be advised of our decision relative to the informal dispute.

WITHDRAWAL OF APPROVAL FOR NURSE AIDE TRAINING PROGRAM
Please note that Federal law, as specified in the Social Security Act at §1819(f)(2)(B) and §1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs

(NATCEP) and nurse aide competency evaluation programs (NACEP) offered by, or in, a facility in which, within the previous two years, one or more of the following exists:

- Operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse);
- Has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care;
- Has been assessed a total civil money penalty of not less than $10,697;
- Has been subject to a denial of payment;
- Appointment of a temporary manager;
- Terminated from participation, and/or
- In the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Your facility will receive further information regarding this from the State Agency.

APPEAL RIGHTS

The following remedies are being imposed:

- Directed Plan of Correction
- DPNA

If you disagree with this action imposed on your facility, you or your legal representative are required to file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/. To file a new appeal using DAB E-File, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

Clicking the File New Appeal link on the Manage Existing Appeals screen, then clicking Civil Remedies Division on the File New Appeal screen. Entering and uploading the requested information and documents on the "File New Appeal- Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. The DAB will set the location for the hearing. Counsel may represent you at a hearing at your own expense.

All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions for using DAB E-File in cases before the DAB’s

Civil Remedies Division can be found by clicking the button marked E-Filing Instructions after logging-in to DAB E-File.
For questions regarding the E-Filing system, please contact E-File System Support at OSDABImmediateOffice@hhs.gov.
Please note that all hearing requests must be filed electronically unless you have no access to the internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. Such a request should be made to:
Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201
A request for a hearing must be filed no later than 60 days from the date of receipt of this notice.
A copy of the hearing request shall be submitted electronically to:
kevin.wright@cms.hhs.gov

If you believe you have achieved substantial compliance, you should contact the CMS RO. In addition, if substantial compliance has not been achieved within six (6) months after the last date of the survey identifying noncompliance, June 19, 2020, we will terminate your Medicare provider agreement effective December 19, 2020.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/covid-19 . This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

CONTACT INFORMATION

Thank you for the time and courtesy extended to our surveyors during the survey. If you have any questions regarding the survey, please contact Marilyn Mihalovich, Nurse Consultant. For questions regarding enforcement, Kevin Wright, Health Insurance Specialist. Both can be reached in our Kansas City Regional Office at (816) 426-2011.

Sincerely,

CDR Marsophia R. Powers
Long Term Care Branch Manager
Survey & Operations Group
Center for Clinical Standards & Quality

CMS Kansas City

Enclosures
CMS 2567

Copies via e-mail to:
NE DHHS
Powers/Grimes/Mihalovich
WPS
OGC

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 2, 2020

Stephanie Hahn, Administrator
Mitchell Care Center
1723 23rd Street
Mitchell, NE 69357

CMS CERTIFICATION NUMBER: 285287

Dear Ms. Hahn:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 24, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

June 24, 2020

Jennifer Coffman, Administrator
Monument Rehabilitation And Care Center
111 West 36th Street
Scottsbluff, NE 69361

CMS CERTIFICATION NUMBER: 285095

Dear Ms. Coffman:

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

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 22, 2020

Stephanie Simmons, Administrator
Mother Hull Home
125 East 23rd Street
Kearney, NE 68847

CMS CERTIFICATION NUMBER: 285254

Dear Ms. Simmons:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 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

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

June 29, 2020

Emily Birdsley, Administrator
Mt Carmel Home- Keens Memorial
412 West 18th Street
Kearney, NE 68845

CMS CERTIFICATION NUMBER: 285216

Dear Ms. Birdsley:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 16, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0001	A. BUILDING: _____ B. WING _____	07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK VETERANS HOME	600 E BENJAMIN AVENUE NORFOLK, NE 68701

(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 000	INITIAL COMMENTS References to Title 175 of the Nebraska Administrative Code, Chapter 12-"Regulations Governing Licensure of Skilled Nursing Facilities, Nursing Facilities and Intermediate Care Facilities" have been included in the survey report as they apply to deficient practices identified.	O 000		
O 242	12-006.17 Infection Control The facility must maintain facility practices to provide a sanitary environment and to avoid sources and transmission of infections and communicable diseases. This includes the establishment and maintenance of an infection control program for the prevention, control, and investigation of infections and communicable disease. This Standard is not met as evidenced by: Licensure Reference Number 175 NAC 12-006.17 Based on observation, interview and record review, the facility failed to provide a face covering to residents to avoid the transmission of infection of COVID-19 (a mild to severe respiratory illness caused by a contagious virus that can spread from person to person). For 11 residents (Residents 1,2,3,5,6,7,8,9,10, 11,12,and 13,) of 15 sampled residents. The facility census was 138. Findings are: A. Observation on 7/14/20 at 9:00a.m. in the Memory support unit revealed, residents were social distancing in common area. Resident's(Residents 1,2,3,) were not wearing face coverings in the common area.	O 242		

Licensure Unit
LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0001	A. BUILDING: _____ B. WING _____	07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK VETERANS HOME	600 E BENJAMIN AVENUE NORFOLK, NE 68701

(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 242	Continued From page 1 B. Interview on 7/14/20 at 2:20 p.m. with RN-E (Registered Nurse) on the Memory support unit revealed, residents in Memory support unit do not wear masks or face coverings in the unit. RN-E stated it is difficult to keep the face masks on Dementia or Alzheimer residents. RN-E stated a lot of the residents that live here are not able to keep a face mask or face covering on. RN-E stated if an emergency would happen and a resident from the Memory support unit would have to go out the double secured doors, the resident would have a mask or face covering on as much as possible. C. Interview with DON (Director of Nursing) on 7/14/20 at 3:25 p.m. revealed, residents in the memory support unit are encouraged to wear a mask or face covering. DON stated a lot of the memory support residents will try to eat the masks or face coverings. DON stated masks or face coverings are offered to the residents in memory support. DON revealed care plans are updated with a COVID-19 care plan stating why residents in the memory support unit are not wearing face coverings. D. Observation on 7/14/20 at 5:00 p.m. revealed Resident's(Residents 1,2,3,) were not wearing face coverings in the common area. D. Record review of COVID-19 care plans dated 4/8/20 for residents 1,2,3 revealed residents 1,2,3 at risk for developing COVID-19. Resident care plans revealed no documentation for not wearing face coverings. An observation on 7/14/20 at 5:07 PM revealed Residents 5,6,7,8,9, 10,11,12 and 13 were sitting in wheelchair or common area chairs out side of	O 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0001	A. BUILDING: _____ B. WING _____	07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK VETERANS HOME	600 E BENJAMIN AVENUE NORFOLK, NE 68701

(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 242	Continued From page 2 dinning area with out face covering on. Record review of Residents 5,6,7,8,9,10,11,12 and 13 COVID-19 Care Plan's dated 4/8/20 revealed Residents 5,6,7,8,9 need opportunities to socialize. Please accommodate as possible within the limits of my isolation precautions and to offer resident a cloth mask or tissue when staff interact with them. Record review of Residents 5,6,7,8,9, 10,11,12 and 13 Electronic Health Record revealed Residents 5,6,7,8,9, 10,11,12 and 13 were not currently on isolation precautions. An interview on 7/14/20 at 5:08 PM with ADON (Assistant Director of Nursing) confirmed Residents 5,6,7,8,9,10, 11,12 and 13 did not have face covering on. ADON stated residents are encouraged but not required to wear face covering outside of their room. Record review of facility policy title COVID-19 Re-Opening Plan dated 6/16/20 revealed during group activities residents are to wear cloth or surgical face masks for All activities for inter and external activities. According to the CDC dated 7/9/20 Implement Universal Source Control Measures Source control refers to use of cloth face coverings or facemask's to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing. Because of the potential for asymptomatic and pre-symptomatic transmission, source control measures are recommended for everyone in a healthcare facility, even if they do not have symptoms of COVID-19. "Patients and visitors should, ideally, wear their	O 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0001	A. BUILDING: _____ B. WING _____	07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK VETERANS HOME	600 E BENJAMIN AVENUE NORFOLK, NE 68701

(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 242	Continued From page 3 own cloth face covering (if tolerated) upon arrival to and throughout their stay in the facility. If they do not have a face covering, they should be offered a facemask or cloth face covering, as supplies allow. Patients may remove their cloth face covering when in their rooms but should put it back on when around others (e.g., when visitors enter their room) or leaving their room.	O 242		
O 244	12-006.17B Prevention of Cross-Contamination The facility must prevent cross-contamination between residents in provision of care, sanitation of equipment and supplies, and cleaning of resident's rooms. This Standard is not met as evidenced by: Licensure Reference Number 175 NAC 12-006.17B Based on observation, interview and record review, the facility failed to prevent potential spread of COVID -19 between residents in the gray zone (Resident that are new admissions or readmission to the facility and have an unknown covid -19 status) and green zone (Resident that do not have Covid-19) by 1) staff not wearing N95 masks and reusing surgical masks in isolation. This affected 2 of 5 residents sampled (Residents 4 and 14) and 2) all staff resusing surgical masks for multiple shifts. This had the potential to affect all resident in the facility . The facility census was 138. Findings are: 1) According to CDC Responding to Coronavirus (COVID-19) in Nursing Homes - Considerations	O 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0001	A. BUILDING: _____ B. WING _____	07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK VETERANS HOME	600 E BENJAMIN AVENUE NORFOLK, NE 68701

(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 244	Continued From page 4 for the Public Health Response to COVID-19 in Nursing Homes dated April 30, 2020 revealed the following information under section "Considerations for new admission or readmission to the facility" All recommended COVID-19 PPE (Personal Protective Equipment) should be worn during care of resident under observation, which includes use of an N95 mask or higher respirator, eye protection, gloves and gown. An interview on 7/14/20 at 8:30 AM with Administrator revealed that facility has not had any issues receiving PPE (Personal Protective Equipment) including masks (surgical, N95's, Gowns, gloves, face shields). An observation on 7/14/20 at 9:30 AM revealed outside of resident 14"s room a plastic dresser with PPE (Personal Protective Equipment) over bed table and hands sanitizer were present. On the wall outside of Resident 14's room were 4 small brown paper bags taped to the wall. 2 of the 4 brown paper bags had the word "isolation" written on them. On Resident 10's door was a Gray zone Procedure sign. Record review of gray zone procedure sheet on Resident 14"s door stated the following : for step by step DONNING and DOFFING when entering gray isolation room (in this order): - Change regular surgical mask to isolation surgical mask grabbing only the ear loops (Separate paper bag used for each mask) - Apply gown and tie both ties in back - Apply face shield - Apply gloves	O 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0001	A. BUILDING: _____ B. WING _____	07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK VETERANS HOME	600 E BENJAMIN AVENUE NORFOLK, NE 68701

(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 244	Continued From page 5 -Enter room WITH BASIN and place on bedside stand inside the room. EXITING GRAY ISOLATION ROOMS (in this order) Inside room - Remove gloves - Remove gown - Remove dirty face shield and place in basin on bedside stand. - Sanitize hands and exit holding the basin on the outside, with face shield inside Outside room - Place basin on bedside table outside room - Sanitize hands - Remove ISOLATION surgical mask by ear pieces and place in paper bag labeled "isolation" - Apply your regular surgical mask by only touching the ear pieces while removing it from the paper bag. - Sanitize hands - Apply gloves - Clean the face shield, basin, and bedside stand - Hang face shield to dry on hooks - Discard gloves - Sanitize hands - **All isolation masks are to be thrown away at the end of your shift. A new mask is to be worn each day in isolation rooms. Record review on 7/14/20 at 2:30 p.m. of Nebraska Veterans Home Policy for Personal Protective Equipment--Using face masks, dated October 2010 revealed, in guidelines under miscellaneous: Use a mask only once and then discard it. An observation on 7/14/20 at 10:40 AM revealed LPN (Licensed Practical Nurse) - G exited	O 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0001	A. BUILDING: _____ B. WING _____	07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK VETERANS HOME	600 E BENJAMIN AVENUE NORFOLK, NE 68701

(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 244	Continued From page 6 Resident 14's room wearing surgical mask. LPN -G removed and cleaned face shield, hung it up to air dry on hook outside of residents room. Removed surgical mask and placed it in a brown paper bag with words isolation on it. LPN-G then preformed hand hygiene with hand sanitizer. An observation on 7/14/20 at 10:50 AM revealed MA (Medication Aide) H preformed hand hygiene with hand sanitizer, removed surgical mask , placed in brown paper bag that was taped to wall outside of Resident 14's room, Applied another surgical mask from brown paper bag marked " isolation" , applied yellow reusable gown from storage container, face shield and gloves. MA -H entered Resident 14's room and assisted resident to restroom. Resident 10 told MA-H (gender) no longer needed to use restroom. MA-H assisted Resident 14's out of restroom and assisted to reposition resident in wheelchair. Resident 14 had call light with in reach when MA-H was leaving room. In side residents room 2 large container one for trash and one for lines. MA-H removed gloves, discard in trash, untied gown and touched only outside of gown and rolled "dirty' side into its self and discarded into trash. MA-H then placed face shield in gray basin applied hand sanitizer and cared gray basin with face shield out side of Resident 10's room. MA -H applied hand sanitizer, cleaned face shield with Clorox wipes and placed face shield on hook to air dry. MA-H then removed surgical mask "isolation"mask and placed it in brown paper bag labeled "isolation" MA-H then applied surgical mask from brown paper bag. An interview on 7/14/20 at 11:00 AM with MA -H revealed staff are provided with a surgical mask at the start of shift and that mask is kept until it becomes soiled or "fuzzy", masks are stored in	O 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0001	A. BUILDING: _____ B. WING _____	07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK VETERANS HOME	600 E BENJAMIN AVENUE NORFOLK, NE 68701

(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 244	Continued From page 7	O 244		

brown paper bags in administrative area of facility. MA- H states (gender) usually wear 1 surgical mask for about shifts (each shift approximately 8 hours). When working with resident in isolation staff get 1 surgical mask per isolation room and store that mask outside of residents room in a brown paper bag taped to the wall. At the end of shift all "isolation" masks are to be discarded. MA -H has not wore N95 mask or been told to use it. MA was fit tested and has a N95 mask and was provided education on how to wear it.

An interview on 7/14/20 at 1:30 PM with IP and DON revealed staff were not wearing N95 in Gray zones due to local health department advising facility it was ok to use surgical masks in gray and yellow zones. IP and DON both confirmed they followed ICAP (Infection Control Assessment and Promotion Program) and used there Zoning recommendations regarding PPE and had listened to and read ICAP's webinar on 6/25/20 about using N95 in gray zones due to availability.

Record review of Email Sent to Local Health Department dated 6/25/20 at 3:46 PM
Clarification question
Our system has difficulty obtaining an adequate supply of N95 masks. Our Central Office staff have determined that we can utilize surgical masks and face shield for residents in our yellow and gray zone to conserve our N95 supplies which we utilize in our red zones. Just wanted to make sure that you are aware of and are in agreement with our plans. Signed by Facilities IP.

Record review of email received from Local Health Department dated 6/25/20 at 3:48 PM
Re: Clarification question
Yes, That is perfectly acceptable. Thank you for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0001	A. BUILDING: _____ B. WING _____	07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK VETERANS HOME	600 E BENJAMIN AVENUE NORFOLK, NE 68701

(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 244	Continued From page 8 checking! - signed by Staff at Local Health Department. Administrator provided the following document on 7/14/20 at 8:30 AM and stated this was the facilities current supply of PPE in the building. Personal Protective Equipment (PPE) Inventory Counts revealed the facility has current census of 139 Residents. Gloves available boxes total was 1709, Gowns disposable 7,250, reusable cloth gowns - 495, Shoe covers- 440 pairs, Eye protection goggles- 8, glasses 143, shields - 676. Masks Surgical- 19,913. KN-95 1800, N-95 5,835, Vented N-95 470. An interview on 7/14/20 at 2:15 PM with IP revealed that the facility currently had lots of N95's but was worried about the future and had decided not to use them to conserve for future use. 2) An observation on 7/14/20 at 8:25 AM revealed in administration area on the side of cubical was multiple brown paper bags with names on them and surgical masks sticking out of each. An observation 7/14/20 at 8:25 AM revealed on the reception desk at the front entrance was a binder with large sign that informed staff to reuse surgical masks. An interview on 7/14/20 at 1:20 PM with Front desk assistant revealed that staff screening is preformed including taking staff's temperature and asking covid questions. Staff then enter administration area and collect there brown paper bag and mask, then go to there assigned unit. At	O 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0001	A. BUILDING: _____ B. WING _____	07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK VETERANS HOME	600 E BENJAMIN AVENUE NORFOLK, NE 68701

(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 244	Continued From page 9 the end of each shift staff then return there brown paper bag with surgical mask and hang it back on cubical wall. An interview on 7/14/20 at 11:55 AM with R. N - I revealed that surgical masks are worn until it becomes soiled or "fuzzy" staff are to reuse surgical masks for multiple shifts. An interview on 7/14/20 at 1:30 PM with DON and IP confirmed the facility had plenty of surgical masks available for staff use. 1) A. Observation outside Resident 4's room on 7/14/20 at 0930 revealed room door closed, paper bags taped to wall outside of room. Observed staff names on paper bags. Signs on outside of door state the following: 1) Keep door closed at all times. 2) Contact and droplet precautions, with examples of what to DON(to put on) when entering room. 3) DONNING and DOFFING (how to take off) step by step procedures for staff. B. Observation of Resident 4's room identified as a gray/isolation zone room on 7/14/20 at 0945 revealed bedside table with hand sanitizer, 2 plastic basins. Opposite side a 3 drawer plastic cubby with gloves, Clorox wipes, extra surgical face masks, cloth gowns and red garbage bags. Above cubby 2 hooks on wall with face shields hanging on the hooks. C. Interview with MA-A on 7/14/20 at 10:00 am revealed the paper bags hanging outside of Gray	O 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0001	A. BUILDING: _____ B. WING _____	07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK VETERANS HOME	600 E BENJAMIN AVENUE NORFOLK, NE 68701

(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 244	Continued From page 10 Zone room are for staff to change face masks when entering the room, staff take off the surgical mask, put in the paper bag labeled with the word "floor" and staff name. Staff proceed to take mask out of paper bag labeled "Isolation" with the staff member name on it and apply to face. MA-A revealed at the end of every shift the" floor" mask gets discarded. D. Observation on 7/14/20 at 10:30 a.m., revealed MA-A and LPN-B going into gray room. 1) Hand hygiene completed. 2) Surgical floor mask changed to an isolation surgical mask, staff grabbed only the ear loops and put mask in separate paper bag labeled floor. 3) Gown applied and tied, hand hygiene with ABHR (Alcohol based hand rub) completed. 4) Face shield applied. 5) Gloves applied. 6) MA-A and LPN-B entered room with plastic basin and placed on bedside stand inside the room. E. Observation of staff exiting gray room on 7/14/20 at 10:50 a.m. revealed, staff removed gloves, and gowns, placed gowns in designated containers in room. Removed face shield, placed in basin on bedside stand. Hand hygiene completed with ABHR, staff left gray zone room holding the basin on the outside with face shield inside. 1) Staff members placed basin on bedside table outside the gray zone room, sanitized hands with ABHR (Alcohol based hand rub). 2) Removed "isolation surgical mask" by ear loops and placed in paper bag labeled "isolation". 3) Reached into paper bag labeled "floor" by touching ear loops with pinky finger when removing from paper bag and applied surgical mask.	O 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0001	A. BUILDING: _____ B. WING _____	07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK VETERANS HOME	600 E BENJAMIN AVENUE NORFOLK, NE 68701

(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 244	Continued From page 11 4) Sanitized hands with ABHR. 5) Applied gloves. 6) Cleaned face shields with Clorox wipes, left wet for 3 minutes, placed face shield on hooks to dry. 7) Cleaned basin and bedside table with Clorox wipes. 8) Removed gloves. 9) Hand hygiene with soap and water completed for 20 seconds. F) Record review of gray zone procedure sheet on 7/14/20 at 2:15 p.m. for step by step DONNING and DOFFING attached to gray zone room door. When entering gray isolation room (in this order): - Change regular surgical mask to isolation surgical mask grabbing only the ear loops (Separate paper bag used for each mask) - Apply gown and tie both ties in back - Apply face shield - Apply gloves -Enter room WITH BASIN and place on bedside stand inside the room. EXITING GRAY ISOLATION ROOMS (in this order) Inside room - Remove gloves - Remove gown - Remove dirty face shield and place in basin on bedside stand. - Sanitize hands and exit holding the basin on the outside, with face shield inside Outside room - Place basin on bedside table outside room - Sanitize hands - Remove ISOLATION surgical mask by ear pieces and place in paper bag labeled "isolation"	O 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0001	A. BUILDING: _____ B. WING _____	07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK VETERANS HOME	600 E BENJAMIN AVENUE NORFOLK, NE 68701

(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 244	Continued From page 12 - Apply your regular surgical mask by only touching the ear pieces while removing it from the paper bag. - Sanitize hands - Apply gloves - Clean the face shield, basin, and bedside stand - Hang face shield to dry on hooks - Discard gloves - Sanitize hands - **All isolation masks are to be thrown away at the end of your shift. A new mask is to be worn each day in isolation rooms. G) Record review on 7/14/20 at 2:30 p.m. of Facility Policy for Personal Protective Equipment--Using face masks, dated October 2010 revealed, in guidelines under miscellaneous: Use a mask only once and then discard it. H) Record Review on 7/14/20 at 2:35 p.m. of Facility Policy for Personal Protective Equipment for face masks dated August 2019 revealed, face mask should be used only once and then discarded into the appropriate receptacle located in the room in which the procedure is being performed. 2) Interview on 7/14/20 at 10:55 a.m. with MA-A and LPN-B revealed they reuse their surgical masks. MA-A revealed at the end of the shift, face mask sometimes will get discarded that was worn all shift. Interview with DON (Director of Nursing) and IPC-D (Infection Control Preventionist/Quality Assurance coordinator) on 7/14/15 at 3:15 p.m.	O 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0001	A. BUILDING: _____ B. WING _____	07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORFOLK VETERANS HOME	600 E BENJAMIN AVENUE NORFOLK, NE 68701

(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 244	Continued From page 13 revealed due to shortages of surgical masks they are reusing the surgical masks. IPC-D revealed email sent to Public Health about shortage of surgical masks and no response was received. Record review of burn rate(estimation of PPE needed for resident care) for PPE(Personal Protective Equipment) dated 7/14/20 revealed facility has 20,000 surgical masks at this time, and 5800 N95 masks at this time in storage.	O 244		

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

August 3, 2020

Mr. Jerry Eisenhauer, Administrator,
Norfolk Veterans Home
600 E Benjamin Avenue
Norfolk, NE 68701-0830

Dear Mr. Eisenhauer:

The attached report documents the results of a licensure inspection which includes one or more findings of noncompliance with the licensure regulations for Skilled Nursing Facilities, Nursing Facilities, Intermediate Care Facilities. The report was prepared following the compliance infection control investigation at your facility completed on July 14, 2020 by representatives of the Nebraska Department of Health and Human Services, Division of Public Health.

The violations found did not create imminent danger of death or serious physical harm and no direct or immediate adverse effect on the health, safety, or security of residents residing in the assisted-living facility. Therefore, the Department requests a written statement of compliance be submitted to the Department within 10 working days of receipt of this letter. The statement of compliance must include the following:

1) Steps which have been or will be taken to correct each violation;

2) The period of time estimated to be necessary to correct each violation; and

3) Title of the responsible staff.

If you fail to submit and implement a statement of compliance, the Department may initiate disciplinary action against the facility license in accordance with 175 NAC 12-008.

We thank you and your staff for your cooperation and assistance at the time of the survey. If you have any questions regarding this correspondence, 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: Compliance Infection Control Investigation Report

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 27, 2020

Carolyn Riggs, Administrator
North Platte Care Center, Llc
2900 West E Street
North Platte, NE 69101

CMS CERTIFICATION NUMBER: 285165

Dear Ms. Riggs:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 8, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 2, 2020

Shelley Ramirez, Administrator
Northfield Retirement Communities Care Center
2100 Circle Drive
Scottsbluff, NE 69361

CMS CERTIFICATION NUMBER: 285271

Dear Ms. Ramirez:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 22, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Kansas City Regional Office
601 East 12th Street, Room 355
Kansas City, Missouri 64106

MIDWEST DIVISION OF SURVEY AND CERTIFICATION

July 2, 2020

D. Kirk Sweeney, Administrator
Nye Legacy Health & Rehabilitation Center
3210 N Clarkson
Fremont, NE 68025

CMS Certification No: 285278

Dear Mr. Sweeney:

SUBJECT: SURVEY RESULTS
Cycle Start Date: June 17, 2020

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES
The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-20-All*, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS
On June 17, 2020, the Centers for Medicare & Medicaid Services (CMS) completed a COVID-19 Focused Survey at Nye Legacy Health & Rehabilitation Center to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was in substantial compliance with participation requirements and no deficiencies were cited. The findings from this survey are documented on the enclosed form CMS 2567.

No additional action is required on the facility's part.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES
The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at QIO Program Website. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at Locate Your QIO.

CONTACT INFORMATION
If you have any questions please contact Kevin Wright, Principal Program Representative at (816) 426-2011.

Sincerely,

Kevin Wright
Long Term Care Branch
Survey & Operations Group
Center for Clinical Standards & Quality
CMS Kansas City

cc:
NE DHHS
Powers/Grimes

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Kansas City Regional Office
601 East 12th Street, Room 355
Kansas City, Missouri 64106

MIDWEST DIVISION OF SURVEY AND CERTIFICATION

IMPORTANT NOTICE – PLEASE READ CAREFULLY

Ju1y 1, 2020

D. Kirk Sweeney, Administrator
Nye Pointe Health & Rehab Center
2700 Laverna Street
Fremont, NE 68025

CMS Certification No: 285235

Subject: Survey Results
Cycle Start Date: June 18, 2020

Dear Mr. Sweeney,

COVID-19 FOCUSED INFECTION CONTROL SURVEY

The Secretary of the U.S. Department of Health and Human Services (DHHS) has the duty and responsibility to protect the health, safety, welfare and rights of Medicare/Medicaid beneficiaries. The Secretary has delegated authority to administer and provide oversight of the Medicare program to Centers for Medicare & Medicaid Services (CMS).
The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-31-All, CMS and the State Survey Agency are conducting unannounced onsite surveys at certain Medicare certified provider and supplier types.
SURVEY RESULTS
On June 18, 2020, a survey was completed at Nye Point Health & Rehab Center by CMS to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the enclosed form CMS 2567.

PLAN OF CORRECTION

A Plan of Correction (PoC) for the deficiencies must be submitted within ten (10) calendar days of your receipt of this notice. Use the space provided to the right of each item of deficiency to type your PoC and the expected date of completion. A PoC must be entered for each item clearly identifying HOW, WHAT, WHEN, AND WHERE it was or will be corrected. The plan should also include provisions instituted to prevent reoccurrence. The PoC must contain the following:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of the quality assurance being implemented, the earliest correction date will be the date of the revisit; and
- Include dates when corrective action will be completed. The corrective action completion dates must be written in the completion date column within acceptable time frames. If the PoC is unacceptable for any reason, you will be notified in writing by this office. If the PoC is acceptable, you will be notified via telephone, e-mail, etc. Please note that the facility is ultimately accountable for compliance, and that responsibility is not alleviated in cases where notification regarding the acceptability of the facility's PoC is not made timely. The PoC will serve as the facility's allegation of compliance.

You must send this office the original, signed and dated Statement of Deficiencies (SoD) with the PoC to:

Kristin Allen, Nurse Consultant
Kristin.Allen@cms.hhs.gov

ENFORCEMENT REMEDIES
Based on the Statement of Deficiencies (Form CMS-2567), the following remedies are imposed:

Civil Money Penalty (CMP)

In determining the amount of the Federal Civil Money Penalty (CMP) that we are imposing, we have considered your facility's history, including any repeated deficiencies; and the factors specified in the Federal requirement at 42 CFR § 488.404. Additionally, CMS issued new CMP policies for infection control deficiencies in QSOG Memorandum QSO 20-31-ALL, effective June 1, 2020. We are imposing the following CMP in accordance with these policies:

- A per-instance Federal Civil Money Penalty in the amount of $10,000.00 for the deficiency described at the Federal citation, F0880 -- S/S: F -- 483.80(a)(1)(2)(4)(e)(f) - Infection Prevention & Control.

The total amount of the CMP is $10,000.00.

Directed Plan of Correction:
In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction (DPOC) is imposed on the facility. In accordance with 42 CFR § 488.402(f), this remedy is effective July 16, 2020. The DPOC may be completed before or after that date. The effective date is not a deadline for completion of the DPOC. However, CMS will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice.
The DPOC requires that your plan of correction include the following:
- A plan for all Environmental Services staff to view the two Centers for Disease Control

(CDC) training videos located at the following: https://youtu.be/YYTATw9yav4 and https://youtu.be/7srwrF9MGdw. Training may be supervised by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion by all staff.

- A Root Cause Analysis (RCA) of the deficient practices cited, conducted with assistance from the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee and Governing Body. The RCA should be incorporated into the intervention plan. Information regarding RCAs can be found at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies, within 10 days after receipt of the Form CMS 2567. Please send all documentation to CMS at the following:
Kristin Allen, Nurse Consultant
Email: Kristin.Allen@cms.hhs.gov

Please note, if documentation includes any resident personal identifiable information (PII) or personal health information (PHI) it must be sent encrypted.

Imposition of Denial of Payment for New Admissions (DPNA):

Payment will be denied for all NEW Medicare and Medicaid admissions, beginning August 15, 2020, in accordance with the statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal regulations at 42 CFR §488.417. Your Medicare Administrative Contractor will be notified of the date the denial of payment begins. DPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated.

FINANCIAL HARDSHIP

If you believe your facility's financial condition lacks the ability to support the amount of the CMP, you can request a financial hardship review. For CMS to consider whether payment of the CMP would create a financial hardship and allow your request for installment payments, the following documents should be submitted to this office (kevin.wright@cms.hhs.gov) within fifteen (15) days from the receipt of this notice:

- Written, dated request specifying the reason financial hardship is alleged.
- Brief summary listing the supporting documents being submitted (if all documents cannot be included please provide rationale as to why).
- Organizational chart with an explanation/description concerning the related entities. If there is a Parent Company, provide names and addresses (please indicate in your written request if you have a Parent company).
- The following financial statements for the Provider and the Parent Company (of note, we need consolidated financials for the Parent Company and complete financials for the subsidiary (not by facility)):
- Current Balance sheet (segregated by CURRENT assets and liabilities);
- Current Income statement or Statement of Operations or Profit and Loss Statement (has to include NET INCOME);
- Current Statement of Cash Flows (to include the total change in cash flow);
- Most recent, full-year audited financial statements prepared by an independent accounting firm (including footnotes). If audited financial statements are not available, most recent tax returns may be substituted;
- Most recent full-year audited financial statements of the home office and/or related entities (including footnotes). If audited financial statements are not available, most recent tax returns may be substituted;
- Schedule showing amounts due to/from related companies, or individuals, included in the balance sheets. The schedule should list the names of related organizations, or persons,

and indicate where the amounts appear on the balance sheet (e.g., Accounts Receivable, Notes Receivable, etc.);
- Copy of tax returns for the preceding two years;
- Disclosure of expenses and amounts paid/accrued to the home office and/or related entities;
- Documentation of any/all financing arrangements including mortgages, long term debt, and lines of credit;
- If the nursing home requests an extended payment schedule of more than twelve (12) months duration, the provider must submit a letter from a financial institution denying the provider's loan request for the amount of the CMP (requests for extended payment schedules are reviewed based on financial need).

Knowingly and willfully sending false or fraudulent information, or concealing materials of fact, can lead to penalties under 18 U.S.C. §§ 1001, 1035 and 1516.

INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with §488.431, when a civil money penalty (CMP) is imposed and is subject to being collected and placed in an escrow account, you have one opportunity to question cited deficiencies through an Independent Informal Dispute Resolution (IIDR) process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of substandard quality of care (SQC) or IJ. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing the deficiencies, including the scope and severity assessments of deficiencies which have been found to constitute SQC or IJ) to:

CDR Marsophia R. Powers, Long Term Care Branch Manager

Email: marsophia.powers@cms.hhs.gov

This request must be sent within 10 calendar days of receipt of this notice. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

WITHDRAWAL OF APPROVAL FOR NURSE AIDE TRAINING PROGRAM

Please note that Federal law, as specified in the Social Security Act at §1819(f)(2)(B) and §1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs (NATCEP) and nurse aide competency evaluation programs (NACEP) offered by, or in, a facility in which, within the previous two years, one or more of the following exists:
- Operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse);
- Has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care;
- Has been assessed a total civil money penalty of not less than $10,697;
- Has been subject to a denial of payment;
- Appointment of a temporary manager;
- Terminated from participation, and/or
- In the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Your facility will receive further information regarding this from the State Agency.

APPEAL RIGHTS

The following remedies are being imposed:
- CMP
- Directed Plan of Correction
- DPNA

If you disagree with this action imposed on your facility, you or your legal representative are required to file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/. To file a new appeal using DAB E-File, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

Clicking the File New Appeal link on the Manage Existing Appeals screen, then clicking Civil Remedies Division on the File New Appeal screen. Entering and uploading the requested information and documents on the "File New Appeal- Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. The DAB will set the location for the hearing. Counsel may represent you at a hearing at your own expense.

All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions for using DAB E-File in cases before the DAB's Civil Remedies Division can be found by clicking the button marked E-Filing Instructions after logging-in to DAB E-File.

For questions regarding the E-Filing system, please contact E-File System Support at OSDABImmediateOffice@hhs.gov.

Please note that all hearing requests must be filed electronically unless you have no access to the internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. Such a request should be made to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

A request for a hearing must be filed no later than 60 days from the date of receipt of this notice.

A copy of the hearing request shall be submitted electronically to:
kevin.wright@cms.hhs.gov

WAIVER

If you would like to waive your right to a hearing, you must do so in writing to this office (kevin.wright@cms.hhs.gov) within 60 calendar days of the date of the notice of imposition. If

you waive your right to a hearing in accordance with the requirements specified at 42 CFR 488.436, the amount of the CMP will be reduced by 35 percent. After you submit a timely written waiver of your right to a hearing, CMS will send you a letter with instructions on how to remit the adjusted amount of the CMP.

If you believe you have achieved substantial compliance, you should contact the CMS RO. In addition, if substantial compliance has not been achieved within six (6) months after the last date of the survey identifying noncompliance, June 4, 2020, we will terminate your Medicare provider agreement effective December 18, 2020.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at QIO Program Website. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at Locate Your QIO.

CONTACT INFORMATION

Thank you for the time and courtesy extended to our surveyors during the survey. If you have any questions regarding the survey, please contact Kristin Allen, Nurse Consultant. For questions

regarding enforcement, Kevin Wright, Health Insurance Specialist. Both can be reached in our Kansas City Regional Office at (816) 426-2011.

Sincerely,

CDR Marsophia R. Powers
Long Term Care Branch Manager
Survey & Operations Group
Center for Clinical Standards & Quality
CMS Kansas City

Enclosures
CMS 2567

Copies via e-mail to:
NE DHHS
Powers/Grimes/Allen
WPS
OGC

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285235	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NYE POINTE HEALTH & REHAB CTR	2700 LAVERNA STREET FREMONT, NE 68025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on June 18, 2020. The facility was found to not be in compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The facility census was: 38	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/21/2020

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
	285235	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NYE POINTE HEALTH & REHAB CTR	2700 LAVERNA STREET FREMONT, NE 68025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 1 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285235	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NYE POINTE HEALTH & REHAB CTR	2700 LAVERNA STREET FREMONT, NE 68025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2	F 880		

The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:

Based upon observation, interview, and record review, the facility failed to ensure that infection control practices were implemented during the cleaning of resident rooms to reduce the possible spread/transmission of infections. Specifically, Environmental Services staff (ES1) failed to sanitize her hands upon entering, cleaning, and exiting multiple residents' rooms.

The facility did not have any residents with COVID-19 currently or in the past.

The facility census was 38.

Findings include:
An observation on 6/18/2020 at:
8:25am showed, ES1 applied gloves to both hands, without performing hand hygiene, and entered R1's room with her mop and cleaning cloth.
8:26am showed, ES1 exited R1's room, removed her gloves and placed them in the trash, applied a new mop head to the mop, applied fresh gloves, without performing hand hygiene, and entered R2's room with her mop and new cleaning cloth.
8:27am showed, ES1 cleaned the sink and sink counter, entered the resident's bathroom, exited the resident's bathroom to obtain her mop, mopped the resident's bathroom, and vacuumed the floor of the resident's room.
8:34am showed, ES1 exited R2's room, removed her soiled gloves, and without performing hand hygiene, applied a fresh set of gloves.
8:36am showed, ES1 entered R3's room and

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285235	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NYE POINTE HEALTH & REHAB CTR	2700 LAVERNA STREET FREMONT, NE 68025

(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 3 entered the bathroom with her cleaning cloth and mop. 8:38am showed, ES1 exited R3's room, removed her gloves and placed them in the trash, applied fresh gloves, without performing hand hygiene, and entered R4's room. 8:44am showed, ES1 exited R4's room, removed her gloves and placed them in the trash and applied fresh gloves, without performing hand hygiene. 8:45am showed, ES1 entered R5's room with her mop and cleaning cloth. 8:47am showed, ES1 exited R5's room, removed the used mop head and replaced it with a clean one, removed her gloves and placed the gloves in the trash and applied fresh gloves, without performing hand hygiene. An interview with ES1 on 6/18/20 at 8:49am showed: She had been educated on Infection Control Practices to prevent cross-contamination between residents and between staff and residents. The facility has trained staff on handwashing and using alcohol based hand rub to sanitize their hands. Environmental Services staff are supposed to change their gloves every time they enter a different resident room. She has been trained on hand hygiene "a couple of times". She doesn't have to wash her hands between rooms as long as she changes gloves. She was instructed to use alcohol based hand rub "if the opportunity arises". An interview with the Environmental Services Supervisor on 6/18/20 at 9:45am showed:	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
	285235	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NYE POINTE HEALTH & REHAB CTR	2700 LAVERNA STREET FREMONT, NE 68025

(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 All Environmental Services staff have received training on COVID-19, Infection Control practices to prevent cross-contamination, and on hand washing and use of alcohol based hand rub (ABHR) if staff is unable to wash their hands. All staff are expected to perform hand hygiene upon entering and exiting a resident room, and whenever they have to change their gloves. It would not be appropriate for facility staff to change gloves in between resident rooms without performing hand hygiene. All ES staff have been trained to wash their hands or use ABHR whenever they remove gloves, and before applying fresh gloves. An interview with the Education Coordinator (EC) at 10:35am showed: All staff have been trained on Infection Control and Hand Hygiene procedures. She has completed competencies on all staff to ensure hand hygiene is done appropriately and is in the process of completing the second competency on all staff. Environmental Services staff have all been trained to wash their hands or use alcohol gel every time they enter or exit a resident's room before proceeding to the next one. All staff are expected to perform hand hygiene after removing gloves, and upon entry and exit of a resident's room. It would not be appropriate to only change gloves between resident rooms and not perform hand hygiene. Record Review on 6/18/20 of the Infection and Exposure Prevention and Control Program showed: The infection prevention and control program is set up to provide: A sanitary environment to avoid	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
	285235	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NYE POINTE HEALTH & REHAB CTR	2700 LAVERNA STREET FREMONT, NE 68025

(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 sources and transmission of infections and communicable diseases and interventions to reduce or prevent exposure, such as Personal Protective Equipment (PPE), and work practice controls. Record Review on 6/18/20 of the facility's COVID-19 Guideline showed: The recommended measures to prevent COVID-19 outbreaks mimic the same interventions advised by the Centers for Disease Control (CDC) to implement routinely for Influenza and other similar respiratory based infections. The facility maintains an Infection Prevention and Control Program. Everyday standard precautions and preventive actions, and universal source control efforts should be used and include: Appropriate hand hygiene. Wash your hands for at least 20 seconds especially after using the restroom, before eating and after blowing your nose, coughing, or sneezing. Hands must be washed if visibly soiled. Staff is to use an alcohol based hand sanitizer if soap and water is not readily available and/or when hands are not visibly soiled. Hand washing and use of PPE competencies to be completed.	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
	285235	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NYE POINTE HEALTH & REHAB CTR	**2700 LAVERNA STREET FREMONT, NE 68025**

(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 Initial Comments: E000: A COVID-19 Focused Emergency Preparedness Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on June 18, 2020. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6).	E 000		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

07/21/2020

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
	285281	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND HEIGHTS	207 SOUTH ENGDAHL AVENUE OAKLAND, NE 68045

(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 the 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		7/29/20

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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285281	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND HEIGHTS	207 SOUTH ENGDAHL AVENUE OAKLAND, NE 68045

(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: NAC Licensure Reference Number 175 NAC 12-006.17A and 12-006.17B	F 880	The plan of correction constitutes a written allegation of substantial	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285281	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND HEIGHTS	207 SOUTH ENGDAHL AVENUE OAKLAND, NE 68045

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observation, and interview; the facility failed to prevent potential for cross contamination of COVID-19 related to storage of surgical facemasks for use in an isolation room for 1 resident (resident 1) of 3 sampled residents. The facility had a total census of 39 residents. The findings are: A. An observation on 6/29/20 at 10:15 am of resident 1's room revealed several paper bags hanging on a bulletin board on outside door labeled with a Gray zone (residents transferred from hospital to facility are kept in this zone for 14 days) label. B. An observation on 6/29/20 at 1:08 pm revealed Nursing Assistant A performed hand hygiene, applied standard isolation gown, performed hand hygiene, took brown paper bag with nursing assistant A name on it, took out surgical mask, put surgical mask on paper towel, tacked brown paper bag back on bulletin board, performed hand hygiene with ABHR (alcohol based hand rub), applied face mask and face shield, completed hand hygiene with ABHR, applied gloves and entered resident 1's room to empty Foley catheter (a flexible tube that a clinician passes through the urethra (the duct by which urine is carried out of the body from the bladder) and into the bladder to drain urine). Nursing Assistant A removed gown, and gloves, performed hand hygiene with soap and water for 25 seconds. Walked out of resident 1's room, applied ABHR for 20 seconds, removed face shield, placed face shield on paper towel on plastic cube. Completed hand hygiene with ABHR, removed brown paper bag off bulletin	F 880	compliance with federal Medicare and Medicaid compliance. 1. Resident number 1: The board that held the brown bags of masks were removed on 6/29/2020 and destroyed. 2. Any resident in gray zone will not have brown paper bags on the door of their room. 3. All direct care staff are now given a surgical mask at the beginning of their shift. They are to dispose of it at the end of the shift. For the Gray Zone, staff that are assigned, will be given an N-95 or KN-95 (deemed on availability). Staff who enter the Gray Zone will remove surgical mask and apply the N-95/KN-95. While in the room, the surgical mask will go into brown bag while wearing the N-95/KN-95. When completing cares then the N-95/KN-95 will be placed in the bag until the end of the shift and the bag and mask will be thorn away. Staff was educated of this process on June 29, 2020. 4. The Infection Preventest, Director of Nursing Services or designee will perform 5x's per week audits for 4 weeks to ensure that staff that enter the Gray Zone are wearing proper PPE, storing and deposing of PPE properly. Then 3x's per week times 4 weeks. Then 1 time per week for 4 weeks. The results of the audits will be presented monthly at QAPI to ensure compliance times 3 months.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285281	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND HEIGHTS	**207 SOUTH ENGDAHL AVENUE OAKLAND, NE 68045**

(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 3 board with nursing assistant A name on it. Placed dirty surgical mask in brown paper bag, and tacked back up on bulletin board with rest of brown paper bags. Nursing Assistant A performed hand hygiene with ABHR. C. An interview on 6/29/20 at 1:20pm with staff member Nursing Assistant A revealed, that staff have their names on the brown paper bags hanging outside of the Gray zone door with 2 surgical masks in each brown paper bag. D. An interview on 6/29/20 at 1:25pm with the DON (Director of Nursing) confirmed a potential for cross contamination due to putting a dirty mask with a clean mask in the same brown paper bag. DON confirmed the brown paper bags were not dated. DON reported that the facility started putting 2 masks in the brown paper bags on June 24, 2020. DON reported we were told we could put the 2 different face masks in the paper bags. DON confirmed no policy for reuse of surgical masks in same brown paper bag.	F 880		

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 14, 2020

Amie Clausen, Administrator
Oakland Heights
207 South Engdahl Avenue
Oakland, NE 68045-0086 **CMS Certification No. 285281**

Subject: Survey Results
Cycle Start Date: June 29, 2020

Dear Administrator,

UNANNOUNCED COVID-19 SURVEY

The Secretary of the U.S. Department of Health and Human Services (DHHS) has the duty and responsibility to protect the health, safety, welfare and rights of Medicare/Medicaid beneficiaries. The Secretary has delegated authority to administer and provide oversight of the Medicare program to Centers for Medicare & Medicaid Services (CMS).

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-31-All*, CMS and the State Survey Agency are conducting unannounced onsite surveys at certain Medicare certified provider and supplier types.

SURVEY RESULTS

On June 29, 2020, a survey was completed at Oakland Heights by the State Survey Agency to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the CMS 2567 and will be posted on the ePOC system.

PLAN OF CORRECTION

A Plan of Correction (PoC) for the deficiencies must be submitted **by July 24, 2020**, to the State Survey Agency Contact. **Failure to submit an acceptable PoC by July 24, 2020 may result**

in the imposition of additional remedies.

The PoC must contain the following:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of the quality assurance being implemented, the earliest correction date will be the date of the revisit; and
5. Include dates when corrective action will be completed. **The corrective action completion dates must be written in the completion date column within acceptable time frames.** If the PoC is unacceptable for any reason, you will be notified in writing by this office. If the PoC is acceptable, you will be notified via ePOC. Please note that the facility is ultimately accountable for compliance, and that responsibility is not alleviated in cases where notification regarding the acceptability of the facility's PoC is not made timely. **The PoC will serve as the facility's allegation of compliance.**

ENFORCEMENT REMEDIES

Based on the Statement of Deficiencies (Form CMS-2567), the following remedies are imposed:

- **Directed Plan of Correction:**

  In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction is imposed on the facility. In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. The effective date is not a deadline for completion of the DPOC. However, the State Agency will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice.

  Training option(s) which are the most appropriate for the type of noncompliance cited. For examp

  Sparkling Surfaces - https://youtu.be/t7OH8ORr5Ig
  Clean Hands - https://youtu.be/xmYMUly7qiE
  Closely Monitor Residents - https://youtu.be/1ZbT1Njv6xA
  Keep COVID-19 Out! - https://youtu.be/7srwrF9MGdw
  Lessons - https://youtu.be/YYTATw9yav4

Please send all documentation to the State Agency at the following:

Connie Vogt, RN, BSN

Email: dhhs.healthcarefacilities@Nebraska.gov

In the Subject Line please put: DPOC

For states participating in the ePOC program, the DPOC may be added as an attachment.

Please note, if documentation includes any resident personal identifiable information (PII) or personal health information (PHI) it must be sent encrypted.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies, within 10 days after receipt of the Form CMS 2567. Please see the attached instructions (DPOC attachment) for detailed guidance.

INFORMAL DISPUTE RESOLUTION (IDR)

Background:
Regulations at 42 CFR 488.331 require that CMS and the States, as appropriate, offer skilled nursing facilities, nursing facilities, and dually participating facilities an informal opportunity to dispute cited deficiencies upon the facility's receipt of the official Form CMS-2567. The following is a suggested example of IDR language that can be used.

You have one opportunity to dispute the deficiencies cited on the survey date through (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Connie Vogt, RN, BSN at dhhs.healthcarefacilities@Nebraska.gov

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

This request must be submitted within 10 days from the date of the enforcement letter. An incomplete Informal Dispute Resolution process will not delay the effective date of any enforcement action.

Informal Dispute Resolution is in no way to be construed as a formal evidentiary hearing. It is an informal internal process to review additional information submitted by the facility. You will be advised of our decision relative to the informal dispute.

APPEAL RIGHTS

Background:
When non-compliance is associated with an infection control deficiency, enforcement remedies include a Directed Plan of Correction, Discretionary Denial of Payment for New Admissions, and Civil Money Penalties. When enforcement remedies are imposed by the State Survey Agency, appeal rights' language must be included in the notice to the facility. The following is a suggested example of appeal language that can be used.

If you disagree with the determination to impose remedies made on the basis of noncompliance identified at the June 29, 2020 survey, you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board (DAB). The appeal rights are set forth at 42 C.F.R. § 498.5 and the procedures for requesting a hearing are set forth at §498.40, et seq. You must file your hearing request electronically by using the DAB's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov/, unless you obtain a waiver from the DAB (*see* DAB Civil Remedies Division Procedures, § 6(a)(i)(1)). Your appeal must be filed no later than 60 days from the date of receipt of this letter.

We request that you provide an electronic copy of the request for appeal to ROkcmSCB@cms.hhs.gov and to the CMS Regional Chief Counsel OGCKansasCityGeneralInbox@hhs.gov.

If you elect to dispute deficiencies through the Informal Dispute Resolution (IDR) process, this will not extend the 60 day period to file your appeal before the Departmental Appeals Board. Filing an appeal will not stop the imposition of any enforcement remedy.

If you experience problems with, or have questions about DAB e-File, please contact e-File System Support at OSDABImmediateOffice@hhs.gov. If you have questions about using the DAB e-file System, please visit: https://dab.efile.hhs.gov/appeals/to_crd_instructions?locale=en.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at QIO Program Website. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at Locate Your QIO.

CONTACT INFORMATION

If you have any questions please contact this office.

Sincerely,



Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

Enclosures: CMS 2567

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285281	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND HEIGHTS	207 SOUTH ENGDAHL AVENUE OAKLAND, NE 68045

(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 the 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		7/29/20

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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285281	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND HEIGHTS	207 SOUTH ENGDAHL AVENUE OAKLAND, NE 68045

(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: NAC Licensure Reference Number 175 NAC 12-006.17A and 12-006.17B	F 880	The plan of correction constitutes a written allegation of substantial	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285281	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND HEIGHTS	207 SOUTH ENGDAHL AVENUE OAKLAND, NE 68045

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observation, and interview; the facility failed to prevent potential for cross contamination of COVID-19 related to storage of surgical facemasks for use in an isolation room for 1 resident (resident 1) of 3 sampled residents. The facility had a total census of 39 residents. The findings are: A. An observation on 6/29/20 at 10:15 am of resident 1's room revealed several paper bags hanging on a bulletin board on outside door labeled with a Gray zone (residents transferred from hospital to facility are kept in this zone for 14 days) label. B. An observation on 6/29/20 at 1:08 pm revealed Nursing Assistant A performed hand hygiene, applied standard isolation gown, performed hand hygiene, took brown paper bag with nursing assistant A name on it, took out surgical mask, put surgical mask on paper towel, tacked brown paper bag back on bulletin board, performed hand hygiene with ABHR (alcohol based hand rub), applied face mask and face shield, completed hand hygiene with ABHR, applied gloves and entered resident 1's room [redacted] Nursing Assistant A removed gown, and gloves, performed hand hygiene with soap and water for 25 seconds. Walked out of resident 1's room, [redacted] removed face shield, placed face shield on paper towel on plastic cube. Completed hand hygiene with ABHR, removed brown paper bag off bulletin	F 880	compliance with federal Medicare and Medicaid compliance. 1. Resident number 1: The board that held the brown bags of masks were removed on 6/29/2020 and destroyed. 2. Any resident in gray zone will not have brown paper bags on the door of their room. 3. All direct care staff are now given a surgical mask at the beginning of their shift. They are to dispose of it at the end of the shift. For the Gray Zone, staff that are assigned, will be given an N-95 or KN-95 (deemed on availability). Staff who enter the Gray Zone will remove surgical mask and apply the N-95/KN-95. While in the room, the surgical mask will go into brown bag while wearing the N-95/KN-95. When completing cares then the N-95/KN-95 will be placed in the bag until the end of the shift and the bag and mask will be thorn away. Staff was educated of this process on June 29, 2020. 4. The Infection Preventest, Director of Nursing Services or designee will perform 5x's per week audits for 4 weeks to ensure that staff that enter the Gray Zone are wearing proper PPE, storing and deposing of PPE properly. Then 3x's per week times 4 weeks. Then 1 time per week for 4 weeks. The results of the audits will be presented monthly at QAPI to ensure compliance times 3 months.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285281	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND HEIGHTS	**207 SOUTH ENGDAHL AVENUE OAKLAND, NE 68045**

(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 3 board with nursing assistant A name on it. Placed dirty surgical mask in brown paper bag, and tacked back up on bulletin board with rest of brown paper bags. Nursing Assistant A performed hand hygiene with ABHR. C. An interview on 6/29/20 at 1:20pm with staff member Nursing Assistant A revealed, that staff have their names on the brown paper bags hanging outside of the Gray zone door with 2 surgical masks in each brown paper bag. D. An interview on 6/29/20 at 1:25pm with the DON (Director of Nursing) confirmed a potential for cross contamination due to putting a dirty mask with a clean mask in the same brown paper bag. DON confirmed the brown paper bags were not dated. DON reported that the facility started putting 2 masks in the brown paper bags on June 24, 2020. DON reported we were told we could put the 2 different face masks in the paper bags. DON confirmed no policy for reuse of surgical masks in same brown paper bag.	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
	285281	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND HEIGHTS	**207 SOUTH ENGDAHL AVENUE OAKLAND, NE 68045**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in compliance with the Emergency Preparedness tag at E0024.	E 000		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 16, 2020

Tiffany Shangreaux, Administrator
Oglala Sioux Lakota Nursing Home
7835 Elders Drive, State Highway 87
Rushville, NE 69360-5114

CMS CERTIFICATION NUMBER: 28E300

Dear Ms. Shangreaux:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 8, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285299	A. BUILDING _____ B. WING _____	C 06/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD CHENEY REHABILITATION	**5431 SOUTH 16TH STREET LINCOLN, NE 68512**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in compliance with the Emergency Preparedness tag at E0024.	E 000		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 16, 2020

Sara Bunting, Administrator
Old Cheney Rehabilitation
5431 South 16th Street
Lincoln, NE 68512 **CMS Certification No. 285299**

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 Old Cheney 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 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 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 July 31, 2020 which is 15 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.

- **Termination of Provider Agreement if Substantial Compliance is not Achieved:**

  Unless your facility achieves substantial compliance before December 11, 2020, CMS will terminate your facility's provider agreement in accordance with the statutory provisions at §1819(h)(2)(C) and §1919(h)(3)(D) and Federal regulations at 42 CFR §488.12 and §488.456. In accordance with 42 CFR 489.53(d) CMS will publish legal notice of your pending termination action on the CMS website fifteen (15) days prior to the effective termination date.

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)

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
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

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 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 Wright 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
	285299	A. BUILDING _____ B. WING _____	C 06/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD CHENEY REHABILITATION	**5431 SOUTH 16TH STREET LINCOLN, NE 68512**

(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=L	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		8/10/20

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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285299	A. BUILDING _____ B. WING _____	C 06/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD CHENEY REHABILITATION	**5431 SOUTH 16TH STREET LINCOLN, NE 68512**

(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 12-006.17A	F 880	Old Cheney Rehab Infection Control Abatement Plan	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285299	A. BUILDING _____ B. WING _____	C 06/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD CHENEY REHABILITATION	5431 SOUTH 16TH STREET LINCOLN, NE 68512

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observation, interview and record review, the facility failed to isolate and implement transmission based precautions for 72 residents admitted since March 6th 2020 with an unknown COVID -19 status. The resident sample reviewed was 7, with 5 residents admitted since March 6th, 2020. The facility also failed to screen 56 facility employees and agency staff as they came in the building and failed to assess 5 (staff members M, N, O, P and Q) staff members who exhibited signs or symptoms of COVID -19 and were allowed to remain at work at the facility with ongoing symptoms. This had the potential to affect all residents that resided in the facility. The census was 33. The findings are: Isolation / Transmission -based precautions: A. A review of CMS Memo QSO-20-14-NH, last revised on 3/13/20 revealed the following guidance for nursing homes: -"Nursing homes should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present. Also, if possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital. This can serve as a step-down unit where they remain for 14 days with no symptoms (instead of integrating as usual on short-term rehab floor, or returning to long-stay original room." B. A review of the facility's COVID-19 Infection Prevention and Control Policy and Procedures, last revised 5/13/20 and effective as of 6/2/20, revealed the following: "-Unless patient is already designated as	F 880	Plan Started Immediately on 6/10/2020 Abated on 6/10/2020 1. Immediate Action: Staff screening completed at door upon arrival to work. Point of Contact will screen staff as well as review screening tool to assure staff is safe to work with patients. If staff exhibit signs or symptoms of COVID-19, description must be documented on screening tool. Ask the individual if they have any of the following respiratory symptoms: cough, shortness of breath or difficulty breathing or at least 2 of the following symptoms: fever or chills, repeated shaking with chills, headache, new loss of taste or smell, diarrhea, congestion or runny nose, muscle or body aches, sore throat, nausea or vomiting or fatigue. If yes to any, ask individual if they have an alternative diagnosis that are causing symptoms. If no alternative diagnosis, restrict from entering patient areas. Any staff with signs or symptoms COVID-19, staff member will be assessed and sent home. Staff educated to come through front entrance and no longer utilize service door for entry. Started 6/10/2020. *Abatement Plan revised due to new guidelines 7/27/2020. 2. Immediate Action: Educate staff on entering building through front door upon arrival to work, importance of COVID-19 screen, abnormal temperatures related to COVID-19, transmission-based precautions, and pre-screening admissions for COVID-19 prior to actual admission. 3. Immediate Action: All patients	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285299	A. BUILDING _____ B. WING _____	C 06/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD CHENEY REHABILITATION	5431 SOUTH 16TH STREET LINCOLN, NE 68512

(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 3 laboratory tested COVID-19 negative by discharging institution, initiate quick and consistent triage of incoming patients per CDC evaluation guide to identify potential Persons Under Investigation). -5/4/20 update: Patients 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 them in Transmission-Based Precautions in a separate observation area or in a single room until 14 days have elapsed since admission." C. A review of Resident 3's medical record indicated Resident 3 was admitted to the facility on [redacted] from an acute hospital setting. Further review did not reveal Resident 3 was in isolation or on any transmission-based precautions. In an interview on 6/10/20 at 1:15 PM, Resident 3 reported being able to come out of (gender) room for therapy and to do visits at the front door of the facility with Resident 3's spouse. Resident 3 reported having to wear a mask in the hallway, but was otherwise not restricted from leaving (gender) room. Observations at this time did not reveal any signs for transmission-based precautions or PPE outside of Resident 3's room. D. A review of Resident 4's medical record indicated Resident 4 was admitted to the facility on [redacted] from an acute hospital setting. Further review did not reveal Resident 4 was in isolation or on any transmission-based precautions. In an interview on 6/10/20 at 2:50 PM, Resident 4 reported being able to come out of (gender) room	F 880	admitted regardless of a negative COVID screen will be placed in transmission (droplet) precautions for 14 days in designated gray zone or via ICAP recommendations. Started 6/10/2020 4. Contact ICAP/ICAR for zoning patients with unknown COVID-19 status. Will contact 6/11/2020 as it is 1840 currently on 6/10/2020. I have made contact with Susan Beach and now waiting to hear from the Infection Preventionist. 6/11/2020 Attached: " Point of Contact education on Screening of Employees and process with positive-screened employees " Education provided to Admission Personal on requirement of negative COVID-19 test or screening prior to admission " Education provided to staff on transmission-based precautions Quality Assurance of practice will be reviewed at QAPI meetings. 1. Random Audits of the staff and medical provider screening checklist will be completed 3 times per week for the next 60 days. DON or designee will audit completion and follow up. 2. Staff education will be completed on new staff members upon starting at Old Cheney Rehabilitation. 3. Resident admission system has been implemented beginning 6/10/2020 and will continue until new or further recommendations are issued via CMS	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285299	A. BUILDING _____ B. WING _____	C 06/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD CHENEY REHABILITATION	5431 SOUTH 16TH STREET LINCOLN, NE 68512

(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 for therapy with a mask on. Resident 4 also reported walking with therapy in the hallway since admission. Observations at this time did not reveal any signs for transmission-based precautions or PPE outside Resident 4's room. E. A review of Resident 2's medical record revealed Resident 2 was admitted to facility on [redacted] from an acute hospital setting. Further review did not reveal resident 2 was on any transmission-based precautions or placed in isolation for 14 days after admission. F. In an interview on 6/10/20 at 2:45 PM, Physical Therapist L reported therapy staff take new admissions to walk in the hallways of the facility if they are ambulatory and also for wheelchair training. Physical Therapist L stated both the therapist and resident wear a mask. G. In an interview on 6/10/20 at 2:00 PM, the DON (Director of Nursing), confirmed newly-admitted residents are not isolated or put on transmission-based precautions for 14 days after admission. The DON stated the facility relies on the hospital to do a COVID-19 test or screen upon discharge and the facility does a COVID screen upon admission and monitors temperatures. The Medical Director would make any recommendations as to if isolation was needed. H. A review of education done by DON with staff on 6/10/20 revealed the following: I. "If a patient is admitted without a negative COVID test, they must be placed in transmission-based precautions (If no systems are present the patient will be placed in contact	F 880	and/or CDC. 4. ICAP was contacted on 6/11/2020. Precautions via ICAP recommendations started on 6/11/2020. Any audits found out of compliance will be reviewed at QAPI meeting. DPOC will be completed on or before 8/14/2020. DPOC education will be attached in an additional document. DPOC education will go to current staff as well as contract agency staff.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285299	A. BUILDING _____ B. WING _____	C 06/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD CHENEY REHABILITATION	**5431 SOUTH 16TH STREET LINCOLN, NE 68512**

(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 precautions, each patient will be assessed individually if other precautions must be implemented) and are not to leave their room for any reason for 14 days, this includes therapy." J. A review of facility Admission/Discharge Report dated 6/10/20 revealed the facility admitted 72 residents from acute care hospitals 3/6/20 - 6/10/20. The facility indicated on the report that 13 of the 72 residents were tested for COVID-19 prior to discharge from the hospital. Staff Screening Process and Follow-Up K. A review of the facility's COVID-19 Infection Prevention and Control Policy and Procedures, last revised 5/13/20 and effective as of 6/2/20, revealed the following: "-Facility will conduct and record COVID-19 sign and symptom evaluations - including temperature checks - for all staff members. -1. Facility may utilize CDC -2. Conduct screenings at beginning of all employee shifts. -3. Actively take their temperature and document absence of COVID-19 indicative symptoms. -Fever is either measured temperature above 100.0 or subjective fever. Note that fever may be intermittent or may not be present in some individuals, such as those who are elderly, immunocompromised, or taking certain medications. Clinical judgement should be used to guide testing of individuals in such situations. Medical evaluation may be warranted for lower temperatures (below 100.0) or other symptoms (e.g., muscle aches, nausea, vomiting, diarrhea, abdominal pain, headache, runny nose, fatigue) based on assessment by authorized healthcare provider.	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
	285299	A. BUILDING _____ B. WING _____	C 06/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD CHENEY REHABILITATION	5431 SOUTH 16TH STREET LINCOLN, NE 68512

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6 -a. If employees present ill, have them keep their cloth face covering or facemask on and leave the workplace." L. In interviews on 6/10/20 at 8:46 AM and 11:15 AM, the DON (Director of Nursing) stated staff are screened upon arrival to facility for work. If staff have a temperature above 99.5, or symptoms of COVID-19, they are assessed by a nurse (utilizing a separate "Employee Health Questionnaire" form that is completed and signed by a nurse) and then sent home. Staff would always have a mask on during that time and cannot assess themselves. M. In an interview on 6/10/20 at 9:05 AM, the Administrative Assistant reported being at the door to screen visitors from 8:00 AM until 4:30 PM. The Administrative Assistant stated staff screen themselves in their offices or at the nurses' station in the center of the building for the nursing staff. The Administrative Assistant reported that a temperature above 100.5 would warrant getting a nurse for further evaluation and the nurse would decide if that person could come into the facility. N. Observations on 6/10/20 between 5:45 PM and 5:50 PM revealed LPN-R and RN-S walked through the front door of the facility and to the nurses' station in the center of the facility not wearing masks. LPN-R and RN-S put masks on at the nurses' station, took their own temperatures and screened themselves at the nurse's station. O. A review of staff screening logs revealed the following screenings of staff at beginning of shifts: -On 3/21/20 LPN-M answered "yes" to exhibited	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
	285299	A. BUILDING _____ B. WING _____	C 06/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD CHENEY REHABILITATION	5431 SOUTH 16TH STREET LINCOLN, NE 68512

(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	F 880		

signs of COVID-19 on screening questionnaire and had a temperature of 99.3.
-On 3/22/20 LPN-M answered "yes" to exhibited signs of COVID-19 on screening questionnaire.
-On 3/22/20 LPN-N had a temperature of 100.3.
-On 3/23/20 LPN-N answered "yes" to exhibited signs of COVID-19 on screening questionnaire and had a temperature of 99.3.
-On 3/24/20 LPN-N answered "yes" to exhibited signs of COVID-19 on screening questionnaire and had a temperature of 100.2.
-On 3/24/20 LPN-M answered "yes" to exhibited signs of COVID-19 on screening questionnaire.
-On 3/25/20 LPN-M answered "yes" to exhibited signs of COVID-19 on screening questionnaire.
-On 3/25/20 CNA-O answered "yes" to exhibited signs of COVID-19 on screening questionnaire and had a temperature of 99.3.
-On 3/26/20 CNA-O answered "yes" to exhibited signs of COVID-19 on screening questionnaire.
-On 3/27/20 CNA-O answered "yes" to exhibited signs of COVID-19 on screening questionnaire.
-On 3/29/20 Dietary Staff P answered "yes" to exhibited signs of COVID-19 on screening questionnaire and had a temperature of 99.9.
-On 3/29/20 RN-Q answered "yes" to exhibited signs of COVID-19 on screening questionnaire and had a temperature of 99.7.
-On 3/30/20 LPN-M answered "yes" to exhibited signs of COVID-19 on screening questionnaire and had a temperature of 99.8.
-On 3/31/20 LPN-M answered "yes" to exhibited signs of COVID-19 on screening questionnaire.
-On 5/10/20 CNA-O had a temperature of 100.1.
Further review of the staff screening logs revealed the above staff all screened themselves.

P. In an interview on 6/10/20 at 3:25 PM, the DON confirmed no follow-up was done for staff

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285299	A. BUILDING _____ B. WING _____	C 06/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD CHENEY REHABILITATION	5431 SOUTH 16TH STREET LINCOLN, NE 68512

(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 8 members LPN-M, LPN-N, CNA-O, Dietary Staff-P, or RN-Q when they presented to work with signs or symptoms of COVID-19. Isolation / Transmission -based precautions: Q. Observation on 8/10/20 at 9:50 AM revealed Resident 1 seated in the resident's room. There were no isolation or transmission based precautions in place for Resident 1 at the time of the observation. Interview on 6/10/20 at 9:50 AM with Resident 1 revealed that they had been admitted to the facility on [redacted] from the hospital. Resident 1 stated that the facility staff did not isolate or make [redacted] stay in the residents' room after admission and they could come and go about the facility as desired. The resident stated that they had participated in therapy in the therapy room after admission and wore a mask when out of the residents' room. Record review of Resident 1's admission tracking MDS dated 3/28/20 revealed that Resident 1 had been admitted on [redacted] from an acute care hospital. Review of Section O0100 of Resident 1's 5 day MDS (Minimum Data Set-a comprehensive assessment tool used to develop a resident's care plan) revealed no isolation or quarantine in place after admission. R. Observation on 8/10/20 at 2:50 PM revealed Resident 7 seated in the resident's room. There were no isolation or transmission based precautions in place for Resident 7 at the time of the observation. Interview on 6/10/20 at 2:50 PM with Resident 7 revealed that they had been recently admitted to	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
	285299	A. BUILDING _____ B. WING _____	C 06/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD CHENEY REHABILITATION	**5431 SOUTH 16TH STREET LINCOLN, NE 68512**

(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 9	F 880		

the facility on [redacted] from the hospital. Resident 7 stated that the facility staff did not isolate or make her stay in the residents' room after admission and they could come and go about the facility as desired. Resident 7 said they had been out of the room 3 times since admission, 2 times to the therapy room and 1 time to the vending machine. Resident 7 stated the staff made [gender] wear a mask when out of the residents' room.

Record review of Resident 7's admission tracking MDS dated 6/4/20 revealed that Resident 7 had been admitted on [redacted] from an acute care hospital.

Staff screening:

S. Interviews on 6/10/20 between 2:30 PM and 2:50 PM with the following staff revealed no consistent knowledge of the temperature required to report to a higher level for assessment of symptoms of COVID -19: The interviews revealed:
- Nurse Aide [NA] B stated the temperature required to report to upper management staff was 100.4.
- NA C stated the temperature required to report to upper management staff was 100.1.
- Licensed Practical Nurse [LPN] A stated the temperature required to report to upper management staff was 100.
- NA H stated the temperature required to report to upper management staff was 100.4.
- NA E stated the temperature required to report to upper management staff was 100.1
- LPN I stated the temperature required to report to upper management staff was 100.4.
- Registered Nurse [RN] J stated the temperature required to report to upper management staff was

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285299	A. BUILDING _____ B. WING _____	C 06/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD CHENEY REHABILITATION	**5431 SOUTH 16TH STREET LINCOLN, NE 68512**

(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 10 99.6. - RN G stated the temperature required to report to upper management staff was 100.4. An abatement by the facility was completed on 6/10/20 revealed; The facility plan started immediately on 6/10/2020 with the following: 1. Immediate Action: Staff screening completed at door upon arrival to work. Point of Contact will screen staff as well as review screening tool to assure staff is safe to work with patients. If staff exhibit signs or symptoms of COVID-19, description must be documented on screening tool. Any staff with signs or symptoms or have been directly exposed to COVID-19, staff member given a facemask and sent home immediately. All abnormal temperatures above 100.5 will be reviewed by a nurse on duty. Staff educated to come through front entrance and no longer utilize service door for entry. Started 6/10/2020. 2. Immediate Action: Educate staff on entering building through front door upon arrival to work, importance of COVID-19 screen, abnormal temperatures related to COVID-19, transmission-based precautions, and pre-screening admissions for COVID-19 prior to actual admission. 3. Immediate Action: All patients admitted regardless of a negative COVID screen will be placed in transmission (droplet) precautions for 14 days in designated gray zone or via ICAP recommendations. Started 6/10/2020 4. Contact ICAP/ICAR for zoning patients with	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
	285299	A. BUILDING _____ B. WING _____	C 06/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD CHENEY REHABILITATION	**5431 SOUTH 16TH STREET LINCOLN, NE 68512**

(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 11 unknown COVID-19 status. Will contact 6/11/2020 as it is 1840 currently on 6/10/2020. I have made contact with Susan Beach and now waiting to hear from the Infection Preventionist. 6/11/2020	F 880		

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 2, 2020

Michele Dein, Administrator
Old Mill Rehabilitation (omaha Tcu)
1131 Papillion Parkway
Omaha, NE 68154

CMS CERTIFICATION NUMBER: 285289

Dear Ms. Dein:

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

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

June 29, 2020

Cameron Farr, Administrator
Omaha Nursing And Rehabilitation Center
4835 South 49th Street
Omaha, NE 68117

CMS CERTIFICATION NUMBER: 285240

Dear Mr. Farr:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 16, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

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 Septer Administrative Contractor will be notified of the date the denial of payment begins. DPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated.

INFORMAL DISPUTE RESOLUTION (IDR)

You have one opportunity to dispute the deficiencies cited on the survey date through (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

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 July 14, 2020 survey, you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board (DAB). The appeal rights are set forth at 42 C.F.R. § 498.5 and the procedures for requesting a hearing are set forth at §498.40, et seq. You must file your hearing request electronically by using the DAB's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov/, unless you obtain a waiver from the DAB (*see* DAB Civil Remedies Division Procedures, § 6(a)(i)(1)). Your appeal must be filed no later than 60 days from the date of receipt of this letter.

We request that you provide an electronic copy of the request for appeal to: ROkcm
and to the CMS Regional Chief Counsel at:
OGCKansasCityGeneralInbox@hhs.gov

If you elect to dispute deficiencies through the Informal Dispute Resolution (IDR) process, this will not extend the 60 day period to file your appeal before the Departmental Appeals Board. Filing an appeal will not stop the imposition of any enforcement remedy.

If you experience problems with, or have questions about DAB e-File, please contact e-File System Support at OSDABImmediateOffice@hhs.gov. If you have questions about using the DAB e-file System, please visit: https://dab.efile.hhs.gov/appeals/to_crd_instructions?locale=en.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at QIO Program Website. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at Locate Your QIO.

CONTACT INFORMATION
If you have any questions please contact this office.

Sincerely,



Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

Enclosures: CMS 2567

Copies via e-mail to: CMS-RO
DHHS - State Medicaid Agency
DHHS - Nursing Support

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285240	A. BUILDING _____ B. WING _____	07/14/2020

PENDING ACKNOWLEDGEMENT

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OMAHA NURSING AND REHABILITATION CENTER	4835 SOUTH 49TH STREET OMAHA, NE 68117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in compliance with the Emergency Preparedness tag at E0024.	E 000		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/31/2020

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.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Kansas City Regional Office
601 East 12th Street, Room 355
Kansas City, Missouri 64106

MIDWEST DIVISION OF SURVEY AND CERTIFICATION

July 13, 2020

Linnea Detrick, Administrator
Papillion Manor
610 South Polk Street
Papillion, NE 68046

CMS Certification No: 285268

Dear Ms. Detrick:

SUBJECT: SURVEY RESULTS
Cycle Start Date: June 24, 2020

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES
The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-20-All*, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS
On June 24, 2020, the Centers for Medicare & Medicaid Services (CMS) completed a COVID-19 Focused Survey at Papillion Manor to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was in substantial compliance with participation requirements and no deficiencies were cited. The findings from this survey are documented on the enclosed form CMS 2567.

No additional action is required on the facility's part.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES
The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at QIO Program Website: https://qioprogram.org/covid-19. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at Locate Your QIO:

https://qioprogram.org/locate-your-qio.

CONTACT INFORMATION
If you have any questions please contact Lisa Hauptman, Principal Program Representative at (816) 426-2011.

Sincerely,

Lisa Hauptman

Lisa Hauptman
Long Term Care Branch
Survey & Operations Group
Center for Clinical Standards & Quality
CMS Kansas City

cc:
NE DHHS
Power/Grimes

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

August 14, 2020

Linnea Detrick, Administrator
Papillion Manor
610 South Polk Street
Papillion, NE 68046

CMS CERTIFICATION NUMBER: 285268

Dear Ms. Detrick:

This is to acknowledge the results of the Infection Control survey conducted at your facility on August 13, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 30, 2020

Robert Sheckler, Administrator
Park View Haven Nursing Home
309 North Madison Street
Coleridge, NE 68727-2602 **CMS Certification No. 285073**

Subject: Survey Results
Cycle Start Date: June 18, 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 18, 2020, a survey was completed at Park View Haven 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 August 9, 2020**, to the State Survey Agency Contact. **Failure to submit an acceptable PoC by August 9, 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.

- **Imposition of Denial of Payment for New Admissions (DPNA):**

  Payment will be denied for all NEW Medicare and Medicaid admissions, September 13, 2020 in accordance with the statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal regulations at 42 CFR §488.417. Your Medicare Administrative Contractor will be notified of the date the denial of payment begins. DPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated.

WITHDRAWAL OF APPROVAL FOR NURSE AIDE TRAINING PROGRAM

Please note that Federal law, as specified in the Social Security Act at §1819(f)(2)(B) and §1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs (NATCEP) and nurse aide competency evaluation programs (NACEP) offered by, or in, a facility which, within the previous two years, if one or more of the following exists:

- Operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse);
- Has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care;
- Has been assessed a total civil money penalty of not less than $10,697;
- Has been subject to a denial of payment;
- Appointment of a temporary manager;
- Terminated from participation, and/or
- In the case of an emergency, has been closed and/or had its residents transferred to other facilities.

INFORMAL DISPUTE RESOLUTION (IDR)

You have one opportunity to dispute the deficiencies cited on the survey date through (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Connie Vogt, RN, BSN
Email: dhhs.healthcarefacilities@Nebraska.gov
In the Subject Line of the email put: Request IDR

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

This request must be submitted within 10 days from the date of the enforcement letter. An incomplete Informal Dispute Resolution process will not delay the effective date of any enforcement action.

Informal Dispute Resolution is in no way to be construed as a formal evidentiary hearing. It is an informal internal process to review additional information submitted by the facility. You will be advised of our decision relative to the informal dispute.

APPEAL RIGHTS
If you disagree with the determination to impose remedies made on the basis of noncompliance identified at the June 18, 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

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285073	A. BUILDING _____ B. WING _____	06/18/2020

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW HAVEN NURSING HOME	309 NORTH MADISON STREET COLERIDGE, NE 68727

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility was not in compliance with Emergency Preparedness tag at E0024.	E 000		
E 024 SS=F	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by:	E 024		8/9/20

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
	285073	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW HAVEN NURSING HOME	309 NORTH MADISON STREET COLERIDGE, NE 68727

POC NOT FINAL

(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 024	Continued From page 1 Based on record review and interview, the facility failed to develop policies and procedures for ensuring sufficient staffing to meet the needs of the residents in the event of an emergency such as a COVID-19 outbreak. The total sample size was 4 and the facility census was 30. Findings are: Record review of the facility Emergency Preparedness Plan (undated) revealed the plan did not contain policies and procedures to ensure sufficient staffing in the case of staffing shortages related to a pandemic. Interview on 6/17/20 at 11:00 AM with the Director of Nursing confirmed that the Emergency Preparedness Plan did not contain policies and procedures to assure resident care needs were met if the facility faced staffing shortages related to a pandemic.	E 024	• The Director of Nursing or Designee is responsible for conducting daily assessment of staffing status and needs, and prioritizing critical and nonessential services based on resident's health and status, functional limitations, and disabilities essential to facility operations. • The Administrator/Director of Nursing and/or Designee will consult with the Medical Director and/or the State Health Department to determine the declaring of a facility "staffing crisis" to provide appropriate emergency staffing alternative. • The staffing plan includes strategies for collaborating with local agencies (i.e. Aventure Staffing, Helping Hands, Alliance Medical Staffing) to address widespread health care staffing shortage. • Daily Assignment Sheet is wrote up daily and hung outside of DON Office. o Contact our Facility Staff that is currently not working or those that are PRN status. o Northeast Nebraska Public Health Department: 402-375-2200 o Aventure Staffing: 712-224-2722 o Helping Hands: 712-560-4894 o Alliance Medical Staffing: 402-512-1392 Monitoring Process for the system change including frequency and title of the person responsible: Audits confirming the report of reportable events will be completed 3x a week for 4 weeks, 1x a week for 3 months, monthly thereafter. Results of the audits will be presented to QAPI team monthly during QAPI. Interdisciplinary	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285073	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW HAVEN NURSING HOME	309 NORTH MADISON STREET COLERIDGE, NE 68727

POC NOT FINAL

(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 024	Continued From page 2	E 024	Team will decide when it is appropriate to discontinue the audits. Audits will be completed by the DON or designee.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285073	A. BUILDING _____ B. WING _____	06/18/2020

PENDING ACKNOWLEDGEMENT

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW HAVEN NURSING HOME	309 NORTH MADISON STREET COLERIDGE, NE 68727

(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		8/9/20

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
	285073	A. BUILDING _____ B. WING _____	06/18/2020

PENDING ACKNOWLEDGEMENT

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW HAVEN NURSING HOME	309 NORTH MADISON STREET COLERIDGE, NE 68727

(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	Screening Residents • Temperature will be taken every day	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285073	A. BUILDING _____ B. WING _____	06/18/2020

PENDING ACKNOWLEDGEMENT

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW HAVEN NURSING HOME	309 NORTH MADISON STREET COLERIDGE, NE 68727

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observation, interview, and record view; the facility failed to ensure transmission-based precautions (the second tier of basic infection control and to be used in addition to Standard Precautions for patients who may be infected with certain infectious agents for which additional precautions are needed to prevent infection) were implemented for 2 (residents 2 and 3) of 3 residents with a potential exposure to COVID-19 (a highly contagious virus primarily spread from person to person through respiratory droplets, which can lead to serious illness and even death). The sample size was 4 and the facility census was 30. 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 (Center for Disease Control) website for information and resources. Per the CDC, prompt detection, triage, and isolation of potentially infectious residents are essential to prevent unnecessary exposures among residents and healthcare personnel; -restriction of all visitors and non-essential healthcare personnel except for certain end of life situations; -if possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital where they would remain for 14 days with no symptoms; and -remind residents to practice social distancing.	F 880	and night shift and logged into PCC. • For a temperature that is 100 or above recheck with Tympanic thermometer • If temperature remains at 100 or above quarantine resident and contact PCP and medical director. • Residents will be monitored for s/s of Covid-19 and symptoms will be documented in PCC. • Notify ADMIN and DON of increased temperature. Resident's Leaving Facility • Resident's who frequently leave facility for medically necessary purposes (i.e. Dialysis, chemo, Ortho follow up appointments, etc) will be required to wear a mask in facility when not in their room when in dining room eating so long as social distancing is being practiced. • Residents who leave facility occasionally will be allowed to cohort as long as there is a six-foot distance from roommate. The resident who has gone out and is cohorting, is required to wear a mask if no within a six-foot distance of roommate. • All residents occasionally leaving the facility will be allowed to go out of room to dining room but must wear a mask while walking in halls, into and out of the dining room for 14 days. • Residents who leave facility frequently will not be allowed to cohort with a roommate and must wear a mask at all times when out of room except for in the dining room while eating so long as social distancing is being practiced.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285073	A. BUILDING _____ B. WING _____	06/18/2020

PENDING ACKNOWLEDGEMENT

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW HAVEN NURSING HOME	309 NORTH MADISON STREET COLERIDGE, NE 68727

(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 3 B. Review of The CMS Center for Clinical Standards and Quality, Safety and Oversight Group dated 4/24/20 revealed the following guidance for infection control and prevention of Coronavirus Disease 2019 (COVID-19); -the facility should consider the necessity of appointments outside of the facility to the resident's health, whether it is critical for the resident to attend; -if attending the appointment is necessary, the facility should help arrange for the resident to attend the appointment by taking precautions to minimize the risk of transmission of COVID-19; and -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 the observation of asymptomatic residents). C. Review of Resident 2's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 5/29/20 revealed [redacted] Review of the resident's Nursing Progress Notes revealed the following: -3/25/20 at 3:53 PM the resident returned from [redacted] in spouse's vehicle; -3/27/20 at 3:50 PM the resident returned from [redacted] in spouse's personal vehicle; -3/30/20 at 3:50 PM the resident returned to the facility via spouse's vehicle; -3/31/20 at 8:45 AM the resident left the facility for [redacted] in the spouse's vehicle; -4/3/20 at 4:00 PM the resident returned from an appointment per family vehicle;	F 880	• Resident's will wear a mask upon leaving facility, at appointment and when returning to facility. • Resident's temperatures will be taken and s/s of Covid-19 will be monitored two times a day per facility protocol. Infection Prevention & Control RE: Resident #2 • Resident is being taken and picked up from all appointments via facility vehicle and facility staff. Resident is wearing at mask at all times. Per Chemo and Dialysis infection protocol resident if provided with a new mask upon entering and the mask that was being wore prior to entering is given back to her when leaving. • Resident wears a mask at all times other than when she is in her room or in the DR eating with social distancing being followed. • Resident's roommate was moved to another room on 7-2-2020 so this resident is the only person in her room. • F880- 1 door to the dining room is closed with a CN (Charge Nurse) or CNA (Certified Nursing Assistant) monitoring the door way to ensure social distancing is being followed as they enter and exit dining room. • F880- Chairs across from Nurses Station have been removed. X marks placed on the floor to ensure that social distancing is being followed. • F880- If residents are not social distancing (i.e. playing cards in a group of	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285073	A. BUILDING _____ B. WING _____	06/18/2020

PENDING ACKNOWLEDGEMENT

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW HAVEN NURSING HOME	309 NORTH MADISON STREET COLERIDGE, NE 68727

(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 -4/8/20 at 4:08 PM the resident returned from an appointment with spouse; -4/10/20 at 3:15 PM the resident returned to the facility per spouse's personal vehicle; -4/13/20 at 9:00 AM the resident left the facility for an appointment with spouse; -4/17/20 at 3:25 PM the resident returned from an appointment with spouse; -4/21/20 at 8:15 AM the resident left for a [redacted] appointment and was transported and accompanied by spouse; -4/22/20 at 6:00 PM the resident returned from [redacted] with spouse; -5/6/20 at 3:50 PM the resident returned from [redacted] appointment with spouse; -5/25/20 at 8:10 AM the resident left the facility with spouse for [redacted] appointment; -5/26/20 at 5:44 PM the resident returned from [redacted] accompanied by spouse; -5/27/20 at 3:55 PM the resident returned from [redacted] with spouse; -6/2/20 at 2:20 PM the resident returned from a [redacted] appointment via spouse's personal vehicle; and -6/3/20 at 4:57 PM resident returned from [redacted] with spouse. Observation of Resident 2's room on 6/17/20 at 09:08 AM revealed the resident was in a shared room with another resident. There was no signage in or around the doorway and there was also no isolation equipment in or around the resident's doorway to indicate the resident needed transmission-based precautions. D. Observations on 6/17/20 from 9:00 AM to 9:30 AM revealed the following: -3 residents attempted to exit the facility dining room through the same corridor access. The	F 880	4) each resident wears a mask. • F880- Specific markers are placed in areas of congestion (across from Nurses Station and in front lobby) to ensure residents are social distancing. • New admission/readmission will be quarantined for 14 days in private room if possible. Regardless of Covid-19 test results from acute care facility. • Temp will be monitored every day and night shift documented in PCC. • Will be monitored for symptoms of Covid-19 (i.e. cough, sore throat, congestion, temp greater than 100 degrees F.) Appendix 1: Daily Monitoring of Employee Screening for Covid-19 screening will be completed by the day time Charge Nurse at 0900 AM after all first shift employees are screened. The Charge Nurse will monitor the screening log again at 1600 and 1900 after all second shift employees have been screened. Monitoring Process for the system change including frequency and title of the person responsible: Audits confirming the report of reportable events will be completed 3x a week for 4 weeks, 1x a week for 3 months, monthly thereafter. Results of the audits will be presented to QAPI team monthly during QAPI. IDT will decide when it is appropriate to discontinue the audits. Audits will be completed by the	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285073	A. BUILDING _____ B. WING _____	06/18/2020

PENDING ACKNOWLEDGEMENT

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW HAVEN NURSING HOME	309 NORTH MADISON STREET COLERIDGE, NE 68727

(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 residents were directly next to each other and were not 6 feet apart. None of the residents were wearing a mask. Several staff passed by the residents and no cues were provided to assure social distancing; -2 residents were seated in chairs across from the Nurses Station. Residents were not 6 feet apart and were not wearing masks; and -3 residents were seated in wheelchairs in the front lobby area by the television. The residents were not maintaining a social distance and were not wearing masks. E. During an interview on 6/17/20 at 10:30 AM the Director of Nursing (DON) confirmed the following: -Resident 2 was never placed in transmission-based precautions despite frequent appointments outside of the facility for [redacted] even though the resident had an increased risk for exposure to COVID-19; -the resident's spouse does take the resident to frequent appointments despite the facility's restriction on visitors; -residents do not maintain social distancing when exiting the dining room or when positioned by the Nurse's Station; -residents do not wear masks; and -staff do not provide encouragement for residents to maintain social distancing or to wear a mask when out of their rooms. F. Review of Resident 3's MDS dated 6/9/20	F 880	DON or designee. --Training on the 5 COVID Training policies (Sparkling Surfaces, Clean Hands, Closely Monitor Residents, Keep COVID-19 Out, Lessons) per recommendation of State completed on: 07/17/2020	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285073	A. BUILDING _____ B. WING _____	06/18/2020

PENDING ACKNOWLEDGEMENT

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW HAVEN NURSING HOME	309 NORTH MADISON STREET COLERIDGE, NE 68727

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6 revealed diagnoses of [redacted]. The resident was admitted to the facility on [redacted] from the hospital. During an interview on 6/17/20 at 11:30 AM the DON confirmed Resident 3 had not been placed in isolation or quarantine since being admitted from the hospital on [redacted]	F 880		

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 22, 2020

Lucas Kaup, Administrator
Parkside Manor
P O Box 350, 607 North Main Street
Stuart, NE 68780-0350

CMS CERTIFICATION NUMBER: 285245

Dear Mr. Kaup:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 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

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 2, 2020

Miranda Isernhagen, Administrator
Parkview Haven Nursing Home
P O Box 667, 1203 4th Street
Deshler, NE 68340-0667

CMS CERTIFICATION NUMBER: 285261

Dear Ms. Isernhagen:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 15, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 8, 2020

Lori Franzluebbers, Administrator
Parkview Home, Inc.
930 2nd Street
Dodge, NE 68633-3555 **CMS Certification No. 285243**

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 Parkview Home, Inc. by the State Survey Agency to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the CMS 2567 and will be posted on the ePOC system.

PLAN OF CORRECTION

A Plan of Correction (PoC) for the deficiencies must be submitted **by July 18, 2020**, to the State Survey Agency Contact. **Failure to submit an acceptable PoC by July 18, 2020 may result in the imposition of additional remedies.**

The PoC must contain the following:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of the quality assurance being implemented, the earliest correction date will be the date of the revisit; and
5. Include dates when corrective action will be completed. **The corrective action completion dates must be written in the completion date column within acceptable time frames.** If the PoC is unacceptable for any reason, you will be notified in writing by this office. If the PoC is acceptable, you will be notified via ePOC. Please note that the facility is ultimately accountable for compliance, and that responsibility is not alleviated in cases where notification regarding the acceptability of the facility's PoC is not made timely. **The PoC will serve as the facility's allegation of compliance.**

ENFORCEMENT REMEDIES

Based on the Statement of Deficiencies (Form CMS-2567), the following remedies are imposed:

- **Directed Plan of Correction:**

  In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction is imposed on the facility. In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. The effective date is not a deadline for completion of the DPOC. However, the State Agency will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice.

  Training option(s) which are the most appropriate for the type of noncompliance cited. For examp

  Sparkling Surfaces - https://youtu.be/t7OH8ORr5Ig
  Clean Hands - https://youtu.be/xmYMUly7qiE
  Closely Monitor Residents - https://youtu.be/1ZbT1Njv6xA
  Keep COVID-19 Out! - https://youtu.be/7srwrF9MGdw
  Lessons - https://youtu.be/YYTATw9yav4

  Please send all documentation to the State Agency at the following:

Connie Vogt, RN, BSN

Email: dhhs.healthcarefacilities@Nebraska.gov

In the Subject Line please put: DPOC

For states participating in the ePOC program, the DPOC may be added as an attachment.

Please note, if documentation includes any resident personal identifiable information (PII) or personal health information (PHI) it must be sent encrypted.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies, within 10 days after receipt of the Form CMS 2567. Please see the attached instructions (DPOC attachment) for detailed guidance.

- **Imposition of Denial of Payment for New Admissions (DPNA):**

Payment will be denied for all NEW Medicare and Medicaid admissions, beginning August 8, 2020 in accordance with the statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal facility achieves substantial compliance or your provider agreement is terminated.

INFORMAL DISPUTE RESOLUTION (IDR)

You have one opportunity to dispute the deficiencies cited on the survey date through (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Connie Vogt, RN, BSN
Email: dhhs.healthcarefacilities@Nebraska.gov
In the Subject Line please type: Request IDR

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by

counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

This request must be submitted within 10 days from the date of the enforcement letter. An incomplete Informal Dispute Resolution process will not delay the effective date of any enforcement action.

Informal Dispute Resolution is in no way to be construed as a formal evidentiary hearing. It is an informal internal process to review additional information submitted by the facility. You will be advised of our decision relative to the informal dispute.

APPEAL RIGHTS

If you disagree with the determination to impose remedies made on the basis of noncompliance identified at the 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 Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

Enclosures: CMS 2567

Copies via e-mail to: CMS-RO
DHHS - State Medicaid Agency
DHHS - Nursing Support

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

August 12, 2020

Krystyn Turman, Administrator
Pioneer Manor Nursing Home
P O Box 310, 318 N 3rd Street
Hay Springs, NE 69347

CMS CERTIFICATION NUMBER: 285212

Dear Ms. Turman:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 13, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 20, 2020

Nicole Hoffmann, Administrator
Pioneer Memorial Community Hospital
P O Box 578, 206 Nw 4th Street
Mullen, NE 69152 **CMS Certification No. 28E175**

Subject: Survey Results
Cycle Start Date: July 13, 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 13, 2020, a survey was completed at Pioneer Memorial Community Hospital 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 30, 2020**, to the State Survey Agency Contact. **Failure to submit an acceptable PoC by July 30, 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, September 3, 2020 in accordance with the statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal regulations at 42 CFR §488.417. Your Medicare Administrative Contractor will be notified of the date the denial of payment begins. DPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated.

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 13, 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

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28E175	A. BUILDING _____ B. WING _____	07/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MEMORIAL COMMUNITY HOSPITAL	P O BOX 578, 206 NW 4TH STREET MULLEN, NE 69152

(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		7/31/20

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/23/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28E175	A. BUILDING _____ B. WING _____	07/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MEMORIAL COMMUNITY HOSPITAL	P O BOX 578, 206 NW 4TH STREET MULLEN, NE 69152

(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 12-006.17D	F 880	Survey date: 7/13/2020	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28E175	A. BUILDING _____ B. WING _____	07/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MEMORIAL COMMUNITY HOSPITAL	P O BOX 578, 206 NW 4TH STREET MULLEN, NE 69152

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observations, interviews, and record reviews, the facility failed to comply with regulations and recommendations to control the COVID 19 virus by failure to: 1) ensure staff were pre-screened by another individual upon entry to begin their duties; 2) ensure residents were separated by a minimum of six feet during meal service. Facility census was 23. The failure could potentially result in the spread of COVID 19 which could affect all facility residents. Findings are: A. Interviews with direct care staff (Nurse Aides-A, B, and C) on 7/13/2020 at 10:30 a.m. revealed the three staff members explained the facility process for screening staff members when coming on duty. Nurse Aides A, B, and C stated when they come to work, they fill out a questionnaire and take their temperatures at the nurse's station. When asked who performs the temperature checks, Nurse Aides A, B, and C all stated they self screen. Record review of CMS (Centers for Medicare and Medicaid Services) memorandum QSO-20-30-NH dated 5/18/2020 (a memorandum to provide recommendations for State and local officials to prevent the transmission of COVID-19) revealed facilities in Phase 1 status (highest level of vigilance) instructions to screen all persons entering the facility and all staff at the beginning of each shift. This screening process included temperature checks, completing a questionnaire, and "Observation of any signs or symptoms". Interview with the facility Administrator on 7/13/2020 at 1:00 p.m. verified staff coming on	F 880	STATEMENT OF COMPLIANCE: this Plan of Correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. 7/31/2020 F880 Infection Prevention and Control A. CORRECTION TO RESIDENT AFFECTED: Surveyors met with staff and the administrator to discuss the staff COVID-19 screening process. The surveyors found that staff have been self-screening, including taking their own temperatures. It was discussed that this practice could fail to identify symptoms or provide accuracy of the temperatures taken. The staff screening station was promptly moved downstairs by the time clock and staff members were told to take each other□s temperatures and screen each other for symptoms upon entry of the building on the east or northeast sides. 7/13/2020 SYSTEM CHANGES (IDENTIFICATION AND CORRECTION FOR OTHER RESIDENTS POTENTIALLY AFFECTED): The screening station was moved away from the resident area in the facility. Staff members have been told to enter the building through the east or northeast entrances, and to take each other□s temperatures and screen each other for symptoms. Administrator will monitor staff	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28E175	A. BUILDING _____ B. WING _____	07/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MEMORIAL COMMUNITY HOSPITAL	P O BOX 578, 206 NW 4TH STREET MULLEN, NE 69152

(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 3 duty were self-screening. Further discussion with the Administrator revealed that persons self screening would have the potential for failing to identify symptoms or accuracy of the temperatures taken and that another staff member should be performing the screening to ensure the accuracy of the information and an observation of staff symptoms upon entry. B. Interview with RN (Registered Nurse)-D on 7/13/2020 at 10:15 a.m. revealed RN-D was working as the facility's charge nurse. During the interview, RN-D was asked about COVID-19 restrictions pertaining to facility procedures with dining. RN-D stated all residents but 2 come to the dining room for communal dining during all meals. RN-D stated the facility policy was for residents to "social distance" during meal times. Observation of the noon meal on 7/13/2020 at 12 noon revealed residents were escorted or came to the dining room independently and were seated at tables. Further observation revealed 9 tables with 2 residents at each table sitting on opposite ends of the table. One table had 3 residents seated, 2 on opposite ends and 1 in the middle. Two residents received room trays. Following the meal, observation and measurement of the distance between residents seated at the 9 tables across from one another measured 4 floor tiles. Measurement of the floor tiles each tile was 12 inches or one foot. The distance between residents during the meal service at these tables was 4 feet. Measurement of the distance between residents at the table with three residents revealed a distance of 3 feet between the residents seated at	F 880	screening station and make sure screening is being completed between staff members, instead of self-screening. Communication will be kept active between departments as well. 7/23/2020 MONITORING PROCESS FOR THE SYSTEM CHANGE INCLUDING FREQUENCY AND PERSON RESPONSIBLE: Updates and continued communication regarding the staff screening station will be brought to QAPI and monthly administrative meetings by the administrator as needed. 8/6/2020 Administrator and department heads will continue to listen to weekly webinars by the state and other organizations to keep up on the latest guidelines for staff screening. 8/6/2020 B. CORRECTION TO RESIDENT AFFECTED: Surveyors met with nursing staff and administrator to discuss distance between residents during meals. It was found that residents were 3-4 feet apart during meals, instead of the recommended 6 feet. The tables were promptly measured and different tables were brought in to accommodate the 6 foot recommendation. 7/13/2020 SYSTEM CHANGES (IDENTIFICATION AND CORRECTION FOR OTHER RESIDENTS POTENTIALLY AFFECTED):	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28E175	A. BUILDING _____ B. WING _____	07/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MEMORIAL COMMUNITY HOSPITAL	P O BOX 578, 206 NW 4TH STREET MULLEN, NE 69152

(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 this table. Record review of facility electronic document entitled "Facility Billitens" revealed a 7/10/2020 bulliten which read: "Revert to Phase 1: due to an increase in local COVID cases, we are reverting back to Phase 1 of our reopening plan. This includes: . . . Activities and dining will be conducted 6 feet apart . . ." Record review of the CMS memorandum QSO-20-30-NH dated 5/18/2020 revealed facilities in Phase 1 status instructions revealed for "Communal Dining (for COVID-19 negative or asymptomatic residents only) but residents may eat in the same room with social distancing (limited number of people at tables and spaced by at least 6 feet).	F 880	Larger tables were brought in to ensure that 6 feet were between residents at meals. Administration, nursing staff, dietary staff and housekeeping will continue to monitor these distances at mealtimes as necessary. 7/23/2020 MONITORING PROCESS FOR THE SYSTEM CHANGE INCLUDING FREQUENCY AND PERSON RESPONSIBLE: Updates and additional communication will be brought to administrative meetings and QAPI meetings by administration and environmental services as necessary. 8/6/2020 Administrator and department heads will continue to listen to weekly webinars by the state and other organizations to keep up on the latest recommended guidelines for dining. 8/6/2020	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28E175	A. BUILDING _____ B. WING _____	07/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MEMORIAL COMMUNITY HOSPITAL	P O BOX 578, 206 NW 4TH STREET MULLEN, NE 69152

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in compliance with the Emergency Preparedness tag at E0024.	E 000		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/23/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285273	A. BUILDING _____ B. WING _____	07/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW MANOR	**P O BOX 219, 101 HARPER STREET PLAINVIEW, NE 68769**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 7/17/20. The facility was found to not be in compliance with 42 CFR 483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. A determination was made that the facility's noncompliance with one or more of the requirements of participation placed all residents in immediate jeopardy. On 7/16/20 at 11am, the Administrator was notified of the immediate jeopardy at F880 Infection Prevention and Control. Survey Date: 7/15-7/17/20 The facility census was: 36	F 000		
F 880 SS=L	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:	F 880		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285273	A. BUILDING _____ B. WING _____	07/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW MANOR	**P O BOX 219, 101 HARPER STREET PLAINVIEW, NE 68769**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 1 §483.80(a)(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: (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	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
	285273	A. BUILDING _____ B. WING _____	07/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW MANOR	**P O BOX 219, 101 HARPER STREET PLAINVIEW, NE 68769**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 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: Based on observation, interview, and document review, the facility failed to protect all residents in the facility by not following acceptable infection control practice recommendations for COVID-19 from the Centers for Disease Control (CDC) and the Centers for Medicare and Medicaid (CMS) Services. The facility failed to have a screening system in place to ensure all staff and visitors who entered the facility were screened for signs and symptoms of COVID-19 prior to having contact or providing care to the residents. Specifically, a staff screening station was set up at the nurse's station next to the time clock. Staff entered the facility from two separate entrances of the facility and both entrances required staff to either pass by resident rooms or resident common areas prior to being screened for signs and symptoms of COVID-19. The screening form used for staff did not collect all the required screening information to monitor for COVID-19 signs, symptoms, and/or exposure. Once at the nurses' station, staff were instructed to conduct a self-assessment of their temperature, use hand sanitizer, obtain a mask and clock in for their shift. The facility had a screening station set up at	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
	285273	A. BUILDING _____ B. WING _____	07/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW MANOR	**P O BOX 219, 101 HARPER STREET PLAINVIEW, NE 68769**

(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 3 the front entrance of the facility for visitors to self-screen themselves by assessing their temperature prior to entering into resident care areas or having contact with any of the residents. Documentation showed the visitors temperatures were assessed upon entrance to the facility or at the nurses' station. This deficient practice placed all 36 residents at risk for contracting COVID-19 and resulted in Immediate Jeopardy (IJ). The IJ was determined to have started on 3/11/20 with the failure to adequately screen the staff and visitors for sign and symptoms of COVID-19. As a result of the identified non-compliance, the Administrator was notified on 7/16/20 at 11am of the Immediate Jeopardy (IJ). The facility submitted an acceptable plan and the IJ was removed on 7/17/20 after verification of implementation of the removal plan. The deficient practice remained at a level "F". Findings include: Professional References Review of CMS, Center for Clinical Standards and Quality, Safety and Oversight (QSO) Memo 20-14-NH, dated 3/13/20, provided guidance to long term care facilities which included screening 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 ill, have them self-isolate at home. Facilities should actively screen and restrict visitation by those who meet the following criteria:	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
	285273	A. BUILDING _____ B. WING _____	07/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW MANOR	**P O BOX 219, 101 HARPER STREET PLAINVIEW, NE 68769**

(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 Signs and symptoms of respiratory infection, such as fever, cough shortness of breath, or sore throat. In the last 14 days, has had contact with someone with a confirmed diagnosis of COVID-19, or under investigation for COVID-19, or are ill with a respiratory illness. International travel within the last 14 days to countries with sustained community transmission. Residing in a community where community-based spread of COVID-19 is occurring. Review of the CDC's Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings, dated 3/13/20, showed the following: -Screen all healthcare professionals (HCP) at the beginning of their shift for fever and symptoms consistent with COVID-19. If they are ill, have them keep their facemask on and leave the workplace. -Fever is either measured temperature >100.0 degrees Fahrenheit or subjective fever. Respiratory symptoms consistent with COVID-19 are cough, shortness of breath and sore throat. - Screen visitors for fever and symptoms consistent with COVID-19, or known exposure to someone with COVID-19. Restrict anyone with fever, symptoms, or known exposure from entering the facility. Facility Policy Review of the facility's COVID Pandemic/Infection Control Emergency plan dated 6/18/20 showed the following: - "All visitors would be screened upon entry of the facility (Screening: temperature taken and COVID questionnaire asked)."	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
	285273	A. BUILDING _____ B. WING _____	07/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW MANOR	**P O BOX 219, 101 HARPER STREET PLAINVIEW, NE 68769**

(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 -"Staff will take their own temperature upon arrival for their shift at the nurse's station and log it into the time clock binder by the time clock. Staff were to also log temperature upon completion of their shift. Staff would also answer COVID questions of having a fever greater than 100.4 degrees Fahrenheit, a cough, shortness of breath or difficulty breathing, any travel in the past fourteen days to regions affected by COVID-19 or a hot spot, or been in close contact with anyone who has a confirmed COVID-19 diagnosis." Observations During a tour of the facility on 7/15/20 with the facility Administrator, she identified that all staff entered the facility through the "front door" and went to the nurses' station to screen themselves for signs and symptoms of COVID-19. She stated staff were responsible to screen themselves, with the charge nurse providing oversight. She stated that if they had any signs or symptoms of COVID-19, they were to report to the charge nurse. The Administrator identified that she was responsible to ensure all staff and visitors were screened for signs and symptoms of COVID-19. Observation on 7/15/20 showed when staff entered the front door of the facility, they proceeded approximately 25 feet to the nurses' station by the time clock. Observation on 7/15/20 showed when staff entered the facility from the "back" door they proceeded past a resident room before reaching the COVID-19 screening station located at the corner of the nurses' station by the time clock. Observation on 7/15/20 at 1:25pm showed a staff member standing at the corner of the nurses'	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
	285273	A. BUILDING _____ B. WING _____	07/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW MANOR	**P O BOX 219, 101 HARPER STREET PLAINVIEW, NE 68769**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6 station in the area identified as the screening station for staff to screen themselves for signs and symptoms of COVID-19, which was next to the time clock. The staff person was assessing her temperature and completing the assessment form for signs and symptoms of COVID-19. An unidentified resident was sitting in a wheelchair less than 2 feet from the staff person. The resident was not wearing a mask. Observations made on 7/15/20 between 10am and 3pm showed residents in hallways and common areas of the facility with no face coverings on. Interviews During an interview on 7/15/20 at 11:51am, Nurse Aide (NA) 1, stated she enters the facility through the front door, goes to the time clock at the nurses' station, takes her temperature, and puts a mask on and clocks in for her shift. During an interview on 7/15/20 at 12:02pm, NA2 stated she enters the facility through the front door, goes to the time clock at the nurses' station, checks and records her temperature. She stated the facility just started using a new form which now included a section for answering "yes" or "no" to signs to some symptoms of COVID-19. During an interview on 7/15/20 at 12:10pm, NA3 stated he enters the facility through the front door, puts a mask on, uses hand sanitizer and proceeds to the nurses' station to check and document his temperature and clock in for his shift. He stated a few weeks ago the facility initiated a new form to assess for signs and symptoms of COVID-19 which included sore throat and cough.	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
	285273	A. BUILDING _____ B. WING _____	07/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW MANOR	**P O BOX 219, 101 HARPER STREET PLAINVIEW, NE 68769**

(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 During an interview on 7/15/20 at 12:18pm, NA4 stated she also worked in the Assisted Living facility located within the Skilled Nursing Facility. She stated she enters the facility through the front door, washes her hands, takes her temperature and clocks in at the time clock which is located at the nurses' station. She stated the facility recently updated the COVID-19 screening form to include if they have experienced any symptoms of COVID-19. During an interview on 7/15/20 at 12:45pm, Housekeeper (HK1), stated she works two additional jobs besides her job at the facility. She stated she works as a bartender in a bar in a neighboring town and as a waitress at a local restaurant. She stated she worked at the restaurant about a week ago but the restaurant had since changed to carry out only. She stated she was not going to work at the bar anymore due to hearing there were positive COVID-19 cases in that community. She stated she comes in the front door of the facility, goes to the time-clock, puts a mask on, checks and documents her temperature. She stated the facility updated the assessment form a couple of weeks ago to include a section which asked about some signs and symptoms of COVID-19. During an interview on 7/15/20 at 12:50pm, HK2 stated she enters the facility through the basement, and then went to the nurses' station to complete the assessment form for signs and symptoms of COVID-19 which included her name, the date, the time and what her temperature was. She said she completes this form at the beginning and the end of her shift. She stated a couple of weeks ago the facility	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
	285273	A. BUILDING _____ B. WING _____	07/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW MANOR	**P O BOX 219, 101 HARPER STREET PLAINVIEW, NE 68769**

(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 8 added a section to the form which included some symptoms of COVID-19 that she had to check "yes" or "no" on. During an interview on 7/15/20 at 1:20pm, Dietary staff (DS1) stated she enters the facility through the front door but most of the other dietary staff enter the facility through the "back door." She stated after she enters the facility she goes to the nurses' station to screen herself for COVID-19. She stated she would take her temperature and document it in the book, put a mask on and clock in for her shift. Document Review Review of the facility's COVID-19 screening assessment form for staff, initiated on 3/16/20, showed the form contained a section to identify the date, time, employee name and what their temperature reading was at the beginning and the end of their shift. There was no other information on the form showing staff were actively screened for signs and symptoms of COVID-19 prior to having contact and providing care to the residents. Review showed the form was utilized from March 16 until July 2, 2020. The facility failed to actively screen all staff for signs and symptoms of COVID-19 from March 16th until July 2, 2020. On July 2, 2020 the form was updated to include a section which staff were supposed to answer "yes" or "no" if they had had any shortness of breath, change in cough or sore throat (not related to allergies). On July 9, 2020 the form was updated and identified if staff had answered "yes" to any of the COVID-19 shortness of breath, change in cough or sore throat, they were directed to complete an additional form and to see the nurse for additional screening.	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
	285273	A. BUILDING _____ B. WING _____	07/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW MANOR	**P O BOX 219, 101 HARPER STREET PLAINVIEW, NE 68769**

(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 9 The facility failed to update the screening form to ensure that staff were actively screened for all signs and symptoms of COVID-19 which included: shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, congestion or runny nose, nausea or vomiting, diarrhea, if they had been in contact with someone with a confirmed diagnosis of COVID-19 or under investigation for COVID-19, traveled to countries with sustained community transmission or resided in a community where community based spread of COVID-19 was occurring. Review of an employee document provided by the Administrator on 7/15/20 showed 3 employees who were also working at another long term care facility, had been tested for COVID-19 due to staff in the other facility testing positive for COVID-19. Review of the visitor sign in book showed 284 visitors entered the facility between March 11 and June 27, 2020. The book contained the date and time the visitor entered and exited the facility. Review showed 270 of the visitors during this time frame had a temperature documented, with some of those temperature assessments being obtained at the nurses' station and 14 visitors had no temperature assessment or active screening for signs and symptoms of COVID-19. There was no other information on the form showing visitors who entered the facility were actively screened for signs and symptoms of COVID-19 prior to entering resident care area and/or providing care to the residents. Interviews	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
	285273	A. BUILDING _____ B. WING _____	07/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW MANOR	**P O BOX 219, 101 HARPER STREET PLAINVIEW, NE 68769**

(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 10 During an interview on 7/15/20 at 10:30am, the Administrator stated the facility had been shut down since March 11, 2020 and had only allowed Hospice nurses, aides, and Chaplin, contracted therapy staff and 2 family members of any Hospice resident who was considered to be at the end of life, and essential vendors into the facility. They were to enter through the front entrance and conduct an assessment on themselves prior to entering resident care areas. During an interview on 7/15/20 at 1:38pm, the Director of Nursing (DON) stated that staff were screened for COVID-19 at the nurses' station but the Infection Control Nurse could provide better answers regarding the facility's staff and visitor screening process. During an interview on 7/15/20 at 1:42pm, the Infection Control Nurse (ICN) stated screening for signs and symptoms of COVID-19 was conducted at the nurses' station. She stated the form that was utilized for the screening had been "a work in progress." She stated between March 16th and July 2, 2020, the expectation was that the charge nurse would contact her if staff had any signs or symptoms of COVID-19 when reporting for work. She stated that she thought it was very important to assess staff and visitors for signs and symptoms of COVID-19.	F 880		

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
CMS Kansas City - Survey & Operations Group
601 East 12th Street, Room 355
Kansas City, Missouri 64106

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 31, 2020

Juleen Johnson, Administrator
Plainview Manor
P O Box 219, 101 Harper Street
Plainview, NE 68769-0219

CMS Certification No: 285273

Subject: Survey Results
Cycle Start Date: July 17, 2020

Dear Ms. Johnson,

COVID-19 FOCUSED INFECTION CONTROL SURVEY

The Secretary of the U.S. Department of Health and Human Services (DHHS) has the duty and responsibility to protect the health, safety, welfare and rights of Medicare/Medicaid beneficiaries. The Secretary has delegated authority to administer and provide oversight of the Medicare program to Centers for Medicare & Medicaid Services (CMS).
The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-31-All, CMS and the State Survey Agency are conducting unannounced onsite surveys at certain Medicare certified provider and supplier types.
SURVEY RESULTS
On July 17, 2020, a survey was completed at Plainview Manor by CMS to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance and the conditions in the facility constituted immediate jeopardy to resident health and safety. The findings from this survey are documented on the enclosed form CMS 2567.

PLAN OF CORRECTION

A Plan of Correction (PoC) for the deficiencies must be submitted within ten (10) calendar days of your receipt of this notice. Use the space provided to the right of each item of deficiency to type your PoC and the expected date of completion. A PoC must be entered for each item clearly identifying HOW, WHAT, WHEN, AND WHERE it was or will be corrected. The plan should also include provisions instituted to prevent reoccurrence. The

PoC must contain the following:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of the quality assurance being implemented, the earliest correction date will be the date of the revisit; and
- Include dates when corrective action will be completed. The corrective action completion dates must be written in the completion date column within acceptable time frames. If the PoC is unacceptable for any reason, you will be notified in writing by this office. If the PoC is acceptable, you will be notified via telephone, e-mail, etc. Please note that the facility is ultimately accountable for compliance, and that responsibility is not alleviated in cases where notification regarding the acceptability of the facility's PoC is not made timely. The PoC will serve as the facility's allegation of compliance.

You must send this office the original, signed and dated Statement of Deficiencies (SoD) with the PoC to:

Marilyn Mihalovich, Nurse Consultant
Marilyn.Mihalovich@cms.hhs.gov

ENFORCEMENT REMEDIES
Based on the Statement of Deficiencies (Form CMS-2567), the following remedies are imposed:

Civil Money Penalty (CMP):

In determining the amount of the Federal Civil Money Penalty (CMP) that we are imposing, we have considered your facility's history, including any repeated deficiencies; and the factors specified in the Federal requirement at 42 CFR § 488.404. Additionally, CMS issued new CMP policies for infection control deficiencies in Quality, Safety & Oversight Group Memorandum QSO 20-31-ALL, effective June 1, 2020. We are imposing the following CMP in accordance with these policies:

- A per day Federal Civil Money Penalty in the amount of $15,310.00 beginning July 15, 2020 for the deficiency described at the Federal citation, F0880 -- S/S: L -- 483.80(a)(1)(2)(4)(e)(f) - Infection Prevention & Control.

As a result of the removal of the IJ, the CMP accrued through July 16, 2020. The CMP was reduced to $415.00 per day effective July 17, 2020 and will continue until you have made the necessary corrections to achieve substantial compliance with the participation requirements or your provider agreement is terminated. If the seriousness or scope of the deficiencies change, the amount of the CMP may be increased or decreased.

Directed Plan of Correction:
In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction (DPOC) is imposed on the facility. In accordance with 42 CFR § 488.402(f), this remedy is

effective August 15, 2020. The DPOC may be completed before or after that date. The effective date is not a deadline for completion of the DPOC. However, CMS will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice.
The DPOC requires that your plan of correction include the following:

- The Infection Preventionist and Director of Nursing, in conjunction with the Medical Director, and senior leadership/Governing Body concurrence, shall complete the following:

  - Develop and implement procedures to utilize an at-the-door symptom check for all visitors, vendors and others before entering the facility.
  - Develop and implement procedures for screening all staff at the beginning of their shift for fever and respiratory symptoms before they enter areas accessible to residents. This will include actively measuring and recording staff temperatures and assessment of shortness of breath, new or changed cough, and sore throat. Screening logs will be maintained and signed by the staff member who conducts the screening.

- A Root Cause Analysis (RCA) of the deficient practices cited, conducted with assistance from the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee and Governing Body. The RCA should be incorporated into the intervention plan. Information regarding RCAs can be found at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies, within 10 days after receipt of the Form CMS 2567.

Please send all documentation to CMS at the following:
Marilyn Mihalovich, Nurse Consultant
Marilyn.Mihalovich@cms.hhs.gov

Please note, if documentation includes any resident personal identifiable information (PII) or personal health information (PHI) it must be sent encrypted.
Imposition of Denial of Payment for New Admissions (DPNA):
Payment will be denied for all NEW Medicare and Medicaid admissions, beginning August 15, 2020, in accordance with the statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal regulations at 42 CFR §488.417. Your Medicare Administrative Contractor will be notified of the date the denial of payment begins. DPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated.
FINANCIAL HARDSHIP
If you believe your facility's financial condition lacks the ability to support the amount of the CMP, you can request a financial hardship review. For CMS to consider whether payment of the CMP would create a financial hardship and allow your request for installment payments, the following documents should be submitted to this office (kevin.wright@cms.hhs.gov) within fifteen (15) days from the receipt of this notice:

- Written, dated request specifying the reason financial hardship is alleged.
- Brief summary listing the supporting documents being submitted (if all documents cannot be included please provide rationale as to why).
- Organizational chart with an explanation/description concerning the related entities. If there is a Parent Company, provide names and addresses (please indicate in your written request if you have a Parent company).
- The following financial statements for the Provider and the Parent Company (of note, we need consolidated financials for the Parent Company and complete financials for the subsidiary (not by facility)):

- Current Balance sheet (segregated by CURRENT assets and liabilities);
- Current Income statement or Statement of Operations or Profit and Loss Statement (has to include NET INCOME);
- Current Statement of Cash Flows (to include the total change in cash flow);
- Most recent, full-year audited financial statements prepared by an independent accounting firm (including footnotes). If audited financial statements are not available, most recent tax returns may be substituted;
- Most recent full-year audited financial statements of the home office and/or related entities (including footnotes). If audited financial statements are not available, most recent tax returns may be substituted;
- Schedule showing amounts due to/from related companies, or individuals, included in the balance sheets. The schedule should list the names of related organizations, or persons, and indicate where the amounts appear on the balance sheet (e.g., Accounts Receivable, Notes Receivable, etc.);
- Copy of tax returns for the preceding two years;
- Disclosure of expenses and amounts paid/accrued to the home office and/or related entities;
- Documentation of any/all financing arrangements including mortgages, long term debt, and lines of credit;
- If the nursing home requests an extended payment schedule of more than twelve (12) months duration, the provider must submit a letter from a financial institution denying the provider's loan request for the amount of the CMP (requests for extended payment schedules are reviewed based on financial need).

Knowingly and willfully sending false or fraudulent information, or concealing materials of fact, can lead to penalties under 18 U.S.C. §§ 1001, 1035 and 1516.

INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with §488.431, when a civil money penalty (CMP) is imposed and is subject to being collected and placed in an escrow account, you have one opportunity to question cited deficiencies through an Independent Informal Dispute Resolution (IIDR) process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of substandard quality of care (SQC) or IJ. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing the deficiencies, including the scope and severity assessments of deficiencies which have been found to constitute SQC or IJ) to:

CDR Marsophia R. Powers, Long Term Care Branch Manager
Email: marsophia.powers@cms.hhs.gov

This request must be sent within 10 calendar days of receipt of this notice. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

WITHDRAWAL OF APPROVAL FOR NURSE AIDE TRAINING PROGRAM

Please note that Federal law, as specified in the Social Security Act at §1819(f)(2)(B) and §1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs (NATCEP) and nurse aide competency evaluation programs (NACEP) offered by, or in, a facility in which, within the previous two years, one or more of the following exists:

- Operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse);
- Has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care;
- Has been assessed a total civil money penalty of not less than $10,697;
- Has been subject to a denial of payment;
- Appointment of a temporary manager;

- Terminated from participation, and/or
- In the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Your facility will receive further information regarding this from the State Agency.

APPEAL RIGHTS
The following remedies are being imposed:
- CMP
- Directed Plan of Correction
- DPNA

If you disagree with this action imposed on your facility, you or your legal representative are required to file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/. To file a new appeal using DAB E-File, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.
The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:
Clicking the File New Appeal link on the Manage Existing Appeals screen, then clicking Civil Remedies Division on the File New Appeal screen. Entering and uploading the requested information and documents on the "File New Appeal- Civil Remedies Division" form.
At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. The DAB will set the location for the hearing. Counsel may represent you at a hearing at your own expense.
All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions for using DAB E-File in cases before the DAB's Civil Remedies Division can be found by clicking the button marked E-Filing Instructions after logging-in to DAB E-File.
For questions regarding the E-Filing system, please contact E-File System Support at OSDABImmediateOffice@hhs.gov.
Please note that all hearing requests must be filed electronically unless you have no access to the internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. Such a request should be made to:
Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division

330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201
A request for a hearing must be filed no later than 60 days from the date of receipt of this notice.
A copy of the hearing request shall be submitted electronically to:
kevin.wright@cms.hhs.gov

WAIVER
If you would like to waive your right to a hearing, you must do so in writing to this office (kevin.wright@cms.hhs.gov) within 60 calendar days of the date of the notice of imposition. If you waive your right to a hearing in accordance with the requirements specified at 42 CFR 488.436, the amount of the CMP will be reduced by 35 percent. After you submit a timely written waiver of your right to a hearing, CMS will send you a letter with instructions on how to remit the adjusted amount of the CMP.
If you believe you have achieved substantial compliance, you should contact the CMS RO. In addition, if substantial compliance has not been achieved within six (6) months after the last date of the survey identifying noncompliance, July 17, 2020, we will terminate your Medicare provider agreement effective January 17, 2021.
QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES
The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at QIO Program Website: https://qioprogram.org/covid-19. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at Locate Your QIO: https://qioprogram.org/locate-your-qio

CONTACT INFORMATION
Thank you for the time and courtesy extended to our surveyors during the survey. If you have any questions regarding the survey, please contact Marilyn Mihalovich, Nurse Consultant. For questions regarding enforcement, Kevin Wright, Health Insurance Specialist. Both can be reached in our Kansas City Regional Office at (816) 426-2011.

Sincerely,

CDR Marsophia R. Powers
Long Term Care Branch Manager
Survey & Operations Group
Center for Clinical Standards & Quality

CMS Kansas City

Enclosures
CMS 2567

Copies via e-mail to:
NE DHHS
Powers/Grimes/Mihalovich
OGC
WPS

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285273	A. BUILDING _____ B. WING _____	07/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW MANOR	**P O BOX 219, 101 HARPER STREET PLAINVIEW, NE 68769**

(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 Centers for Medicare & Medicaid Services (CMS) on 7/17/20. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6).	E 000		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 23, 2020

Keith Sladky, Administrator
Plum Creek Care Center
1505 North Adams Street
Lexington, NE 68850

CMS CERTIFICATION NUMBER: 285159

Dear Mr. Sladky:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 15, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

June 29, 2020

Lora Sullivan, Administrator
Ponderosa Villa
P O Box 526, First & Paddock Street
Crawford, NE 69339-0526

CMS CERTIFICATION NUMBER: 285250

Dear Ms. Sullivan:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 15, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285166	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ESTATES OF KENESAW, LLC	**P O BOX 10, 100 WEST ELM AVENUE KENESAW, NE 68956**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS References to Title 175 of the Nebraska Administrative Code, Chapter 12- "Regulations Governing Licensure of Skilled Nursing Facilities, Nursing Facilities, and Intermediate Care Facilities" have been included in survey report as they apply to deficient practices identified.	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		7/24/20

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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285166	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ESTATES OF KENESAW, LLC	**P O BOX 10, 100 WEST ELM AVENUE KENESAW, NE 68956**

(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 12-006.17D	F 880	F880 Resident #8 was assessed by the	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285166	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ESTATES OF KENESAW, LLC	P O BOX 10, 100 WEST ELM AVENUE KENESAW, NE 68956

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observation, record review, and interview 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) prior to putting on disposable gloves and after removing disposable gloves to prevent the potential for cross contamination and Covid-19. This had the potential to affect 5 residents (Residents 12, 11, 8, 9, and 10). The facility census was 48. Findings are: Record review of the undated facility document titled Handwashing Audit revealed that staff are to wash hands between glove changes. Observation on 7/6/20 at 9:07 AM revealed that Medication Aide-C (MA-C) did not perform hand hygiene and put on disposable gloves. MA-C then put on a gown and entered the room of Resident 12. Observation on 7/6/20 at 9:20 AM revealed that Licensed Practical Nurse-D (LPN-D) returned to the medication cart from the room of Resident 15. LPN-D did not perform hand hygiene. LPN-D put on disposable gloves. LPN-D wiped the blood pressure cuff with a disinfectant wipe. LPN-D removed the gloves and performed hand hygiene with ABHR. Observation on 7/6/20 at 9:48 AM revealed that MA-C sat a tray of food items on top of the PPE cart outside the room of Resident 12. MA-C did not perform hand hygiene and put on disposable	F 880	licensed nurse 7/24/2020 for signs and symptoms of infection from testing of blood sugar or injection of insulin with no change in condition noted. LPN was re-educated by DON on 7/17/2020 related the requirements of hand hygiene before and after donning and doffing gloves. Resident # 9 was assessed by the licensed nurse by 7/24/2020 for signs and symptoms of infection from testing of blood sugar or injection of insulin with no change in condition noted. LPN was re-educated by DON on 7/17/2020 related to the requirements of hand hygiene before and after donning and doffing gloves. Resident #10 was assessed by the licensed nurse by 7/24/2020 for signs and symptoms of infection from testing of blood sugar or injection of insulin with no change in condition noted. LPN was re-educated by DON on 7/17/2020 related to the requirements of hand hygiene before and after donning and doffing gloves. Resident #11 was assessed by the licensed nurse by7/24/2020 for signs and symptoms of infection with no change in condition noted. Therapy Director was re-educated by DON on 7/17/2020 related to the requirements of hand hygiene before and after donning and doffing PPE. Resident # 12 was assessed by the licensed nurse by7/24/2020 for signs and symptoms of gastrointestinal infection with no change in condition noted. MA-C was re-educated by DON on 7/17/2020 related to the requirements of hand hygiene before and after donning and doffing PPE.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285166	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ESTATES OF KENESAW, LLC	P O BOX 10, 100 WEST ELM AVENUE KENESAW, NE 68956

(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 3 gloves. MA-C put on a gown to enter the resident's room. Observation on 7/6/20 at 9:58 AM revealed that MA-C exited the room of Resident 12 (a resident new to the facility under isolation precautions) and removed the face shield. MA-C wiped off the face shield with a Sani Cloth disinfectant wipe and removed the disposable gloves. MA-C put the face shield back on. No hand hygiene was performed. Observation on 7/6/20 at 9:58 AM revealed that the facility Therapy Director (TD) put on a gown outside the room of Resident 11. TD did not perform hand hygiene and put on disposable gloves and entered Resident 11's room. Observation on 7/6/20 at 11:29 revealed that Licensed Practical Nurse-E (LPN-E) stood at the treatment cart outside of the room of Resident 8. LPN-E entered Resident 8's room with the [redacted] and obtained the [redacted] for the resident. LPN-E exited the resident's room and discarded the lancet (a small sterile blade used to obtain a small amount of blood for testing) into the sharps disposal container. LPN-E removed the right glove and wiped the [redacted] with a Micro Kill One disinfectant wipe and wrapped the [redacted] in the wipe. LPN-E used the computer mouse to document the [redacted] results in the resident's electronic health medical record. LPN-E removed the left glove and did not perform hand hygiene and put on disposable gloves. LPN-E administered the ordered [redacted] to Resident 8. LPN-E removed the disposable	F 880	MA that cleaned her shield without gloves and who did not preform hand hygiene when she was done was re-educated by DON on 7/17/2020 related to the requirements of hand hygiene and glove use when cleaning equipment. 2. An observational audit will be completed by the DON or designee on or 7/24/2020 related to hand hygiene to ensure staff are completing hand hygiene as required including before and after donning/doffing PPE. Staff will be required to wash hands before applying gloves and after removing gloves for cares including don/doff of isolation PPE, treatments/blood sugars, using and cleaning equipment, and personal cares requiring gloves use for infection control/prevention purposes. 3. The DON or designee will re-educate nursing staff by 7/24/2020 on infection control practices related to hand hygiene for glove use during cares. Care areas to include but not limited to don/doff of isolation PPE; treatments/blood sugars; using and cleaning equipment; and personal cares requiring glove use for infection control/prevention purposes. Directive POC: Facility staff and contract staff will watch the video “Clean Hands and Keep COVID-19 Out” on YouTube by 7/24/20. Nursing staff will complete hand washing competency by 7/24/20. Staff member (part time, PRN or vacation) that do not complete the video or hand washing competency by 7/24/20, will be required to complete prior to the beginning of their next scheduled shift. 4. DON/designee will complete	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285166	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ESTATES OF KENESAW, LLC	P O BOX 10, 100 WEST ELM AVENUE KENESAW, NE 68956

(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 gloves at the treatment cart. LPN-E performed hand hygiene with ABHR. LPN-E pushed the treatment cart to the room of Resident 9. LPN-E did not perform hand hygiene and put on disposable gloves. LPN-E obtained a [redacted] for Resident 9. LPN-E exited the resident's room and wiped the [redacted] with a disinfectant wipe and wrapped the [redacted] in the wipe. LPN-E removed the disposable gloves and did not perform hand hygiene. LPN-E put on disposable gloves. LPN-E administered the ordered [redacted] to Resident 9. LPN-E removed the disposable gloves and performed hand hygiene with ABHR. LPN-E pushed the treatment cart to the room of Resident 10. LPN-E did not perform hand hygiene and put on disposable gloves. LPN-E obtained a [redacted] for Resident 10. LPN-E exited the resident's room and wiped the [redacted] with a disinfectant wipe and wrapped the [redacted] in the wipe. LPN-E removed the disposable gloves. LPN-E did not perform hand hygiene and put on disposable gloves. LPN-E administered the ordered [redacted] to Resident 10. LPN-E removed the right glove. LPN wrapped the [redacted] with a disinfectant wipe. LPN-E removed the left glove and performed hand hygiene with ABHR. Record review of the facility policy titled Infection Prevention dated 11/2016 revealed that Handwashing is the single most important procedure for preventing facility acquired infections. Hands must be washed after the following, including, but not limited to: o Contact with blood/body fluids o Contact with contaminated items or surfaces o Contact with resident/patient o Initiating a clean procedure o Removal of gloves	F 880	observational audits twice weekly for 4 weeks, weekly for 8 weeks to ensure staff continue to complete hand hygiene as required, including before and after donning/doffing PPE. Results of audits will be presented to the QAPI committee monthly for 3 months for review and recommendation as needed. The DON is responsible for monitoring and following up as needed. Date of compliance: 7/24/2020	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285166	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ESTATES OF KENESAW, LLC	P O BOX 10, 100 WEST ELM AVENUE KENESAW, NE 68956

(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 Record review of the facility policy titled Infection Control Manual Infection Prevention dated 03/2015 revealed Standard Precautions Procedure: Handwashing 1. Wash hands after touching the following whether or not gloves are worn: o Blood o Body fluids o Contaminated items o Excretions o Secretions 2. Wash hands promptly: o After gloves are removed o Between resident/patient contact o As indicated to avoid transfer of microorganisms to other resident/patient or environments o Between tasks and procedures on the same resident/patient to prevent cross-contamination of different body sites. Record review of the undated facility policy titled [redacted] Cleaning and Disinfecting revealed the section titled Hand hygiene and gloves: o Wear gloves during [redacted] and during any other procedure that involves potential exposure to blood or bodily fluids. o CHANGE gloves between patients AND perform hand hygiene. ALWAYS perform hand hygiene before putting on gloves. o PERFORM hand hygiene immediately after removal of gloves and before touching other medical supplies intended for multi-patients use including [redacted] Record review of the facility policy titled Infection	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
	285166	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ESTATES OF KENESAW, LLC	**P O BOX 10, 100 WEST ELM AVENUE KENESAW, NE 68956**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6 Control Manual Equipment dated 03/2015 revealed that the facility will appropriately care for resident/patient care equipment and supplies to prevent them from becoming sources of infection. All used equipment and supplies are considered contaminated with potentially infectious material and will be cleaned and disinfected or sterilized as applicable before use with another resident/patient. Interview on 7/7/20 at 3:52 PM with the facility Director of Nursing (DON) confirmed that hand hygiene with sanitizer or hand washing is to be performed by staff between glove changes including before putting gloves on and after removing gloves.	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
	285166	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ESTATES OF KENESAW, LLC	**P O BOX 10, 100 WEST ELM AVENUE KENESAW, NE 68956**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in compliance with the Emergency Preparedness tag at E0024.	E 000		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

August 20, 2020

Ms. Kristin Arrowsmith-Skiles, Administrator
Premier Estates Of Kenesaw, Llc
P O Box 10, 100 West Elm Avenue
Kenesaw, NE 68956

Dear Ms. Arrowsmith-Skiles:

We would like to place your facility back into compliance for the July 7, 2020 survey, however, in order to do that we need you to provide written evidence that shows that you have completed all corrective actions outlined in your Plan of Correction (POC). These examples could be, but are not limited to, new policies and procedures, attendance sign in sheets for education, invoices showing supplies ordered or completed, audits as outlined in the POC, etc. Failure to provide this information may impact your provider agreement with CMS.

Please email the requested information to **dhhs.healthcarefacilities@nebraska.gov** by August 25, 2020.

If you have any questions, please contact this office at the number listed below.

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

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 2, 2020

Kristin Arrowsmith-Skiles, Administrator
Premier Estates Of Pawnee, Llc
P O Box 513, 438 12th Street
Pawnee City, NE 68420-0513

CMS CERTIFICATION NUMBER: 285157

Dear Ms. Arrowsmith-Skiles:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 23, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 27, 2020

Christian Koenig, Administrator
Premier Estates Of Pierce, Llc
P O Box 189, 515 East Main Street
Pierce, NE 68767-0189

CMS CERTIFICATION NUMBER: 285139

Dear Mr. Koenig:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 22, 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
	285104	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE CARE CENTER OF PLATTSMOUTH	602 SOUTH 18TH STREET PLATTSMOUTH, NE 68048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in compliance with the Emergency Preparedness tag at E0024.	E 000		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

June 26, 2020

Chasity Coover, Administrator
Prestige Care Center Of Nebraska City
1420 North 10th Street
Nebraska City, NE 68410

CMS CERTIFICATION NUMBER:
285109

Dear Ms. Coover:

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

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285104	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE CARE CENTER OF PLATTSMOUTH	602 SOUTH 18TH STREET PLATTSMOUTH, NE 68048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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		8/21/20

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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285104	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE CARE CENTER OF PLATTSMOUTH	602 SOUTH 18TH STREET PLATTSMOUTH, NE 68048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 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	1.Immediate action(s) taken for the resident(s) or team members found to	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285104	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE CARE CENTER OF PLATTSMOUTH	602 SOUTH 18TH STREET PLATTSMOUTH, NE 68048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observation, interview and record review; the facility failed to implement infection control practices and Centers for Medicare and Medicaid Services (CMS) guidelines to prevent potential cross contamination including the spread of COVID-19 related to failing to verify screening results for facility employees, failure to ensure the screening sheets contained full staff identifying information including first and last names and titles, failed to report potential symptoms of illness and failed to wear the required Personal Protective Equipment during care for 1 (Resident 2) of 3 sampled residents. The facility failure had the potentail to affect all residents in the building. The facility identified a census of 78. Findings are: A. A record review of the Covid-19 Sign-In Sheet (CSIS, a screening tool for Covid-19 symptoms and exposure) dated 6-28-20 for Employee I, revealed a temperature of 92.6 degrees F. Further review of the CSIS for Employee I revealed there was no evidence of a follow up evaluation prior to allowing Employee I to work. B. A record review of the CSIS dated 6-28-20 for Employee J, revealed a temperature of 92.2 degrees F. Further review of the CSIS for Employee J revealed there was no evidence of a follow up evaluation prior to allowing Employee J to work. C.A record review of the CSIS dated 6-29-20 for Employee K, revealed a temperature of 93.3 degrees F. Further review of the CSIS for	F 880	have been affected include: The CDM immediately in-serviced on the proper COVID-19 reporting, sent home and tested for COIVD-19 □ Negative results Immediately COVID-19 sign-in sheet updated and reviewed. Immediately staff educated on zones and PPE. On 6/29/2020 upon notification of the deficient practice, the Admin/Designee immediately visually observed and instructed all staff to ensure N95 are worn covering the nose to ensure consistent implementation of proper infection prevention and control practices for the prevention of the communicable diseases. 2.Identification of other residents having the potential to be affected was accomplished by: On 6/29/2020 the Admin/Designee identified that the failed practice had the potential to affect all residents that resided at the facility. To ensure the failed practice does not recur, on 6/29/2020 the Admin/Designee immediately conducted documented in-service/education with all staff members to ensure PPE all times to ensure consistent implementation of proper infection prevention and control practices for the prevention of COVID-19 and/or other communicable diseases. 3.Root Cause Analysis: Our complete IDT team members including the Administrator, Director of	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285104	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE CARE CENTER OF PLATTSMOUTH	602 SOUTH 18TH STREET PLATTSMOUTH, NE 68048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 3 Employee K revealed there was no evidence of a follow up evaluation prior to allowing Employee K to work. D.A record review of the CSIS dated 6-29-20 for Employee L, revealed a temperature of 94.8 degrees F. Further review of the CSIS for Employee L revealed there was no evidence of a follow up evaluation prior to allowing Employee L to work. E.A record review of the CSIS dated 6-29-20 for Employee M, revealed a temperature of 94.0 degrees F. Further review of the CSIS for Employee M revealed there was no evidence of a follow up evaluation prior to allowing Employee M to work. F.A record review of the CSIS dated 6-29-20 for Employee N, revealed a temperature of 93.9 degrees F. Further review of the CSIS for Employee N revealed there was no evidence of a follow up evaluation prior to allowing Employee N to work. G.A record review of the CSIS dated 6-29-20 for Employee O, revealed a temperature of 92.4 degrees F. Further review of the CSIS for Employee O revealed there was no evidence of a follow up evaluation prior to allowing Employee O to work. H.A record review of the CSIS sheets dated 6/25/20 through 6/29/20 revealed 52 additional occurrences of temperatures below 96.0 that had been documented with no evidence of a follow up evaluation prior to allowing employees to work. I.On 6/29/20 at 4:11 P.M. an interview was	F 880	Nursing, Physician, Infection Control Preventionist, Asst. Director of Nursing, MDS, Environmental Services Director, Dietary Director, Social Services Director, Business Office Manager, HR Director, Activities Director, and Housekeeping Supervisor met to determine the root cause analysis of the deficient practice with the following findings:From interviews and observation, we found that staff would forget to put N95 in gray zone. Staff being noncompliant with infection control guidelines for PPE. Team increased observation rounds education up to disciplinary action conducted on any/all negative findings. Quality Assurance PIP implemented and ongoing monitoring until compliance is achieved. 4.Actions taken/systems put into place to reduce the risk of future occurrence include: The facility took the following actions to prevent an adverse outcome from reoccurring. Completion Date: 8/21/2020 All applicable facility policies and procedures Prestige Care Center of Plattsmouth were reviewed/revised according to CDC recommendations. Education was provided to all housekeeping and nursing staff regarding applicable facility policies and procedures Tentative Plan, Zones and PPE, identification of COVID-19 illness, transmission-based precautions, and	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285104	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE CARE CENTER OF PLATTSMOUTH	602 SOUTH 18TH STREET PLATTSMOUTH, NE 68048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 4 conducted with the facility Administrator. During the interview, a review of the CSIS sheets for Employees I, J, K, L, M, N and O dated 6/28/20 and 6/29/20 was completed. The facility Administrator confirmed there should have been follow up evaluations regarding employee temperatures and was not. J. Record review of the DSM Covid 19 sign in sheet dated 6-29-2020 at 11:25 AM revealed the DSM did not have a new or worsening cough. On 6-29-2020 at 1:05 PM an observation of the facility staff providing the lunch meal revealed the facility Dietary Services Manager (DSM) had a surgical mask on. The DSM started coughing in a hard deep manor exited through the kitchen. On 6-29-2020 at 1:08 PM an interview was conducted with the DSM. During the interview when asked 3 times if the cough was new, the DSM stated "yes". During the interview the DSM confirmed a possible sign or symptom of COVID 19 was a new or worsening cough. When asked what should have happened, the DSM reported the facility Administrator should have been notified and was not. On 6-29-2020 at 1:40 PM a follow up interview was conducted with the DSM. During the interview the DSM confirmed the cough was new. K. A record review of facility policy titled "Zones and PPE (personal protective equipment refers to protective clothing, gloves, goggles, facemasks designed to protect the wearer from spread of infection)" indicated that the policy was implemented on 6/22/20. The policy identified a "Gray Zone" (Transitional zone) for residents being transferred from the hospital/outside	F 880	hand hygiene. Education was provided to all housekeeping staff on cleaning high-touch areas such as light switches, call lights, doorknobs, and toilets/sinks to ensure sanitary conditions. All licensed and non-licensed nursing, housekeeping, and laundry staff will be in-serviced on the facility□s policy Infection Control. The Administrator hired an outside consultant to improve the facility□s infection control program within the facility. The Staff Development Coordinator or designee will oversee infection prevention and control education for all new hires. The employee COVID-19 sign-in sheet was restructured. Any symptoms will be called directly to the Administrator or designee. Education to all team members regarding proper PPE per CDC guidelines. Cleanable surface education signs placed in residents□ room or bathroom, for PPE reference guide Competency fair conducted on 8/4/2020 for PPE practice Education to the entire facility team members as follows:	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285104	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE CARE CENTER OF PLATTSMOUTH	602 SOUTH 18TH STREET PLATTSMOUTH, NE 68048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 5 facilities or homes but have no known exposure to COVID -19 are admitted to the Gray Zone. All staff who enter resident rooms in the Gray Zone are to wear the following PPE: gown, gloves, eye protection (face shield) and N95 masks a disposable respirator that is intended to filter particles out of the air you breathe). Observation on 6/29/20 at 12:20 PM revealed that Resident 2 resided in the facility Gray Zone. Observation on 6/29/2020 at 12:25PM revealed Employee Q entered Resident 2's room in the Gray Zone with the lunch tray wearing a surgical mask instead of an N95 mask. Interview on 6/29/2020 at 1: 10 PM with Employee Q revealed that surgical masks were the only masks available to staff. Observation on 6/29/2020 at 1:45 PM revealed Employee P took a mug of water into Resident 2's room wearing only a surgical mask for PPE. Interview on 6/29/2020 at 12:50 PM with Employee P revealed that all employees took a surgical mask at the beginning of their shift and no N95 masks were provided.	F 880	Sparkling Surfaces - https://youtu.be/t7OH8ORr5Ig Clean Hands - https://youtu.be/xmYMUly7qiE Closely Monitor Residents - https://youtu.be/1ZbT1Njv6xA Keep COVID-19 Out! - https://youtu.be/7srwrF9MGdw Lessons - https://youtu.be/YYTATw9yav4 COVID-19- sign in education, all personal have been notified to contact administrator or designee with any sign or systems prior to entering. Doors remain locked until further notice. 5.How the corrective action(s) will be monitored to ensure the practice will not recur: The Infection Preventionist or designee is monitoring the 24□COVID-19 report to ensure that any resident/guest/team members with signs and symptoms of COVID-19 is immediately placed on transmission-based precautions or not allowed into the facility. Monitoring will continue daily for 3 months. The DON or designee will randomly monitor hand hygiene practices amongst staff 3 times a week for 1 month and then weekly for 3 months. The DON or designee will do daily observation rounds for PPE for 3 months, then weekly for 1 month. The Administrator implemented a QAPI PIP to gather and process information	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285104	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE CARE CENTER OF PLATTSMOUTH	602 SOUTH 18TH STREET PLATTSMOUTH, NE 68048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6	F 880	from the audits/monitoring processes. Findings will be reported at the monthly QAA meeting for a minimum of 3 months. DON/Designee will present any negative findings for monthly review and recommendations to the QAPI committee.	

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 14, 2020

Chasity Coover, Administrator
Prestige Care Center Of Plattsmouth
602 South 18th Street
Plattsmouth, NE 68048 **CMS Certification No. 285104**

Subject: **Survey Results**
Cycle Start Date: June 29, 2020

Dear Administrator,

UNANNOUNCED COVID-19 SURVEY

The Secretary of the U.S. Department of Health and Human Services (DHHS) has the duty and responsibility to protect the health, safety, welfare and rights of Medicare/Medicaid beneficiaries. The Secretary has delegated authority to administer and provide oversight of the Medicare program to Centers for Medicare & Medicaid Services (CMS).

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-31-All*, CMS and the State Survey Agency are conducting unannounced onsite surveys at certain Medicare certified provider and supplier types.

SURVEY RESULTS

On June 29, 2020, a survey was completed at Prestige Care Center Of Plattsmouth by the State Survey Agency to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the CMS 2567 and will be posted on the ePOC system.

PLAN OF CORRECTION

A Plan of Correction (PoC) for the deficiencies must be submitted **by July 24, 2020**, to the State Survey Agency Contact. **Failure to submit an acceptable PoC by July 24, 2020 may result in the imposition of additional remedies.**

The PoC must contain the following:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of the quality assurance being implemented, the earliest correction date will be the date of the revisit; and
5. Include dates when corrective action will be completed. **The corrective action completion dates must be written in the completion date column within acceptable time frames.** If the PoC is unacceptable for any reason, you will be notified in writing by this office. If the PoC is acceptable, you will be notified via ePOC. Please note that the facility is ultimately accountable for compliance, and that responsibility is not alleviated in cases where notification regarding the acceptability of the facility's PoC is not made timely. **The PoC will serve as the facility's allegation of compliance.**

ENFORCEMENT REMEDIES

Based on the Statement of Deficiencies (Form CMS-2567), the following remedies are imposed:

- **Directed Plan of Correction:**

  In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction is imposed on the facility. In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. The effective date is not a deadline for completion of the DPOC. However, the State Agency will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice.

  Training option(s) which are the most appropriate for the type of noncompliance cited. For examp

  Sparkling Surfaces - https://youtu.be/t7OH8ORr5Ig
  Clean Hands - https://youtu.be/xmYMUly7qiE
  Closely Monitor Residents - https://youtu.be/1ZbT1Njv6xA
  Keep COVID-19 Out! - https://youtu.be/7srwrF9MGdw
  Lessons - https://youtu.be/YYTATw9yav4

  Please send all documentation to the State Agency at the following:

Connie Vogt, RN, BSN

dhhs.healthcarefacilities@Nebraska.gov

In the Subject Line please put: DPOC

For states participating in the ePOC program, the DPOC may be added as an attachment.

Please note, if documentation includes any resident personal identifiable information (PII) or personal health information (PHI) it must be sent encrypted.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies, within 10 days after receipt of the Form CMS 2567. Please see the attached instructions (DPOC attachment) for detailed guidance.

- **Imposition of Denial of Payment for New Admissions (DPNA):**

  Payment will be denied for all NEW Medicare and Medicaid admissions, August 28, 2020 in accordance with the statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal regulations at 42 CFR §488.417. Your Medicare Administrative Contractor will be notified of the date the denial of payment begins. DPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated.

WITHDRAWAL OF APPROVAL FOR NURSE AIDE TRAINING PROGRAM

Please note that Federal law, as specified in the Social Security Act at §1819(f)(2)(B) and §1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs (NATCEP) and nurse aide competency evaluation programs (NACEP) offered by, or in, a facility which, within the previous two years, if one or more of the following exists:

- Operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse);
- Has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care;
- Has been assessed a total civil money penalty of not less than $10,697;
- Has been subject to a denial of payment;
- Appointment of a temporary manager;
- Terminated from participation, and/or
- In the case of an emergency, has been closed and/or had its residents transferred to other facilities.

INFORMAL DISPUTE RESOLUTION (IDR)

You have one opportunity to dispute the deficiencies cited on the survey date through (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Connie Vogt, RN, BSN
Email: dhhs.healthcarefacilities@Nebraska.gov
In the Subject Line of the email put: Request IDR

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

This request must be submitted within 10 days from the date of the enforcement letter. An incomplete Informal Dispute Resolution process will not delay the effective date of any enforcement action.

Informal Dispute Resolution is in no way to be construed as a formal evidentiary hearing. It is an informal internal process to review additional information submitted by the facility. You will be advised of our decision relative to the informal dispute.

APPEAL RIGHTS

If you disagree with the determination to impose remedies made on the basis of noncompliance identified at the June 29, 2020 survey, you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board (DAB). The appeal rights are set forth at 42 C.F.R. § 498.5 and the procedures for requesting a hearing are set forth at §498.40, et seq. You must file your hearing request electronically by using the DAB's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov/, unless you obtain a waiver from the DAB (*see* DAB Civil Remedies Division Procedures, § 6(a)(i)(1)). Your appeal must be filed no later than 60 days from the date of receipt of this letter.

We request that you provide an electronic copy of the request for appeal to:

ROkcmSCB@cms.hhs.gov
and to the CMS Regional Chief Counsel at:
OGCKansasCityGeneralInbox@hhs.gov

If you elect to dispute deficiencies through the Informal Dispute Resolution (IDR) process, this will not extend the 60 day period to file your appeal before the Departmental Appeals Board. Filing an appeal will not stop the imposition of any enforcement remedy.

If you experience problems with, or have questions about DAB e-File, please contact e-File System Support at OSDABImmediateOffice@hhs.gov. If you have questions about using the DAB e-file System, please visit: https://dab.efile.hhs.gov/appeals/to_crd_instructions?locale=en.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at QIO Program Website. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at Locate Your QIO.

CONTACT INFORMATION

If you have any questions please contact this office.

Sincerely,

Connie F Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

Enclosures: CMS 2567

Copies via e-mail to: CMS - RO
DHHS - State Medicaid Agency
DHHS - Nursing Support

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 2, 2020

Alicia Elson, Administrator
Quality Living, Inc
6404 North 70th Plaza
Omaha, NE 68104

CMS CERTIFICATION NUMBER: 28A060

Dear Ms. Elson:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 17, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

June 24, 2020

Mikel Ardley, Administrator
Regency Square Care Center
3501 Dakota Avenue
South Sioux City, NE 68776

CMS CERTIFICATION NUMBER: 285076

Dear Ms. Ardley:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 11, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 16, 2020

Donald Weidermann, Administrator
Regional West Garden County Nursing Home
1100 West 2nd
Oshkosh, NE 69154

CMS CERTIFICATION NUMBER: 28E180

Dear Mr. Weidermann:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 15, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

June 26, 2020

Erin Dye, Administrator
Ridgecrest Rehabilitation Center
3110 Scott Circle
Omaha, NE 68112

CMS CERTIFICATION NUMBER: 285239

Dear Ms. Dye:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 9, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 7, 2020

Ruth (peg) Becker, Administrator
Ridgewood Rehabilitation & Care Center
624 Pinewood Avenue
Seward, NE 68434

CMS CERTIFICATION NUMBER: 285279

Dear Ms. Becker:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 29, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Kansas City Regional Office
601 East 12th Street, Room 355
Kansas City, Missouri 64106

MIDWEST DIVISION OF SURVEY AND CERTIFICATION

May 8, 2020

Aharon Kibel, Administrator
River City Nursing and Rehabilitation
7410 Mercy Road
Omaha, NE 68124

CMS Certification No: 285058

Dear Mr. Kibel:

SUBJECT: SURVEY RESULTS
Cycle Start Date: April 28, 2020

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES
The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS
On April 28, 2020, the Centers for Medicare & Medicaid Services (CMS) completed a COVID-19 Focused Survey at River City Nursing and Rehabilitation to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the enclosed form CMS 2567.

PLAN OF CORRECTION
You must submit an acceptable plan of correction (POC) for the enclosed deficiencies that were cited during the April 28, 2020 survey. River City Nursing and Rehabilitation may choose to delay submission of a POC until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a POC. An acceptable POC will serve as your allegation of compliance. Upon receipt of an acceptable POC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an

acceptable POC can lead to termination of your Medicare and Medicaid participation.

To be acceptable, a provider's POC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice;
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; and
- The date that each deficiency will be corrected.

The POC must be signed and dated by an official facility representative. Please send your POC by fax or email to:
Eddie Grimes and Amanda Spicer
Email: Eddie.Grimes@cms.hhs.gov
Amanda.Spicer@cms.hhs.gov

INFORMAL DISPUTE RESOLUTION
You have one opportunity to dispute the deficiencies cited on the April 28, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Marsophia Powers
Email: Marsophia.Powers@cms.hhs.gov

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

River City Nursing and Rehabilitation may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES
The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at QIO Program Website. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at Locate Your QIO.

CONTACT INFORMATION
If you have any questions please contact Kevin Wright, Principal Program Representative at (816) 426-2011.

Sincerely,

Kevin Wright
Long Term Care Branch
Survey & Operations Group
Center for Clinical Standards & Quality
CMS Kansas City

Enclosure:
CMS 2567

cc:
NE DHHS
Powers/Grimes

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285058	A. BUILDING _____ B. WING _____	04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CITY NURSING AND REHABILITATION	**7410 MERCY ROAD OMAHA, NE 68124**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on April 28, 2020. The facility was found not in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Facility census: 79 Sample size: 6	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/06/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285058	A. BUILDING _____ B. WING _____	04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CITY NURSING AND REHABILITATION	7410 MERCY ROAD OMAHA, NE 68124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 1 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285058	A. BUILDING _____ B. WING _____	04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CITY NURSING AND REHABILITATION	7410 MERCY ROAD OMAHA, NE 68124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain an effective ongoing infection control program that identified, tracked, and trended infections including residents that had the potential to be affected by COVID-19. Specifically, the facility failed to: -Accurately track infections in February 2020, when a Resident (R1) developed [redacted] and the facility documented that R1 had a [redacted] -Accurately document the onset dates of infections for R3 and R4 in March, 2020. -Indicate the site of infections for R5 and R6, who had documented infections in March 2020. -Accurately document onset dates of the infections on the Infection Control Log for R1 and R2 who developed infections in the month of April 2020. -Ensure that ongoing trending of infections was completed, when the facility failed to complete any trending of March 2020 infections, and had not yet started trending of infections for April 2020 until 4/28/20. -Maintain an ongoing system to monitor the illnesses of employees, contractors, volunteers, or other people rendering services to the facility. This failure had the potential to affect all 79 residents that resided in the facility.	F 880		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285058	A. BUILDING _____ B. WING _____	04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CITY NURSING AND REHABILITATION	7410 MERCY ROAD OMAHA, NE 68124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 3 Findings include: 1. Review of the Infection Control Log for the month of February 2020 documented that the facility logged 14 infections for the month. Of the 14 infections, two were indicated to have a diagnostic test completed. The facility failed to indicate if the other 12 infections had diagnostic testing completed, or if testing was not indicated. The facility failed to indicate if the resident's infections originated in the facility or in the community. The facility failed to document signs or symptoms of infection for any of the 14 infections. All 14 infections were treated with antibiotics, however, the facility failed to indicate on the Infection Control Log if the ordered antibiotic was appropriate to treat the infectious organisms or infectious process. The facility failed to document if any of the infections resolved, or were ongoing. The facility failed to document the individual resident locations for the residents documented on the Infection Control Log. The Infection Control Log for February 2020 documented that R1 developed a [redacted] on 2/14/20. Review of a nursing note in R1's chart, dated 2/28/20, documented that R1 readmitted to the facility following hospitalization for [redacted] The Infection Control Log failed to indicate that R1 experienced [redacted] during the month. 2. Review of the Infection Control Log for March 2020 revealed that the facility logged 23 infections for the month. The facility failed to indicate if any of the 23 infections received any	F 880		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285058	A. BUILDING _____ B. WING _____	04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CITY NURSING AND REHABILITATION	7410 MERCY ROAD OMAHA, NE 68124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 4 diagnostic testing, and failed to indicate if any infectious organisms were identified. The facility failed to document any signs or symptoms of infection for any of the 23 infections. The facility failed to indicate if any of the infections resolved, or were ongoing. The facility failed to document the individual resident locations for the residents documented on the Infection Control Log. The Infection Control Log for March 2020 documented that R5 and R6 required antibiotics to treat facility-acquired infections. The facility failed to document any other identifiable information regarding R5 and R6's infections. The Infection Control Log for March 2020 documented that on 3/17/20, R3 required antibiotics to treat [redacted] Review of R3's progress notes, dated 3/7/20, ten days prior, documented that R3 exhibited an increased temperature and decreased oxygen saturation level. R3 was admitted to the hospital Intensive Care Unit (ICU) for treatment. The Infection Control Log for March 2020 documented that on 3/23/20, R4 required antibiotics to treat [redacted] which she contracted in the community. Review of R4's progress notes, dated 3/17/20, documented that R4 began antibiotics for [redacted] on 3/17/20, six days prior. The facility failed to provide any information related to the trending of infections for the month of March 2020. 3. Review of the Infection Control Log for April 2020 documented that the facility logged eight infections for the month. The facility failed to indicate if any infections received any diagnostic	F 880		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285058	A. BUILDING _____ B. WING _____	04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CITY NURSING AND REHABILITATION	7410 MERCY ROAD OMAHA, NE 68124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 5 testing. The facility failed to indicate if any of the infections resolved, or were ongoing. The facility failed to document individual resident locations for the residents documented on the Infection Control Log. The Infection Control Log for April 2020 documented that on 4/15/20, R1 experienced [redacted], and required antibiotic treatment. Review of R1's progress notes, dated 4/12/20, three days prior, documented that R1 experienced [redacted] The Infection Control Log for April 2020 documented that on 4/23/20, R2 experienced [redacted], and was sent to the emergency room from his [redacted] appointment. Review of R2's progress notes, dated 4/7/20, documented that R2 experienced an increased temperature of 100.4F, and was put on isolation precautions. Review of an additional progress note, dated 4/9/20, documented that R2 went to the hospital with [redacted]. The Infection Control Log failed to indicate R2's hospitalization for [redacted] or that he was isolated following an increased temperature. 4. The facility tracked employee absences related to COVID-19 for the month of April 2020, but failed to provide any additional documentation for the months of February 2020 and March 2020. 5. On 4/28/20 at 3:45pm, the Director of Nursing (DON) indicated that the facility failed to complete infection trending for the month of March, and that the facility failed to initiate trending of infections for the month of April 2020 until earlier in the day. The DON indicated that she was	F 880		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285058	A. BUILDING _____ B. WING _____	04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CITY NURSING AND REHABILITATION	7410 MERCY ROAD OMAHA, NE 68124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6 aware that trending of infections was to be an ongoing process. 6. On 4/28/20 at 4:15pm, the DON indicated that the facility failed to document all required applicable information for infections, including but not limited to signs and symptoms of infection, resolution dates of infections, and if diagnostic testing was completed. The DON indicated that ongoing trending of infections would begin in May 2020, and that the facility failed to timely complete infection trending in the past. The DON indicated that tracking of employee illnesses was limited to what was related only to COVID-19, and began in the month of April 2020. 7. The facility policy, dated 10/2018, titled "Infection Prevention and Control Program," documented: "3. Surveillance: A system of surveillance is utilized for prevention, identifying, resorting, investigating, and controlling infections and communicable disease for all residents, staff, volunteers, visitors, and other individuals providing services. . . "	F 880		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285058	A. BUILDING _____ B. WING _____	04/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CITY NURSING AND REHABILITATION	**7410 MERCY ROAD OMAHA, NE 68124**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on April 28, 2020. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6).	E 000		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/06/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 16, 2020

Stacey Knox, Administrator
Rock County Hospital Long Term Care
100 East South Street
Bassett, NE 68714-5510

CMS CERTIFICATION NUMBER: 285304

Dear Ms. Knox:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 8, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Kansas City Regional Office
601 East 12th Street, Room 355
Kansas City, Missouri 64106

MIDWEST DIVISION OF SURVEY AND CERTIFICATION

May 7, 2020

Chris Ulven, Administrator
Rose Blumkin Jewish Home
323 South 132nd Street
Omaha, NE 68154

CMS Certification No: 285059

Dear Mr. Ulven:

SUBJECT: SURVEY RESULTS
Cycle Start Date: April 28, 2020

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES
The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-20-All*, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS
On April 28, 2020, the Centers for Medicare & Medicaid Services (CMS) completed a COVID-19 Focused Survey at Rose Blumkin Jewish Home to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was in substantial compliance with participation requirements and no deficiencies were cited. The findings from this survey are documented on the enclosed form CMS 2567.

No additional action is required on the facility's part.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES
The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at QIO Program Website. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at Locate Your QIO.

CONTACT INFORMATION
If you have any questions please contact Kevin Wright, Principal Program Representative at (816) 426-2011.

Sincerely,

Kevin Wright
Long Term Care Branch
Survey & Operations Group
Center for Clinical Standards & Quality
CMS Kansas City

cc:
NE DHHS
Powers/Grimes

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 23, 2020

Sarah Watson, Administrator
Rose Lane Home
Rr 2 Box 46, 1005 North 8th Street
Loup City, NE 68853-0046

CMS CERTIFICATION NUMBER: 285228

Dear Ms. Watson:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 15, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 16, 2020

Stephanie Clifton, Administrator
Sandhills Care Center
143 N Fullerton Street
Ainsworth, NE 69210-1515

CMS CERTIFICATION NUMBER: 285298

Dear Ms. Clifton:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 7, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

August 6, 2020

Stephanie Clifton, Administrator
Sandhills Care Center
143 N Fullerton Street
Ainsworth, NE 69210-1515

CMS CERTIFICATION NUMBER: 285298

Dear Ms. Clifton:

This is to acknowledge the results of the Infection Control survey conducted at your facility on August 5, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 7, 2020

Janice Edwards, Administrator
Sarah Ann Hester Memorial Home
P O Box 646, 407 Dakota Street
Benkelman, NE 69021

CMS CERTIFICATION NUMBER: 285241

Dear Ms. Edwards:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 29, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Kansas City Regional Office
601 East 12th Street, Room 355
Kansas City, Missouri 64106

MIDWEST DIVISION OF SURVEY AND CERTIFICATION

July 10, 2020

Samuel Prokopec, Administrator
Saunders Medical Center
1760 County Rd J
Wahoo, NE 68066-0185

CMS Certification No: 285296

Dear Mr. Prokopec:

SUBJECT: SURVEY RESULTS
Cycle Start Date: June 16, 2020

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES
The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-20-All*, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS
On June 16, 2020, the Centers for Medicare & Medicaid Services (CMS) completed a COVID-19 Focused Survey at Saunders Medical Center to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was in substantial compliance with participation requirements and no deficiencies were cited. The findings from this survey are documented on the enclosed form CMS 2567.

No additional action is required on the facility's part.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES
The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at QIO Program Website: https://qioprogram.org/covid-19. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance

related to infection control. QIOs per state can be found at Locate Your QIO: https://qioprogram.org/locate-your-qio.

CONTACT INFORMATION
If you have any questions please contact Lisa Hauptman, Principal Program Representative at (816) 426-2011.

Sincerely,

Lisa Hauptman

Lisa Hauptman
Long Term Care Branch
Survey & Operations Group
Center for Clinical Standards & Quality
CMS Kansas City

cc:
NE DHHS
Power/Grimes

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 29, 2020

Judy Frerichs, Administrator
Sidney Regional Medical Center-Extended Care
549 Keller Drive
Sidney, NE 69162-1775 CMS CERTIFICATION NUMBER: 285290

Dear Ms. Frerichs:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 28, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 13, 2020

Ronald Stavely, Administrator
Skyview Care And Rehab At Bridgeport
505 O Street
Bridgeport, NE 69336-4045

CMS CERTIFICATION NUMBER: 285224

Dear Mr. Stavely:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 9, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Kansas City Regional Office
601 East 12th Street, Room 355
Kansas City, Missouri 64106

MIDWEST DIVISION OF SURVEY AND CERTIFICATION

June 30, 2020

Brooke Belina, Administrator
South Haven Living Center
1400 Mark Drive
Wahoo, NE 68066

CMS Certification No: 285231

Subject: Survey Results
Cycle Start Date: June 18, 2020

Dear Ms. Belina,

COVID-19 FOCUSED INFECTION CONTROL SURVEY

The Secretary of the U.S. Department of Health and Human Services (DHHS) has the duty and responsibility to protect the health, safety, welfare and rights of Medicare/Medicaid beneficiaries. The Secretary has delegated authority to administer and provide oversight of the Medicare program to Centers for Medicare & Medicaid Services (CMS).
The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-31-All, CMS and the State Survey Agency are conducting unannounced onsite surveys at certain Medicare certified provider and supplier types.
SURVEY RESULTS
On June 18, 2020, a survey was completed at South Haven Living Center by CMS to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the enclosed form CMS 2567.

PLAN OF CORRECTION

A Plan of Correction (PoC) for the deficiencies must be submitted within ten (10) calendar days of your receipt of this notice. Use the space provided to the right of each item of deficiency to type your PoC and the expected date of completion. A PoC must be entered for each item clearly identifying HOW, WHAT, WHEN, AND WHERE it was or will be corrected. The plan should also include provisions instituted to prevent reoccurrence. The PoC must contain the following:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of the quality assurance being implemented, the earliest correction date will be the date of the revisit; and
- Include dates when corrective action will be completed. The corrective action completion dates must be written in the completion date column within acceptable time frames. If the PoC is unacceptable for any reason, you will be notified in writing by this office. If the PoC is acceptable, you will be notified via telephone, e-mail, etc. Please note that the facility is ultimately accountable for compliance, and that responsibility is not alleviated in cases where notification regarding the acceptability of the facility's PoC is not made timely. The PoC will serve as the facility's allegation of compliance.

You must send this office the original, signed and dated Statement of Deficiencies (SoD) with the PoC to:

Vonda Young, Nurse Consultant
Vonda.Young@cms.hhs.gov

ENFORCEMENT REMEDIES
Based on the Statement of Deficiencies (Form CMS-2567), the following remedies are imposed:

Civil Money Penalty (CMP)

In determining the amount of the Federal Civil Money Penalty (CMP) that we are imposing, we have considered your facility's history, including any repeated deficiencies; and the factors specified in the Federal requirement at 42 CFR § 488.404. Additionally, CMS issued new CMP policies for infection control deficiencies in QSOG Memorandum QSO 20-31-ALL, effective June 1, 2020. We are imposing the following CMP in accordance with these policies:

- A per-instance Federal Civil Money Penalty in the amount of $5,000.00 for the deficiency described at the Federal citation, F0880 -- S/S: E -- 483.80(a)(1)(2)(4)(e)(f) - Infection Prevention & Control.

The total amount of the CMP is $5,000.00.

Directed Plan of Correction:
In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction (DPOC) is imposed on the facility. In accordance with 42 CFR § 488.402(f), this remedy is effective July 16, 2020. The DPOC may be completed before or after that date. The effective date is not a deadline for completion of the DPOC. However, CMS will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice.
The DPOC requires that your plan of correction include the following:
- A plan for all facility staff to view the two Centers for Disease Control (CDC) training videos located at the following: https://youtu.be/YYTATw9yav4 and https://youtu.be/7srwrF9MGdw. Training may be supervised by the Director of Nursing,

Infection Preventionist, or Medical Director with an attestation statement of completion by all staff.

- A Root Cause Analysis (RCA) of the deficient practices cited, conducted with assistance from the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee and Governing Body. The RCA should be incorporated into the intervention plan. Information regarding RCAs can be found at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies, within 10 days after receipt of the Form CMS 2567. Please send all documentation to CMS at the following:
Vonda Young, Nurse Consultant
Email: Vonda.Young@cms.hhs.gov

Please note, if documentation includes any resident personal identifiable information (PII) or personal health information (PHI) it must be sent encrypted.

Imposition of Denial of Payment for New Admissions (DPNA):
Payment will be denied for all NEW Medicare and Medicaid admissions, beginning August 15, 2020, in accordance with the statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal regulations at 42 CFR §488.417. Your Medicare Administrative Contractor will be notified of the date the denial of payment begins. DPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated.

FINANCIAL HARDSHIP
If you believe your facility's financial condition lacks the ability to support the amount of the CMP, you can request a financial hardship review. For CMS to consider whether payment of the CMP would create a financial hardship and allow your request for installment payments, the following documents should be submitted to this office (kevin.wright@cms.hhs.gov) within fifteen (15) days from the receipt of this notice:

- Written, dated request specifying the reason financial hardship is alleged.
- Brief summary listing the supporting documents being submitted (if all documents cannot be included please provide rationale as to why).
- Organizational chart with an explanation/description concerning the related entities. If there is a Parent Company, provide names and addresses (please indicate in your written request if you have a Parent company).
- The following financial statements for the Provider and the Parent Company (of note, we need consolidated financials for the Parent Company and complete financials for the subsidiary (not by facility)):
- Current Balance sheet (segregated by CURRENT assets and liabilities);
- Current Income statement or Statement of Operations or Profit and Loss Statement (has to include NET INCOME);
- Current Statement of Cash Flows (to include the total change in cash flow);
- Most recent, full-year audited financial statements prepared by an independent accounting firm (including footnotes). If audited financial statements are not available, most recent tax returns may be substituted;
- Most recent full-year audited financial statements of the home office and/or related entities (including footnotes). If audited financial statements are not available, most recent tax returns may be substituted;
- Schedule showing amounts due to/from related companies, or individuals, included in the balance sheets. The schedule should list the names of related organizations, or persons, and indicate where the amounts appear on the balance sheet (e.g., Accounts Receivable, Notes Receivable, etc.);

- Copy of tax returns for the preceding two years;
- Disclosure of expenses and amounts paid/accrued to the home office and/or related entities;
- Documentation of any/all financing arrangements including mortgages, long term debt, and lines of credit;
- If the nursing home requests an extended payment schedule of more than twelve (12) months duration, the provider must submit a letter from a financial institution denying the provider's loan request for the amount of the CMP (requests for extended payment schedules are reviewed based on financial need).

Knowingly and willfully sending false or fraudulent information, or concealing materials of fact, can lead to penalties under 18 U.S.C. §§ 1001, 1035 and 1516.

INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with §488.431, when a civil money penalty (CMP) is imposed and is subject to being collected and placed in an escrow account, you have one opportunity to question cited deficiencies through an Independent Informal Dispute Resolution (IIDR) process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of substandard quality of care (SQC) or IJ. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing the deficiencies, including the scope and severity assessments of deficiencies which have been found to constitute SQC or IJ) to:

LCDR Marsophia R. Powers, Long Term Care Branch Manager
Email: marsophia.powers@cms.hhs.gov

This request must be sent within 10 calendar days of receipt of this notice. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

WITHDRAWAL OF APPROVAL FOR NURSE AIDE TRAINING PROGRAM

Please note that Federal law, as specified in the Social Security Act at §1819(f)(2)(B) and §1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs (NATCEP) and nurse aide competency evaluation programs (NACEP) offered by, or in, a facility in which, within the previous two years, one or more of the following exists:

- Operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse);
- Has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care;
- Has been assessed a total civil money penalty of not less than $10,697;
- Has been subject to a denial of payment;
- Appointment of a temporary manager;
- Terminated from participation, and/or
- In the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Your facility will receive further information regarding this from the State Agency.

APPEAL RIGHTS

The following remedies are being imposed:

- CMP
- Directed Plan of Correction
- DPNA

If you disagree with this action imposed on your facility, you or your legal representative are

required to file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/. To file a new appeal using DAB E-File, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

Clicking the File New Appeal link on the Manage Existing Appeals screen, then clicking Civil Remedies Division on the File New Appeal screen. Entering and uploading the requested information and documents on the "File New Appeal- Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. The DAB will set the location for the hearing. Counsel may represent you at a hearing at your own expense.

All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions for using DAB E-File in cases before the DAB's Civil Remedies Division can be found by clicking the button marked E-Filing Instructions after logging-in to DAB E-File.

For questions regarding the E-Filing system, please contact E-File System Support at OSDABImmediateOffice@hhs.gov.

Please note that all hearing requests must be filed electronically unless you have no access to the internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. Such a request should be made to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

A request for a hearing must be filed no later than 60 days from the date of receipt of this notice.

A copy of the hearing request shall be submitted electronically to:
kevin.wright@cms.hhs.gov

WAIVER

If you would like to waive your right to a hearing, you must do so in writing to this office (kevin.wright@cms.hhs.gov) within 60 calendar days of the date of the notice of imposition. If you waive your right to a hearing in accordance with the requirements specified at 42 CFR

488.436, the amount of the CMP will be reduced by 35 percent. After you submit a timely written waiver of your right to a hearing, CMS will send you a letter with instructions on how to remit the adjusted amount of the CMP.

If you believe you have achieved substantial compliance, you should contact the CMS RO. In addition, if substantial compliance has not been achieved within six (6) months after the last date of the survey identifying noncompliance, June 4, 2020, we will terminate your Medicare provider agreement effective December 18, 2020.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at QIO Program Website. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at Locate Your QIO.

CONTACT INFORMATION

Thank you for the time and courtesy extended to our surveyors during the survey. If you have any questions regarding the survey, please contact Vonda Young, Nurse Consultant. For questions

regarding enforcement, Kevin Wright, Health Insurance Specialist. Both can be reached in our Kansas City Regional Office at (816) 426-2011.

Sincerely,

CDR Marsophia R. Powers
Long Term Care Branch Manager
Survey & Operations Group
Center for Clinical Standards & Quality

CMS Kansas City

Enclosures
CMS 2567

Copies via e-mail to:
NE DHHS
Powers/Grimes/Young
WPS
OGC

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 1, 2020

David Bergmann, Administrator
Southlake Village Rehabilitation & Care Center
9401 Andermatt Drive
Lincoln, NE 68526 **CMS Certification No. 285219**

Subject: **Survey Results**
Cycle Start Date: June 11, 2020

Dear Administrator,

UNANNOUNCED COVID-19 SURVEY

The Secretary of the U.S. Department of Health and Human Services (DHHS) has the duty and responsibility to protect the health, safety, welfare and rights of Medicare/Medicaid beneficiaries. The Secretary has delegated authority to administer and provide oversight of the Medicare program to Centers for Medicare & Medicaid Services (CMS).

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-31-All*, CMS and the State Survey Agency are conducting unannounced onsite surveys at certain Medicare certified provider and supplier types.

SURVEY RESULTS

On June 11, 2020, a survey was completed at Southlake Village Rehabilitation & Care Center by the State Survey Agency to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the CMS 2567 and will be posted on the ePOC system.

PLAN OF CORRECTION

A Plan of Correction (PoC) for the deficiencies must be submitted **by July 11, 2020**, to the State Survey Agency Contact. **Failure to submit an acceptable PoC by July 11, 2020 may result in the imposition of additional remedies.**

The PoC must contain the following:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of the quality assurance being implemented, the earliest correction date will be the date of the revisit; and
5. Include dates when corrective action will be completed. **The corrective action completion dates must be written in the completion date column within acceptable time frames.** If the PoC is unacceptable for any reason, you will be notified in writing by this office. If the PoC is acceptable, you will be notified via ePOC. Please note that the facility is ultimately accountable for compliance, and that responsibility is not alleviated in cases where notification regarding the acceptability of the facility's PoC is not made timely. **The PoC will serve as the facility's allegation of compliance.**

ENFORCEMENT REMEDIES

Based on the Statement of Deficiencies (Form CMS-2567), the following remedies are imposed:

- **Directed Plan of Correction:**

  In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction is imposed on the facility. In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. The effective date is not a deadline for completion of the DPOC. However, the State Agency will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice.

  Training option(s) which are the most appropriate for the type of noncompliance cited. For examp

  Sparkling Surfaces - https://youtu.be/t7OH8ORr5Ig
  Clean Hands - https://youtu.be/xmYMUly7qiE
  Closely Monitor Residents - https://youtu.be/1ZbT1Njv6xA
  Keep COVID-19 Out! - https://youtu.be/7srwrF9MGdw
  Lessons - https://youtu.be/YYTATw9yav4

  Please send all documentation to the State Agency at the following:

Connie Vogt, RN, BSN

Email: dhhs.healthcarefacilities@Nebraska.gov

In the Subject Line please put: DPOC

For states participating in the ePOC program, the DPOC may be added as an attachment.

Please note, if documentation includes any resident personal identifiable information (PII) or personal health information (PHI) it must be sent encrypted.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies, within 10 days after receipt of the Form CMS 2567. Please see the attached instructions (DPOC attachment) for detailed guidance.

- **Imposition of Denial of Payment for New Admissions (DPNA):**

Payment will be denied for all NEW Medicare and Medicaid admissions, beginning August 15, 20 of the date the denial of payment begins. DPNA will continue until the day before your facility ac

INFORMAL DISPUTE RESOLUTION (IDR)

You have one opportunity to dispute the deficiencies cited on the survey date through (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Connie Vogt, RN, BSN
Email: dhhs.healthcarefacilities@Nebraska.gov
In the Subject Line please type: Request IDR

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by

counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

This request must be submitted within 10 days from the date of the enforcement letter. An incomplete Informal Dispute Resolution process will not delay the effective date of any enforcement action.

Informal Dispute Resolution is in no way to be construed as a formal evidentiary hearing. It is an informal internal process to review additional information submitted by the facility. You will be advised of our decision relative to the informal dispute.

APPEAL RIGHTS

If you disagree with the determination to impose remedies made on the basis of noncompliance identified at the June 11, 2020 survey, you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board (DAB). The appeal rights are set forth at 42 C.F.R. § 498.5 and the procedures for requesting a hearing are set forth at §498.40, et seq. You must file your hearing request electronically by using the DAB's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov/, unless you obtain a waiver from the DAB (*see* DAB Civil Remedies Division Procedures, § 6(a)(i)(1)). Your appeal must be filed no later than 60 days from the date of receipt of this letter.

We request that you provide an electronic copy of the request for appeal to: ROkcm
and to the CMS Regional Chief Counsel at:
OGCKansasCityGeneralInbox@hhs.gov

If you elect to dispute deficiencies through the Informal Dispute Resolution (IDR) process, this will not extend the 60 day period to file your appeal before the Departmental Appeals Board. Filing an appeal will not stop the imposition of any enforcement remedy.

If you experience problems with, or have questions about DAB e-File, please contact e-File System Support at OSDABImmediateOffice@hhs.gov. If you have questions about using the DAB e-file System, please visit: https://dab.efile.hhs.gov/appeals/to_crd_instructions?locale=en.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at QIO Program Website. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at Locate Your QIO.

CONTACT INFORMATION

If you have any questions please contact this office.

Sincerely,



Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

Enclosures: CMS 2567

Copies via e-mail to: CMS-RO
DHHS - State Medicaid Agency
DHHS - Nursing Support

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

June 24, 2020

Melody Gagner, Administrator
St Jane De Chantal
2200 South 52nd Street
Lincoln, NE 68506-2134

CMS CERTIFICATION NUMBER: 285004

Dear Ms. Gagner:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 9, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 22, 2020

Candace Gibson, Administrator
St Joseph's Hillside Villa
540 E Washington Street
West Point, NE 68788

CMS CERTIFICATION NUMBER: 285303

Dear Ms. Gibson:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 8, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Kansas City Regional Office
601 East 12th Street, Room 355
Kansas City, Missouri 64106

MIDWEST DIVISION OF SURVEY AND CERTIFICATION

July 9, 2020

Rita Raffety, Administrator
St. Joseph Rehabilitation & Care Center
401 North 18th Street
Norfolk, NE 68701

CMS Certification No: 285160

Dear Administrator:

SUBJECT: SURVEY RESULTS
Cycle Start Date: June 25, 2020

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES
The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-20-All*, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS
On June 25, 2020, the Centers for Medicare & Medicaid Services (CMS) completed a COVID-19 Focused Survey at St. Joseph Rehabilitation & Care Center to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was in substantial compliance with participation requirements and no deficiencies were cited. The findings from this survey are documented on the enclosed form CMS 2567.

No additional action is required on the facility's part.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES
The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at QIO Program Website: https://qioprogram.org/covid-19. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance

related to infection control. QIOs per state can be found at Locate Your QIO: https://qioprogram.org/locate-your-qio.

CONTACT INFORMATION
If you have any questions please contact Treesie Farmer, Principal Program Representative at (816) 426-2011.

Sincerely,

Treesie Farmer
Long Term Care Branch
Survey & Operations Group
Center for Clinical Standards & Quality
CMS Kansas City

cc:
NE DHHS
Powers/Grimes

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Kansas City Regional Office
601 East 12th Street, Room 355
Kansas City, Missouri 64106

MIDWEST DIVISION OF SURVEY AND CERTIFICATION

May 8, 2020

Hector Leguillow, Administrator
St. Joseph Villa Nursing Center
2305 South 10th Street
Omaha, NE 68108-1154

CMS Certification No: 285078

Dear Mr. Leguillow:

SUBJECT: SURVEY RESULTS
Cycle Start Date: April 30, 2020

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES
The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-20-All*, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS
On April 30, 2020, the Centers for Medicare & Medicaid Services (CMS) completed a COVID-19 Focused Survey at St. Joseph Villa Nursing Center to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was in substantial compliance with participation requirements and no deficiencies were cited. The findings from this survey are documented on the enclosed form CMS 2567.

No additional action is required on the facility's part.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES
The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at QIO Program Website. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at Locate Your QIO.

CONTACT INFORMATION
If you have any questions please contact Kevin Wright, Principal Program Representative at (816) 426-2011.

Sincerely,

Kevin Wright
Long Term Care Branch
Survey & Operations Group
Center for Clinical Standards & Quality
CMS Kansas City

cc:
NE DHHS
Powers/Grimes

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 7, 2020

Hector Leguillow, Administrator
St. Joseph Villa Nursing Center
2305 South 10th Street
Omaha, NE 68108-1154

CMS CERTIFICATION NUMBER: 285078

Dear Mr. Leguillow:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 24, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 31, 2020

Hector Leguillow, Administrator
St. Joseph Villa Nursing Center
2305 South 10th Street
Omaha, NE 68108-1154

CMS CERTIFICATION NUMBER: 285078

Dear Mr. Leguillow:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 29, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

June 24, 2020

Trisha Steager, Administrator
St. Joseph's Villa, Inc.
927 Seventh Street
David City, NE 68632

CMS CERTIFICATION NUMBER: 285249

Dear Ms. Steager:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 11, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(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
	285102	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANTON HEALTH CENTER	**P O BOX 407, 301 17TH STREET STANTON, NE 68779**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in compliance with the Emergency Preparedness tag at E0024.	E 000		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 15, 2020

April Johnston, Administrator
Stanton Health Center
P O Box 407, 301 17th Street
Stanton, NE 68779-0407 **CMS Certification No. 285102**

Subject: Survey Results
Cycle Start Date: July 1, 2020

Dear Administrator,

UNANNOUNCED COVID-19 SURVEY

The Secretary of the U.S. Department of Health and Human Services (DHHS) has the duty and responsibility to protect the health, safety, welfare and rights of Medicare/Medicaid beneficiaries. The Secretary has delegated authority to administer and provide oversight of the Medicare program to Centers for Medicare & Medicaid Services (CMS).

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-31-All*, CMS and the State Survey Agency are conducting unannounced onsite surveys at certain Medicare certified provider and supplier types.

SURVEY RESULTS

On July 1, 2020, a survey was completed at Stanton Health Center by the State Survey Agency to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the CMS 2567 and will be posted on the ePOC system.

PLAN OF CORRECTION

A Plan of Correction (PoC) for the deficiencies must be submitted **by July 25, 2020**, to the State Survey Agency Contact. **Failure to submit an acceptable PoC by July 25, 2020 may result in the imposition of additional remedies.**

The PoC must contain the following:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of the quality assurance being implemented, the earliest correction date will be the date of the revisit; and
5. Include dates when corrective action will be completed. **The corrective action completion dates must be written in the completion date column within acceptable time frames.** If the PoC is unacceptable for any reason, you will be notified in writing by this office. If the PoC is acceptable, you will be notified via ePOC. Please note that the facility is ultimately accountable for compliance, and that responsibility is not alleviated in cases where notification regarding the acceptability of the facility's PoC is not made timely. **The PoC will serve as the facility's allegation of compliance.**

ENFORCEMENT REMEDIES

Based on the Statement of Deficiencies (Form CMS-2567), the following remedies are imposed:

- **Directed Plan of Correction:**

  In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction is imposed on the facility. In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. The effective date is not a deadline for completion of the DPOC. However, the State Agency will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice.

  Training option(s) which are the most appropriate for the type of noncompliance cited. For examp

  Sparkling Surfaces - https://youtu.be/t7OH8ORr5Ig
  Clean Hands - https://youtu.be/xmYMUly7qiE
  Closely Monitor Residents - https://youtu.be/1ZbT1Njv6xA
  Keep COVID-19 Out! - https://youtu.be/7srwrF9MGdw
  Lessons - https://youtu.be/YYTATw9yav4

  Please send all documentation to the State Agency at the following:

Connie Vogt, RN, BSN

dhhs.healthcarefacilities@Nebraska.gov

In the Subject Line please put: DPOC

For states participating in the ePOC program, the DPOC may be added as an attachment.

Please note, if documentation includes any resident personal identifiable information (PII) or personal health information (PHI) it must be sent encrypted.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies, within 10 days after receipt of the Form CMS 2567. Please see the attached instructions (DPOC attachment) for detailed guidance.

- **Imposition of Denial of Payment for New Admissions (DPNA):**

  Payment will be denied for all NEW Medicare and Medicaid admissions, August 29, 2020 in accordance with the statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal regulations at 42 CFR §488.417. Your Medicare Administrative Contractor will be notified of the date the denial of payment begins. DPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated.

WITHDRAWAL OF APPROVAL FOR NURSE AIDE TRAINING PROGRAM

Please note that Federal law, as specified in the Social Security Act at §1819(f)(2)(B) and §1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs (NATCEP) and nurse aide competency evaluation programs (NACEP) offered by, or in, a facility which, within the previous two years, if one or more of the following exists:

- Operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse);
- Has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care;
- Has been assessed a total civil money penalty of not less than $10,697;
- Has been subject to a denial of payment;
- Appointment of a temporary manager;
- Terminated from participation, and/or
- In the case of an emergency, has been closed and/or had its residents transferred to other facilities.

INFORMAL DISPUTE RESOLUTION (IDR)

You have one opportunity to dispute the deficiencies cited on the survey date through (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Connie Vogt, RN, BSN
Email: dhhs.healthcarefacilities@Nebraska.gov
In the Subject Line of the email put: Request IDR

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

This request must be submitted within 10 days from the date of the enforcement letter. An incomplete Informal Dispute Resolution process will not delay the effective date of any enforcement action.

Informal Dispute Resolution is in no way to be construed as a formal evidentiary hearing. It is an informal internal process to review additional information submitted by the facility. You will be advised of our decision relative to the informal dispute.

APPEAL RIGHTS

If you disagree with the determination to impose remedies made on the basis of noncompliance identified at the July 1, 2020 survey, you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board (DAB). The appeal rights are set forth at 42 C.F.R. § 498.5 and the procedures for requesting a hearing are set forth at §498.40, et seq. You must file your hearing request electronically by using the DAB's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov/, unless you obtain a waiver from the DAB (*see* DAB Civil Remedies Division Procedures, § 6(a)(i)(1)). Your appeal must be filed no later than 60 days from the date of receipt of this letter.

We request that you provide an electronic copy of the request for appeal to:

ROkcmSCB@cms.hhs.gov
and to the CMS Regional Chief Counsel at:
OGCKansasCityGeneralInbox@hhs.gov

If you elect to dispute deficiencies through the Informal Dispute Resolution (IDR) process, this will not extend the 60 day period to file your appeal before the Departmental Appeals Board. Filing an appeal will not stop the imposition of any enforcement remedy.

If you experience problems with, or have questions about DAB e-File, please contact e-File System Support at OSDABImmediateOffice@hhs.gov. If you have questions about using the DAB e-file System, please visit: https://dab.efile.hhs.gov/appeals/to_crd_instructions?locale=en.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at QIO Program Website. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at Locate Your QIO.

CONTACT INFORMATION

If you have any questions please contact this office.

Sincerely,

Connie F Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

Enclosures: CMS 2567

Copies via e-mail to: CMS - RO
DHHS - State Medicaid Agency
DHHS - Nursing Support

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285102	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANTON HEALTH CENTER	**P O BOX 407, 301 17TH STREET STANTON, NE 68779**

(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 the survey report as they apply to deficient practices identified.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285102	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANTON HEALTH CENTER	**P O BOX 407, 301 17TH STREET STANTON, NE 68779**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 1 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Licensure Reference Number 175 NAC 12-006.17B	F 880		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285102	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANTON HEALTH CENTER	**P O BOX 407, 301 17TH STREET STANTON, NE 68779**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observations, interview, and record review; the facility failed to implement infection control precautions to prevent the spread of COVID-19 as: 1) residents on the Memory Care Unit (MCU-secured area used to protect and better meet dementia residents needs and to address behaviors associated with dementia) did not maintain at least 6 feet distance between residents and/or wear masks (the facility reported 12 residents reside in the MCU); 2) staff failed to perform correct use and procedures for use of personal protective equipment (PPE) for residents in isolation; and 3) staff failed to perform appropriate handwashing and gloving. The sample size was 6 and the facility census was 56. Findings are: A. The Centers for Medicare and Medicaid Services (CMS) memorandum dated March 13, 2020 provided guidance for all facilities nationwide to 1) Cancel communal dining and all group activities, such as internal and external group activities, and 2) Remind residents to practice social distancing and perform frequent hand hygiene. B. The Center for Disease Control and Prevention (CDC) "Considerations for Memory Care Units in Long Term Care Facilities", updated May 12, 2020 stated that nursing homes providing memory care should 1) Try to keep environment and routines as consistent as possible while still reminding and assisting with frequent hand hygiene, social distancing, and use of cloth face coverings (if tolerated), and 2) limit the number of residents or space residents at least 6 feet apart as much as feasible when in a common	F 880		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285102	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANTON HEALTH CENTER	**P O BOX 407, 301 17TH STREET STANTON, NE 68779**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 3	F 880		

area where resident and staff spend time, and carefully redirect residents who are ambulatory and are in close proximity to other residents.

C. On 6/30/20 at 9:35 AM surveyor entered the MCU (memory care unit), noted 2 staff members wearing masks and 3 residents unmasked sitting at a table all within 2 feet of each other. Two other residents were noted sitting in easy chairs in the commons area and were not wearing masks.

On 6/30/20 at 12:00 PM all MCU residents were observed sitting in the dining room of the MCU and staff were serving the residents lunch. No social distancing noted. Three tables were present in the room with 5 residents at one table, 3 residents at one table, and 4 residents at one table all sitting within 2 feet or another resident.

An interview on 6/30/20 at 9:40 AM with Medication Aide (MA)-A confirmed that MCU residents were not being monitored for or encouraged to social distance and continued to have communal dining.

D. On 6/30/20 at 10: 15 AM NA-G removed a used face mask and placed it in the clean isolation caddy located on Resident 3's door, and on top of the clean garbage bags located in the caddy. The Director of Nursing (DON) prompted the NA-G to retrieve the face mask from the isolation caddy and instructed NA-G to "put it in your pocket" which NA-G did and entered Resident 3's room.

E. On 6/30/20 at 11:40 AM Housekeeper-E was noted to be in the hallway with cleaning cart. Housekeeper-E was wearing gloves, gathered

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285102	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANTON HEALTH CENTER	**P O BOX 407, 301 17TH STREET STANTON, NE 68779**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 4 some cleaning supplies and entered a resident room, upon leaving the room the gloves were removed and disposed of, new clean gloves were put on without washing or sanitizing hands and Housekeeper-E proceeded to enter the next resident room for cleaning. F. On 6/30/20 at 11:45 AM NA-F was observed standing in the doorway of Resident 1's room (who was on isolation) and put on a gown that was handed to NA-F by NA-G from the hallway. NA-F entered the room, retrieved a face shield from a zip lock bag, and put on the face shield. NA-F grabbed the dirty laundry from the bin within the resident room, but then set the dirty laundry bag back into the bin when NA-G reported that the receiving laundry bin was "overflowing". NA-F then grabbed a clean laundry bag from the isolation caddy on the resident's door without changing gloves or sanitizing hands. NA-F lifted the dirty laundry from the bin and placed a new laundry bag in the bin. NA-F waited approximately 3 minutes and when no one came to assist, removed the face shield and placed it back into a zip lock bag. NA-F then removed the gown and gloves and place them in the laundry and trash receptacles, picked up the soiled laundry bag along with the baggie (containing the dirty face shield) rubbing up against the dirty laundry bag. NA-F left the resident room without washing or sanitizing hands. NA-F carried the laundry bag with the baggie continuing to rub against it, to a storage area to dispose of it. The laundry receptacle was full. After waiting for assistance for approximately 3 minutes, no one arrived so NA-F set the bag down, returned to the facility hallway, went into a bathing area currently being utilized for supplies and placed the baggie containing the dirty face shield into an unlabeled	F 880		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285102	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANTON HEALTH CENTER	**P O BOX 407, 301 17TH STREET STANTON, NE 68779**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 5 box containing 6 other baggies with masks and face shields in them. NA-F then washed hands and left the room. G. An interview with the DON on 6/30/20 at 12:45 PM confirmed: 1) Hand hygiene should be performed before and after gloving; 2) Used face masks and face shields should not be placed on clean surfaces or in staff pockets, and 3) Soiled face shields need to be discarded or properly disinfected and not stored with clean face shields.	F 880		

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Kansas City Regional Office
601 East 12th Street, Room 355
Kansas City, Missouri 64106

MIDWEST DIVISION OF SURVEY AND CERTIFICATION

July 9, 2020

Abby Lehr, Administrator
Sumner Place
1750 South 20th Street
Lincoln, NE 68502

CMS Certification No: 285002

Dear Ms. Lehr:

SUBJECT: SURVEY RESULTS
Cycle Start Date: June 24, 2020

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-20-All*, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS

On June 24, 2020, the Centers for Medicare & Medicaid Services (CMS) completed a COVID-19 Focused Survey at Sumner Place to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was in substantial compliance with participation requirements and no deficiencies were cited. The findings from this survey are documented on the enclosed form CMS 2567.

No additional action is required on the facility's part.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at QIO Program Website. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at Locate Your QIO.

CONTACT INFORMATION
If you have any questions please contact Treesie Farmer, Principal Program Representative at (816) 426-2011.

Sincerely,

Treesie Farmer
Long Term Care Branch
Survey & Operations Group
Center for Clinical Standards & Quality
CMS Kansas City

cc:
NE DHHS
Powers/Grimes

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Kansas City Regional Office
601 East 12th Street, Room 355
Kansas City, Missouri 64106

MIDWEST DIVISION OF SURVEY AND CERTIFICATION

May 28, 2020

Seth Stauffer, Administrator
Sunrise Country Manor
PO Box A, 610 224th Street
Milford, NE 68405

CMS Certification No: 285232

Dear Mr. Stauffer:

SUBJECT: SURVEY RESULTS
Cycle Start Date: January 21, 2020

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES
The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS
On May 19, 2020, the Centers for Medicare & Medicaid Services (CMS) completed a COVID-19 Focused Survey at Sunrise Country Manor to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the enclosed form CMS 2567.

PLAN OF CORRECTION
You must submit an acceptable plan of correction (POC) for the enclosed deficiencies that were cited during the May 19, 2020 survey. Sunrise Country Manor may choose to delay submission of a POC until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a POC. An acceptable POC will serve as your allegation of compliance. Upon receipt of an acceptable POC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable POC can lead to termination of your Medicare and Medicaid participation.

To be acceptable, a provider's POC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice;
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; and
- The date that each deficiency will be corrected.

The POC must be signed and dated by an official facility representative. Please send your POC by fax or email to:
Eddie Grimes
Email: Eddie.Grimes@cms.hhs.gov

INFORMAL DISPUTE RESOLUTION
You have one opportunity to dispute the deficiencies cited on the April 28, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Lisa Hauptman
Email: Lisa.Hauptman@cms.hhs.gov

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

Sunrise Country Manor may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES
The Quality Improvement Organization (QIO) Program is committed to supporting healthcare

facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at QIO Program Website. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at Locate Your QIO.

CONTACT INFORMATION
If you have any questions please contact Kevin Wright, Principal Program Representative at (816) 426-2011.

Sincerely,

Kevin Wright
Long Term Care Branch
Survey & Operations Group
Center for Clinical Standards & Quality
CMS Kansas City

Enclosure:
CMS 2567

cc:
NE DHHS
Hauptman/Grimes

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285232	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE COUNTRY MANOR	**PO BOX A, 610 224TH STREET MILFORD, NE 68405**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted by Healthcare Management Solutions, LLC on behalf of the Centers for Medicare & Medicaid Services (CMS) on 5/18/2020 - 5/19/2020. The facility was found not to be in substantial compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Survey Census: 67 Sample Size: 5 Supplemental: 0	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/08/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285232	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE COUNTRY MANOR	**PO BOX A, 610 224TH STREET MILFORD, NE 68405**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 1 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285232	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE COUNTRY MANOR	**PO BOX A, 610 224TH STREET MILFORD, NE 68405**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure visitors complied with infection control screening procedures and staff screenings were reviewed to rule out any possible communicable disease signs and/or symptoms prior to working with the residents. This screening failure had the potential to expose any of the 67 people residing in the facility and/or staff members working to possible communicable diseases. Findings include: Observation on 5/18/2020 at 1:25 PM showed Hospice Registered Nurse (RN) enter the locked entrance door code, enter the facility, stop at the visitor and staff screening table and fill out the visitor screening form. Hospice RN then left the area and entered Room 102 without taking a temperature. In an interview on 5/18/2020 at 1:30 PM, Hospice RN stated she wrote down her "temperature from earlier today." In an interview on 5/18/2020 at 1:35 PM, the Director of Nursing (DON) stated staff and contractors taking their own temperature was okay but using a temperature from another time was not acceptable.	F 880		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285232	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE COUNTRY MANOR	**PO BOX A, 610 224TH STREET MILFORD, NE 68405**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 3 Observation of the screening table on 5/18/2020 at 1:47 PM showed a food delivery person enter the locked entrance door security code and enter the building. The delivery person stood at the screening table and waited until someone came to the desk to pick up/pay for the food, then exited the building. In an interview on 5/19/2020 at 12:16 PM, the Infection Preventionist RN (IP) stated the employee screening logs are reviewed by her "when I get here and before I leave." At 12:20 PM, the IP clarified her normal hours were 7:00-7:30 AM to 4:00-4:15 PM five days per week. Review of the facility policy "Coronavirus Disease (COVID-19) - Facility Entrance Screening," dated 5/2020, stated: " ...ENTRY PROCEDURE: Entrance to the facility will be restricted to essential facility staff and contract workers (exceptions may be made for end of life). All doors to the facility will remain locked. A keypad at the main entrance will be available for essential workers. The keypad code will be changed at least monthly or with any observed noncompliance. All individuals entering the facility are required to pass through a screening station prior to entry. The screening station will be comprised of the following: -Hand sanitizing stations -Temperature check -Screening questionnaire regarding COVID-19 exposure and symptoms -Facemask distribution area Essential staff whose temperature is above 100 degrees Fahrenheit or that answer YES to any of	F 880		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285232	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE COUNTRY MANOR	**PO BOX A, 610 224TH STREET MILFORD, NE 68405**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 4 the known exposure or symptom screening questions are instructed to go outside and contact charge nurse, infection preventionist, or DON for further instruction. The screening station will be monitored by the infection preventionist upon arrival and departure as well as randomly throughout the day. (Weekends will be monitored at the same frequency by the charge nurse)." Review of the three-ring binder with the employee self-screening logs dated 5/17/2020 (a Sunday), 5/18/2020, and 5/19/2020 showed the initials of the IP in the lower right corner of the page. In an interview on 5/19/2020 at 3:14 PM regarding the employee self-screening logs, the IP confirmed there was no documentation that the weekend Charge Nurse reviewed the logs and stated, "The Charge Nurse may not have done it, I can't say for sure. When I come in, I still go over it." The IP continued to clarify that she reviewed the 5/17/2020 Sunday form "Yesterday [Monday]. As a general rule, when I come in every Monday, I grab them all to review." When asked if there is documentation regarding what is reviewed, the IP stated "No, I don't make any notes. [DON's name], [Administrator's name], and I talk about it, but I don't know that anybody takes notes."	F 880		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285232	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE COUNTRY MANOR	**PO BOX A, 610 224TH STREET MILFORD, NE 68405**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Centers for Medicare & Medicaid Services (CMS) on 5/18/2020 - 5/19/2020. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6).	E 000		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/08/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285277	A. BUILDING _____ B. WING _____	07/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUTTON COMMUNITY HOME, INC.	1106 NORTH SAUNDERS SUTTON, NE 68979

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS References to Title 175 of the Nebraska Administrative Code, Chapter 12- "Regulations Governing Licensure of Skilled Nursing Facilities, Nursing Facilities, and Intermediate Care Facilities" have been included in survey report as they apply to deficient practices identified.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		7/23/20

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/23/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285277	A. BUILDING _____ B. WING _____	07/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUTTON COMMUNITY HOME, INC.	1106 NORTH SAUNDERS SUTTON, NE 68979

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 1 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Licensure reference number 175 NAC 12-006.17	F 880	Residents did not experience any negative outcomes as none of the	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285277	A. BUILDING _____ B. WING _____	07/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUTTON COMMUNITY HOME, INC.	1106 NORTH SAUNDERS SUTTON, NE 68979

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observations, interviews and record reviews, the facility failed to implement infection control practices and Centers for Medicare and Medicaid Services (CMS) guidelines to prevent potential cross contamination including the spread of COVID-19 (a mild to severe respiratory illness that is caused by a coronavirus) the facility failure to verify screening results for facility employees, failure to ensure the screening sheets contained full staff identifying information including first and last names and titles, failure to ensure follow up of symptoms indicated on screening sheets and failure to prevent self screening. The facility failure had the potential to affect all residents in the building. The facility identified a census of 25. Findings are: A. A record review of the Covid-19 Staff Symptoms Evaluation sheet (SSE, a screening tool for Covid-19 symptoms and exposure) dated 07/03/20 for Employee A revealed no temperature was documented prior to allowing Employee A to work. Further review of the SSE for Employee A revealed there was no evidence of a follow up evaluation prior to allowing Employee A to work. B. A record review of the SSE dated 07/02/20 for Employee B revealed an "x" documented in the columns indicating Covid-19 exposure and a fever. Further review of the SSE for Employee B revealed there was no evidence of a follow up evaluation prior to allowing Employee B to work. C. A record review of the SSE dated 07/01/20 for Employee C revealed the SSE had been left	F 880	residents have had any signs or symptoms throughout the building. Screening of all employees is conducted before the employee's shift begins by nursing staff to assure residents are protected against any symptomatic employee. Self screening will not be allowed. If any symptoms are shown, the employee will be sent home immediately and Infection Control nurse or charge nurse will follow up with employee later in the day and if still symptomatic will be sent to either Clinic or Test Nebraska for a Covid test to be completed. Sutton Community Home will ensure that no residents come in contact with any symptomatic employee by all employees being screened before their shift by a member of the nursing staff. Screening will take place at the west entrance prior to employee clocking in for their shift. Any symptom responses of concern will be brought immediately to the charge nurse on duty by the nurse doing the screening. Self screening is not allowed. Any staff that have any "out of the ordinary" symptoms will be immediately sent home and will be followed up by the Infection Control nurse or charge nurse within that day of being sent home and if still symptomatic will be sent to either the Clinic or Test Nebraska for a Covid test to be completed. Employee will not return to work until Covid test results are in and negative. If Employee tests positive, employee will not be allowed to return to work until the employee tests negative	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285277	A. BUILDING _____ B. WING _____	07/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUTTON COMMUNITY HOME, INC.	1106 NORTH SAUNDERS SUTTON, NE 68979

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 3 blank regarding Covid-19 symptoms. Further review of the SSE for Employee C revealed there was no evidence of a follow up evaluation prior to allowing Employee C to work. D. A record review of the SSE dated 07/01/20 for Employee D revealed the SSE had been left blank regarding Covid-19 symptoms. Further review of the SSE for Employee D revealed there was no evidence of a follow up evaluation prior to allowing Employee D to work. E. A record review of the SSE dated 07/01/20 for Employee E revealed Employee E had indicated having a headache. Further review of the SSE for Employee E revealed there was no evidence of a follow up evaluation prior to allowing Employee E to work. F. A record review of the SSE dated for the Director of Nursing (D.O.N.) indicated the D.O.N. had completed their own screen. G. On 07/06/20 at 12:00 P.M. an interview was conducted with the facility D.O.N.. During the interview, a review of the SSE sheets for Employees A, B, C, D, and E was completed. The facility D.O.N. confirmed there should have been follow up evaluations regarding employee symptoms and was not. H. On 07/06/20 at 12:00 P.M. an interview was conducted with the facility Administrator and the facility D.O.N.. During the interview, a review of the SSE for the D.O.N. dated 6/26/20 was completed. The facility D.O.N. confirmed that self screening had occurred	F 880	twice with tests being at 24 hrs or more hours apart or per CDC guidelines for return to work. All Staff have viewed the 5 CMS DPOE videos. Charge Nurse will review sheets each day to assure no symptomatic employees are or have been working. DON or designee will audit the staff screening sheets to assure all questions are being answered and documented appropriately as per guidelines. A copy of the audit sheet is attached. DON or designee will bring audit sheets to QAPI monthly for 3 months.	

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 14, 2020

Janet Lytton, Administrator
Sutton Community Home, Inc.
1106 North Saunders
Sutton, NE 68979-0543 **CMS Certification No. 285277**

Subject: Survey Results
Cycle Start Date: July 6, 2020

Dear Administrator,

UNANNOUNCED COVID-19 SURVEY

The Secretary of the U.S. Department of Health and Human Services (DHHS) has the duty and responsibility to protect the health, safety, welfare and rights of Medicare/Medicaid beneficiaries. The Secretary has delegated authority to administer and provide oversight of the Medicare program to Centers for Medicare & Medicaid Services (CMS).

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-31-All*, CMS and the State Survey Agency are conducting unannounced onsite surveys at certain Medicare certified provider and supplier types.

SURVEY RESULTS

On July 6, 2020, a survey was completed at Sutton Community Home, Inc. by the State Survey Agency to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the CMS 2567 and will be posted on the ePOC system.

PLAN OF CORRECTION

A Plan of Correction (PoC) for the deficiencies must be submitted **by July 24, 2020**, to the State Survey Agency Contact. **Failure to submit an acceptable PoC by July 24, 2020 may result in the imposition of additional remedies.**

The PoC must contain the following:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of the quality assurance being implemented, the earliest correction date will be the date of the revisit; and
5. Include dates when corrective action will be completed. **The corrective action completion dates must be written in the completion date column within acceptable time frames.** If the PoC is unacceptable for any reason, you will be notified in writing by this office. If the PoC is acceptable, you will be notified via ePOC. Please note that the facility is ultimately accountable for compliance, and that responsibility is not alleviated in cases where notification regarding the acceptability of the facility's PoC is not made timely. **The PoC will serve as the facility's allegation of compliance.**

ENFORCEMENT REMEDIES

Based on the Statement of Deficiencies (Form CMS-2567), the following remedies are imposed:

- **Directed Plan of Correction:**

  In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction is imposed on the facility. In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. The effective date is not a deadline for completion of the DPOC. However, the State Agency will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice.

  Training option(s) which are the most appropriate for the type of noncompliance cited. For examp

  Sparkling Surfaces - https://youtu.be/t7OH8ORr5Ig
  Clean Hands - https://youtu.be/xmYMUly7qiE
  Closely Monitor Residents - https://youtu.be/1ZbT1Njv6xA
  Keep COVID-19 Out! - https://youtu.be/7srwrF9MGdw
  Lessons - https://youtu.be/YYTATw9yav4

  Please send all documentation to the State Agency at the following:

Connie Vogt, RN, BSN

dhhs.healthcarefacilities@Nebraska.gov

In the Subject Line please put: DPOC

For states participating in the ePOC program, the DPOC may be added as an attachment.

Please note, if documentation includes any resident personal identifiable information (PII) or personal health information (PHI) it must be sent encrypted.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies, within 10 days after receipt of the Form CMS 2567. Please see the attached instructions (DPOC attachment) for detailed guidance.

- **Imposition of Denial of Payment for New Admissions (DPNA):**

  Payment will be denied for all NEW Medicare and Medicaid admissions, August 13, 2020 in accordance with the statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal regulations at 42 CFR §488.417. Your Medicare Administrative Contractor will be notified of the date the denial of payment begins. DPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated.

WITHDRAWAL OF APPROVAL FOR NURSE AIDE TRAINING PROGRAM

Please note that Federal law, as specified in the Social Security Act at §1819(f)(2)(B) and §1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs (NATCEP) and nurse aide competency evaluation programs (NACEP) offered by, or in, a facility which, within the previous two years, if one or more of the following exists:

- Operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse);
- Has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care;
- Has been assessed a total civil money penalty of not less than $10,697;
- Has been subject to a denial of payment;
- Appointment of a temporary manager;
- Terminated from participation, and/or
- In the case of an emergency, has been closed and/or had its residents transferred to other facilities.

INFORMAL DISPUTE RESOLUTION (IDR)

You have one opportunity to dispute the deficiencies cited on the survey date through (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the

specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Connie Vogt, RN, BSN
Email: dhhs.healthcarefacilities@Nebraska.gov
In the Subject Line of the email put: Request IDR

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

This request must be submitted within 10 days from the date of the enforcement letter. An incomplete Informal Dispute Resolution process will not delay the effective date of any enforcement action.

Informal Dispute Resolution is in no way to be construed as a formal evidentiary hearing. It is an informal internal process to review additional information submitted by the facility. You will be advised of our decision relative to the informal dispute.

APPEAL RIGHTS

If you disagree with the determination to impose remedies made on the basis of noncompliance identified at the July 6, 2020 survey, you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board (DAB). The appeal rights are set forth at 42 C.F.R. § 498.5 and the procedures for requesting a hearing are set forth at §498.40, et seq. You must file your hearing request electronically by using the DAB's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov/, unless you obtain a waiver from the DAB (*see* DAB Civil Remedies Division Procedures, § 6(a)(i)(1)). Your appeal must be filed no later than 60 days from the date of receipt of this letter.

We request that you provide an electronic copy of the request for appeal to:
ROkcmSCB@cms.hhs.gov
and to the CMS Regional Chief Counsel at:

OGCKansasCityGeneralInbox@hhs.gov

If you elect to dispute deficiencies through the Informal Dispute Resolution (IDR) process, this will not extend the 60 day period to file your appeal before the Departmental Appeals Board. Filing an appeal will not stop the imposition of any enforcement remedy.

If you experience problems with, or have questions about DAB e-File, please contact e-File System Support at OSDABImmediateOffice@hhs.gov. If you have questions about using the DAB e-file System, please visit: https://dab.efile.hhs.gov/appeals/to_crd_instructions?locale=en.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at QIO Program Website. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at Locate Your QIO.

CONTACT INFORMATION

If you have any questions please contact this office.

Sincerely,



Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

Enclosures: CMS 2567

Copies via e-mail to: CMS - RO
DHHS - State Medicaid Agency
DHHS - Nursing Support

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 14, 2020

Kelsie Ryan, Administrator
Tabitha At The Landing
6120 South 34th Street
Lincoln, NE 68516-4748 **CMS Certification No. 285288**

Subject: Survey Results
Cycle Start Date: June 30, 2020

Dear Administrator,

UNANNOUNCED COVID-19 SURVEY

The Secretary of the U.S. Department of Health and Human Services (DHHS) has the duty and responsibility to protect the health, safety, welfare and rights of Medicare/Medicaid beneficiaries. The Secretary has delegated authority to administer and provide oversight of the Medicare program to Centers for Medicare & Medicaid Services (CMS).

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-31-All*, CMS and the State Survey Agency are conducting unannounced onsite surveys at certain Medicare certified provider and supplier types.

SURVEY RESULTS

On June 30, 2020, a survey was completed at Tabitha At The Landing by the State Survey Agency to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the CMS 2567 and will be posted on the ePOC system.

PLAN OF CORRECTION

A Plan of Correction (PoC) for the deficiencies must be submitted **by July 24, 2020**, to the State Survey Agency Contact. **Failure to submit an acceptable PoC by July 24, 2020 may result**

in the imposition of additional remedies.

The PoC must contain the following:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of the quality assurance being implemented, the earliest correction date will be the date of the revisit; and
5. Include dates when corrective action will be completed. **The corrective action completion dates must be written in the completion date column within acceptable time frames.** If the PoC is unacceptable for any reason, you will be notified in writing by this office. If the PoC is acceptable, you will be notified via ePOC. Please note that the facility is ultimately accountable for compliance, and that responsibility is not alleviated in cases where notification regarding the acceptability of the facility's PoC is not made timely. **The PoC will serve as the facility's allegation of compliance.**

ENFORCEMENT REMEDIES

Based on the Statement of Deficiencies (Form CMS-2567), the following remedies are imposed:

- **Directed Plan of Correction:**

  In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction is imposed on the facility. In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. The effective date is not a deadline for completion of the DPOC. However, the State Agency will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice.

  Training option(s) which are the most appropriate for the type of noncompliance cited. For examp

  Sparkling Surfaces - https://youtu.be/t7OH8ORr5Ig
  Clean Hands - https://youtu.be/xmYMUly7qiE
  Closely Monitor Residents - https://youtu.be/1ZbT1Njv6xA
  Keep COVID-19 Out! - https://youtu.be/7srwrF9MGdw
  Lessons - https://youtu.be/YYTATw9yav4

Please send all documentation to the State Agency at the following:

Connie Vogt, RN, BSN

Email: dhhs.healthcarefacilities@Nebraska.gov

In the Subject Line please put: DPOC

For states participating in the ePOC program, the DPOC may be added as an attachment.

Please note, if documentation includes any resident personal identifiable information (PII) or personal health information (PHI) it must be sent encrypted.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies, within 10 days after receipt of the Form CMS 2567. Please see the attached instructions (DPOC attachment) for detailed guidance.

INFORMAL DISPUTE RESOLUTION (IDR)

Background:
Regulations at 42 CFR 488.331 require that CMS and the States, as appropriate, offer skilled nursing facilities, nursing facilities, and dually participating facilities an informal opportunity to dispute cited deficiencies upon the facility's receipt of the official Form CMS-2567. The following is a suggested example of IDR language that can be used.

You have one opportunity to dispute the deficiencies cited on the survey date through (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Connie Vogt, RN, BSN at dhhs.healthcarefacilities@Nebraska.gov

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

This request must be submitted within 10 days from the date of the enforcement letter. An incomplete Informal Dispute Resolution process will not delay the effective date of any enforcement action.

Informal Dispute Resolution is in no way to be construed as a formal evidentiary hearing. It is an informal internal process to review additional information submitted by the facility. You will be advised of our decision relative to the informal dispute.

APPEAL RIGHTS

Background:
When non-compliance is associated with an infection control deficiency, enforcement remedies include a Directed Plan of Correction, Discretionary Denial of Payment for New Admissions, and Civil Money Penalties. When enforcement remedies are imposed by the State Survey Agency, appeal rights' language must be included in the notice to the facility. The following is a suggested example of appeal language that can be used.

If you disagree with the determination to impose remedies made on the basis of noncompliance identified at the June 30, 2020 survey, you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board (DAB). The appeal rights are set forth at 42 C.F.R. § 498.5 and the procedures for requesting a hearing are set forth at §498.40, et seq. You must file your hearing request electronically by using the DAB's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov/, unless you obtain a waiver from the DAB (*see* DAB Civil Remedies Division Procedures, § 6(a)(i)(1)). Your appeal must be filed no later than 60 days from the date of receipt of this letter.

We request that you provide an electronic copy of the request for appeal to ROkcmSCB@cms.hhs.gov and to the CMS Regional Chief Counsel OGCKansasCityGeneralInbox@hhs.gov.

If you elect to dispute deficiencies through the Informal Dispute Resolution (IDR) process, this will not extend the 60 day period to file your appeal before the Departmental Appeals Board. Filing an appeal will not stop the imposition of any enforcement remedy.

If you experience problems with, or have questions about DAB e-File, please contact e-File System Support at OSDABImmediateOffice@hhs.gov. If you have questions about using the DAB e-file System, please visit: https://dab.efile.hhs.gov/appeals/to_crd_instructions?locale=en.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at QIO Program Website. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at Locate Your QIO.

CONTACT INFORMATION

If you have any questions please contact this office.

Sincerely,



Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

Enclosures: CMS 2567

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285288	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABITHA AT THE LANDING	**6120 SOUTH 34TH STREET LINCOLN, NE 68516**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS References to Title 175 of the Nebraska Administrative Code, Chapter 12- "Regulations Governing Licensure of Skilled Nursing Facilities, Nursing Facilities, and Intermediate Care Facilities" have been included in survey report as they apply to deficient practices identified.	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		8/4/20

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/23/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285288	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABITHA AT THE LANDING	6120 SOUTH 34TH STREET LINCOLN, NE 68516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 1 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Licensure Reference Number 175 NAC 12-006.17B	F 880	By 8/1/2020 all staff in the facility will have completed education on zoning	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285288	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABITHA AT THE LANDING	6120 SOUTH 34TH STREET LINCOLN, NE 68516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on interviews, CDC guidance, and record review, the facility failed to ensure an Observation zone resident did not ambulate into a green zone area of resident care potentially cross contaminating residents in the Covid Free or green zone area. This had the potential to effect the 14 residents in the Harbor house. The facility census was 43. CDC guidance updated June 25, 2020 titled "Preparing for COVID-19 in Nursing Homes" directs Long Term Facilities to create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown. The directions includes the following; Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. Testing at the end of this period can be considered to increase certainty that the resident is not infected. Record review of Resident 1's electronic health record revealed the resident had admitted to the facility on [redacted]. Further review noted the following. Staff attempted to ambulate the resident out of the "Observation" or "Quarantine" room to the	F 880	definitions, processes to be followed when providing care to any resident in the residents designated zone and the Closely Monitoring Residents video was assigned by the Director of Nursing or designee. All staff were educated on when a resident resides in Transitional Zone (resident□s private room) resident will need to remain in the room for all activity. If a resident needs to leave the facility for a medical appointment, resident will need to have a facemask on while moving from their room (Transitional Zone) to exit the facility. Staff will ensure that no other residents are present in the hallway or immediate area while the resident is being transported to the nearest exit. Telehealth appointments will be set up when available. The charge nurse will complete rounds during their shift to observe the Transitional Zone resident and ensure compliance of remaining in rooms, the nurse will document the results of their findings on the provided auditing tool. Director of Nursing or Designee will monitor the documentation in the electronic health record and the audit performed by the nurse. The Director or Designee will report findings to the QAPI subcommittee team weekly, including trends &/or findings. Adjustments will be directed as deemed necessary by the QAPI subcommittee team. The QAPI team will review quarterly and will recommend continuation or	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285288	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABITHA AT THE LANDING	**6120 SOUTH 34TH STREET LINCOLN, NE 68516**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 3 "Green" zone on 6/19/2020 but the resident refused. The resident was assisted to ambulate out of the "Observation" or "Quarantine" room to the "Green" zone on 6/20/2020 at 10:07 AM and 9 PM. The resident was assisted to ambulate out of the "Observation" or "Quarantine" room to the "Green" zone on 6/21/2020 at 1:30 PM and 9:19 PM. The resident was assisted to ambulate out of the "Observation" or "Quarantine" room to the "Green" zone on 6/22/2020 at 9:57 AM and 9:08 PM. The resident was assisted to ambulate out of the "Observation" or "Quarantine" room to the "Green" zone on 6/23/2020 at 9:55 AM and 2:43 PM. The resident was assisted to ambulate out of the "Observation" or "Quarantine" room to the "Green" zone on 6/24/2020 at 9:50 AM and 6:19 PM. The resident was assisted to ambulate out of the "Observation" or "Quarantine" room to the "Green" zone on 6/25/2020 at 9:38 AM and 9:59 PM. The resident was assisted to ambulate out of the "Observation" or "Quarantine" room to the "Green" zone on 6/26/2020 at 10:15 AM and 9:11 PM. The resident was assisted to ambulate out of the "Observation" or "Quarantine" room to the "Green" zone on 6/27/2020 at 9:47 AM and 2:58 PM. The resident was assisted to ambulate out of the "Observation" or "Quarantine" room to the "Green" zone on 6/28/2020 at 10:34 AM and 7:52 PM. The resident was assisted to ambulate out of the	F 880	discontinuation of the study.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285288	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABITHA AT THE LANDING	**6120 SOUTH 34TH STREET LINCOLN, NE 68516**

(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 "Observation" or "Quarantine" room to the "Green" zone on 6/29/2020 at 10:31 AM and 6:13 PM. The resident was assisted to ambulate out of the "Observation" or "Quarantine" room to the "Green" zone on 6/30/2020 at 10:10 AM. Interview with NA 1 on 6/30/2020 at 3:50 PM revealed the staff member had assisted Resident 1 to ambulate in the room. NA 1 had not assisted Resident 1 out of the room as the resident is in isolation and should not be out of the room. Hospice had performed bed baths as the resident could not go to the whirlpool tub. When anxious Resident 1 enjoyed talking with family on the phone or working on a puzzle in the room. Interview with Director of Nursing on 6/20/2020 at 1:50 PM confirmed Resident 1 had left the "Observation/Quarantine" area multiple times and at various times of the day to go on walks in the facility. All other residents in the Harbor house were considered to be in the "Green" or Covid free area of the facility.	F 880		

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 15, 2020

Sherri Due, Administrator
Tabitha Nursing Center At Crete
1800 East 13th Street
Crete, NE 68333 **CMS Certification No. 285283**

Subject: Survey Results
Cycle Start Date: July 9, 2020

Dear Administrator,

UNANNOUNCED COVID-19 SURVEY

The Secretary of the U.S. Department of Health and Human Services (DHHS) has the duty and responsibility to protect the health, safety, welfare and rights of Medicare/Medicaid beneficiaries. The Secretary has delegated authority to administer and provide oversight of the Medicare program to Centers for Medicare & Medicaid Services (CMS).

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-31-All*, CMS and the State Survey Agency are conducting unannounced onsite surveys at certain Medicare certified provider and supplier types.

SURVEY RESULTS

On July 9, 2020, a survey was completed at Tabitha Nursing Center At Crete by the State Survey Agency to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the CMS 2567 and will be posted on the ePOC system.

PLAN OF CORRECTION

A Plan of Correction (PoC) for the deficiencies must be submitted **by July 25, 2020**, to the State Survey Agency Contact. **Failure to submit an acceptable PoC by July 25, 2020 may result in the imposition of additional remedies.**

The PoC must contain the following:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of the quality assurance being implemented, the earliest correction date will be the date of the revisit; and
5. Include dates when corrective action will be completed. **The corrective action completion dates must be written in the completion date column within acceptable time frames.** If the PoC is unacceptable for any reason, you will be notified in writing by this office. If the PoC is acceptable, you will be notified via ePOC. Please note that the facility is ultimately accountable for compliance, and that responsibility is not alleviated in cases where notification regarding the acceptability of the facility's PoC is not made timely. **The PoC will serve as the facility's allegation of compliance.**

ENFORCEMENT REMEDIES

Based on the Statement of Deficiencies (Form CMS-2567), the following remedies are imposed:

- **Directed Plan of Correction:**

  In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction is imposed on the facility. In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. The effective date is not a deadline for completion of the DPOC. However, the State Agency will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice.

  Training option(s) which are the most appropriate for the type of noncompliance cited. For examp

  Sparkling Surfaces - https://youtu.be/t7OH8ORr5Ig
  Clean Hands - https://youtu.be/xmYMUly7qiE
  Closely Monitor Residents - https://youtu.be/1ZbT1Njv6xA
  Keep COVID-19 Out! - https://youtu.be/7srwrF9MGdw
  Lessons - https://youtu.be/YYTATw9yav4

  Please send all documentation to the State Agency at the following:

Connie Vogt, RN, BSN

dhhs.healthcarefacilities@Nebraska.gov

In the Subject Line please put: DPOC

For states participating in the ePOC program, the DPOC may be added as an attachment.

Please note, if documentation includes any resident personal identifiable information (PII) or personal health information (PHI) it must be sent encrypted.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies, within 10 days after receipt of the Form CMS 2567. Please see the attached instructions (DPOC attachment) for detailed guidance.

- **Imposition of Denial of Payment for New Admissions (DPNA):**

  Payment will be denied for all NEW Medicare and Medicaid admissions, August 29, 2020 in accordance with the statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal regulations at 42 CFR §488.417. Your Medicare Administrative Contractor will be notified of the date the denial of payment begins. DPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated.

WITHDRAWAL OF APPROVAL FOR NURSE AIDE TRAINING PROGRAM

Please note that Federal law, as specified in the Social Security Act at §1819(f)(2)(B) and §1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs (NATCEP) and nurse aide competency evaluation programs (NACEP) offered by, or in, a facility which, within the previous two years, if one or more of the following exists:

- Operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse);
- Has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care;
- Has been assessed a total civil money penalty of not less than $10,697;
- Has been subject to a denial of payment;
- Appointment of a temporary manager;
- Terminated from participation, and/or
- In the case of an emergency, has been closed and/or had its residents transferred to other facilities.

INFORMAL DISPUTE RESOLUTION (IDR)

You have one opportunity to dispute the deficiencies cited on the survey date through (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those

deficiencies, and (4) supporting documentation by fax or email to:

Connie Vogt, RN, BSN
Email: dhhs.healthcarefacilities@Nebraska.gov
In the Subject Line of the email put: Request IDR

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

This request must be submitted within 10 days from the date of the enforcement letter. An incomplete Informal Dispute Resolution process will not delay the effective date of any enforcement action.

Informal Dispute Resolution is in no way to be construed as a formal evidentiary hearing. It is an informal internal process to review additional information submitted by the facility. You will be advised of our decision relative to the informal dispute.

APPEAL RIGHTS

If you disagree with the determination to impose remedies made on the basis of noncompliance identified at the July 9, 2020 survey, you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board (DAB). The appeal rights are set forth at 42 C.F.R. § 498.5 and the procedures for requesting a hearing are set forth at §498.40, et seq. You must file your hearing request electronically by using the DAB's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov/, unless you obtain a waiver from the DAB (*see* DAB Civil Remedies Division Procedures, § 6(a)(i)(1)). Your appeal must be filed no later than 60 days from the date of receipt of this letter.

We request that you provide an electronic copy of the request for appeal to:
ROkcmSCB@cms.hhs.gov
and to the CMS Regional Chief Counsel at:
OGCKansasCityGeneralInbox@hhs.gov

If you elect to dispute deficiencies through the Informal Dispute Resolution (IDR) process, this will not extend the 60 day period to file your appeal before the Departmental Appeals Board. Filing an appeal will not stop the imposition of any enforcement remedy.

If you experience problems with, or have questions about DAB e-File, please contact e-File System Support at OSDABImmediateOffice@hhs.gov. If you have questions about using the DAB e-file System, please visit: https://dab.efile.hhs.gov/appeals/to_crd_instructions?locale=en.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at QIO Program Website. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at Locate Your QIO.

CONTACT INFORMATION

If you have any questions please contact this office.

Sincerely,

Connie F Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

Enclosures: CMS 2567

Copies via e-mail to: CMS - RO
DHHS - State Medicaid Agency
DHHS - Nursing Support

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285283	A. BUILDING _____ B. WING _____	07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABITHA NURSING CENTER AT CRETE	1800 EAST 13TH STREET CRETE, NE 68333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS References to Title 175 of the Nebraska Administrative Code, Chapter 12- "Regulations Governing Licensure of Skilled Nursing Facilities, Nursing Facilities, and Intermediate Care Facilities" have been included in survey report as they apply to deficient practices identified.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		7/29/20

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/16/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285283	A. BUILDING _____ B. WING _____	07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABITHA NURSING CENTER AT CRETE	1800 EAST 13TH STREET CRETE, NE 68333

(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 12-006.17A	F 880	-How will corrective action be accomplished for those residents found to	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285283	A. BUILDING _____ B. WING _____	07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABITHA NURSING CENTER AT CRETE	**1800 EAST 13TH STREET CRETE, NE 68333**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observations, interviews and record reviews, the facility failed to implement infection control practices and Centers for Medicare and Medicaid Services (CMS) guidelines to prevent the potential spread of COVID by failing to ensure staff wore available N95 masks to provide care for residents admitted within the prior 2 weeks. The census was 35 and sample size was 6. A. Record review of direction from the Centers for Disease Control titled "Preparing for Covid-19 in Nursing Homes" dated June 25, 2020 revealed the following. Facilities should create a plan for managing new admissions and readmissions whose Covid-19 status is unknown. Health care personnel should wear an N95 or higher-level respirator if available, eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Review of a document titled "Tabitha Health Care Services Personal Protective Equipment (PPE) Status" dated July 7, 2020 revealed the following. The Tabitha Corporation had 10,565 N95 masks in stock for use in Green/Yellow/and Gray zones. The Tabitha Corporation had 1800 N95 masks in stock for Red zone use. Bulleted at the bottom of the form was the following "Green/Yellow/Transitional Zones are very close to 100%, and Supply Chain will order 3000 N95 masks and 3000 disposable gowns to reach full capacity." The form also directed that N95 masks "need to be used for red, yellow and gray zone activity." Review of an untitled document provided by the facility on 7/8/2020 concluded the facility would require 200 N95 masks per week.	F 880	have been affected by the deficient practice: Staff identified in this report, received training to ensure the proper procedures for wearing N95 masks and PPE for new admits for 14 days. The staff will wear a N95 mask, eye protection, gloves and gown when caring for any new admission for 14 days from date of admission. -How will the facility identify other residents having the potential to be affected by the same deficient practice: Training and education for all staff on proper Infection Control procedures with wearing of N95 masks for new admissions and continue with the proper PPE practices that are already in place. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: At least three unannounced observations will be conducted on proper use of N95 masks in the residences monthly. Variance on amount of observations will depend on number of residents in the transitional zone. -How will the facility monitor performance to make sure the solutions are sustained: At least three unannounced observations	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285283	A. BUILDING _____ B. WING _____	07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABITHA NURSING CENTER AT CRETE	1800 EAST 13TH STREET CRETE, NE 68333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 3 Review of N95 mask requests made from Tabitha of Crete to Corporate revealed requests of 20 masks were made on 5/8, 5/14, 6/11, 6/18 and 6/25. Requests of PPE were made on 5/21 but there were no requests of N95 masks made at this time. The total of all N95 requests made to Tabitha Corporate based upon information provided was a total of 100 N95 masks or the equivalent of a half week of the facility's reported need of N95 masks. Observation of therapy staff member A exiting transitional/gray room # 11 of house #2 at 10:27 AM on 7/8/2020 revealed the staff member had been wearing a surgical mask rather than an available N95 mask to provide care to Resident 2 who had admitted within the prior 2 weeks. Observation of facility Personal Protective Equipment storage on 7/8/2020 at 11:00 AM with Administrator and Director of Nursing (DON) revealed the facility had approximately 8 boxes of unused N95 or KN95 masks with 20 masks per box. Interview with LPN B on 7/8/2020 at 9:00 AM revealed the resident #2 was newly admitted as of [redacted] and remained in 2 weeks of isolation in a transition room. N95 masks were available but were not used in transitional rooms unless the resident would have tested positive. There was plenty of PPE. Staff were to wear a surgical mask, gown, goggles, and gloves when in a transitional room. Interview with RN C on 7/8/2020 at 10:20 AM revealed the difference between gray zones and transitional zones was that gray zones required	F 880	will be conducted on proper use of N95 masks in the residences monthly. Any identified areas of concern will be addressed immediately. The Director of Nursing (or his/her designee) will be responsible for the review, the results of the observations, and direct corrective action as needed. A summary of the audit findings will be submitted to the facilities Performance Improvement Team quarterly, including trends and/or corrective action. Adjustments will be directed as deemed necessary by the Performance Improvement committee. The Performance Improvement Committee will recommend continuation or discontinuation of the study.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285283	A. BUILDING _____ B. WING _____	07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABITHA NURSING CENTER AT CRETE	**1800 EAST 13TH STREET CRETE, NE 68333**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 4 N95 masks and transitional zones only required the use of surgical masks. Interview with the Infection Control Preventionist on 7/8/2020 at 10:40 AM revealed the facility wanted to use CDC guidance to not use N95 masks for new admissions as the facility has not been able to secure enough N95 masks required for transitional zones. The staff person didn't know the current number of N95 masks available at the facility. Supplies were ordered weekly from Corporate by the DON and Infection Control Preventionist. B. Observation on 7/8/20 at 10:21 AM revealed that NA D and NA E where wearing surgical masks and goggles and went into nurses' station and washed hands and then came out and put on gowns, gloves and went into Resident 1's room. Upon exiting Resident 1's room, both NA D and NA E removed gown and gloves and discarded them into trash container sitting by doorway inside of room. NA D and NA E then used hand sanitizer and then removed goggles and mask, then exited room and immediately outside room put on new surgical mask and pair of goggles and then went to nurses' station and washed hands.	F 880		

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 22, 2020

Jade Harrah, Administrator
The Ambassador Lincoln
4405 Normal Blvd
Lincoln, NE 68506

CMS CERTIFICATION NUMBER: 285066

Dear Ms. Harrah:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 13, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

August 11, 2020

Jade Harrah, Administrator
The Ambassador Lincoln
4405 Normal Blvd
Lincoln, NE 68506

CMS CERTIFICATION NUMBER: 285066

Dear Ms. Harrah:

This is to acknowledge the results of the Infection Control survey conducted at your facility on August 10, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 7, 2020

Jessica Crunk, Administrator
The Ambassador Nebraska City
1800 14th Avenue
Nebraska City, NE 68410-0547

CMS CERTIFICATION NUMBER: 285126

Dear Ms. Crunk:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 30, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Kansas City Regional Office
601 East 12th Street, Room 355
Kansas City, Missouri 64106

IMPORTANT NOTICE – PLEASE READ CAREFULLY

June 19, 2020

Jake Bleach, Administrator
The Ambassador Omaha
1540 North 72nd Street
Omaha, NE 68114-1999

CMS Certification Number: 285127

Subject: Survey Results
Cycle Start Date: June 2, 2020

Dear Mr. Bleach,

COVID-19 FOCUSED INFECTION CONTROL SURVEY

The Secretary of the U.S. Department of Health and Human Services (DHHS) has the duty and responsibility to protect the health, safety, welfare and rights of Medicare/Medicaid beneficiaries. The Secretary has delegated authority to administer and provide oversight of the Medicare program to Centers for Medicare & Medicaid Services (CMS).
The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-31-All, CMS and the State Survey Agency are conducting unannounced onsite surveys at certain Medicare certified provider and supplier types.
SURVEY RESULTS
On June 2, 2020, a survey was completed at The Ambassador Omaha by CMS to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the enclosed form CMS 2567.
PLAN OF CORRECTION
A Plan of Correction (PoC) for the deficiencies must be submitted within ten (10) calendar days of your receipt of this notice. Use the space provided to the right of each item of deficiency to type your PoC and the expected date of completion. A PoC must be entered for each item clearly identifying HOW, WHAT, WHEN, AND WHERE it was or will be corrected. The plan should also include provisions instituted to prevent reoccurrence. The PoC must contain the following:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected

by the same deficient practice;

- Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of the quality assurance being implemented, the earliest correction date will be the date of the revisit; and
- Include dates when corrective action will be completed. The corrective action completion dates must be written in the completion date column within acceptable time frames. If the PoC is unacceptable for any reason, you will be notified in writing by this office. If the PoC is acceptable, you will be notified via telephone, e-mail, etc. Please note that the facility is ultimately accountable for compliance, and that responsibility is not alleviated in cases where notification regarding the acceptability of the facility's PoC is not made timely. The PoC will serve as the facility's allegation of compliance.

You must send this office the original, signed and dated Statement of Deficiencies (SoD) with the PoC to:

Amanda Spicer, Nurse Consultant
Amanda.Spicer@cms.hhs.gov

ENFORCEMENT REMEDIES
Based on the Statement of Deficiencies (Form CMS-2567), the following remedies are imposed:

Directed Plan of Correction:
In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction (DPOC) is imposed on the facility. In accordance with 42 CFR § 488.402(f), this remedy is effective July 4, 2020. The DPOC may be completed before or after that date. The effective date is not a deadline for completion of the DPOC. However, CMS will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice.
The DPOC requires that your plan of correction include the following:

- A plan for all facility staff to view the two Centers for Disease Control (CDC) training videos located at the following: https://youtu.be/YYTATw9yav4 and https://youtu.be/7srwrF9MGdw. Training may be supervised by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion by all staff.

- The Infection Preventionist and Director of Nursing, in conjunction with the Medical Director, and senior leadership/Governing Body concurrence, shall complete the following:

o Develop and implement procedures to utilize an at-the-door symptom check for all visitors, vendors and others before entering the facility.
o Develop and implement procedures for screening all staff at the beginning of their shift for fever and respiratory symptoms. This will include actively measuring and recording staff

temperatures and assessment of shortness of breath, new or changed cough, and sore throat. Screening logs will be maintained and signed by the staff member who conducts the screening.

- A Root Cause Analysis (RCA) of the deficient practices cited, conducted with assistance from the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee and Governing Body. The RCA should be incorporated into the intervention plan. Information regarding RCAs can be found at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies, within 10 days after receipt of the Form CMS 2567. Please send all documentation to CMS at the following:
Amanda Spicer, Nurse Consultant
Email: Amanda.Spicer@cms.hhs.gov

Please note, if documentation includes any resident personal identifiable information (PII) or personal health information (PHI) it must be sent encrypted.

Imposition of Denial of Payment for New Admissions (DPNA):

Payment will be denied for all NEW Medicare and Medicaid admissions, beginning August 3, 2020, in accordance with the statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal regulations at 42 CFR §488.417. Your Medicare Administrative Contractor will be notified of the date the denial of payment begins. DPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated.

INFORMAL DISPUTE RESOLUTION (IDR)

You have one opportunity to dispute the deficiencies cited on the survey date through (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Lisa Hauptman, Acting Long Term Care Branch Manager
Email: Lisa.Hauptman@cms.hhs.gov

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for

informal dispute resolution.

This request must be submitted within 10 days from the date of the enforcement letter. An incomplete Informal Dispute Resolution process will not delay the effective date of any enforcement action.

Informal Dispute Resolution is in no way to be construed as a formal evidentiary hearing. It is an informal internal process to review additional information submitted by the facility. You will be advised of our decision relative to the informal dispute.

WITHDRAWAL OF APPROVAL FOR NURSE AIDE TRAINING PROGRAM
Please note that Federal law, as specified in the Social Security Act at §1819(f)(2)(B) and §1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs (NATCEP) and nurse aide competency evaluation programs (NACEP) offered by, or in, a facility in which, within the previous two years, one or more of the following exists:
Operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse);
Has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care;
Has been assessed a total civil money penalty of not less than $10,697;
Has been subject to a denial of payment;
Appointment of a temporary manager;
Terminated from participation, and/or
In the case of an emergency, has been closed and/or had its residents transferred to other facilities.
Your facility will receive further information regarding this from the State Agency.

APPEAL RIGHTS
The following remedies are being imposed:
- Directed Plan of Correction
- DPNA

If you disagree with this action imposed on your facility, you or your legal representative are required to file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/. To file a new appeal using DAB E-File, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.
The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:
Clicking the File New Appeal link on the Manage Existing Appeals screen, then clicking Civil Remedies Division on the File New Appeal screen. Entering and uploading the requested information and documents on the "File New Appeal- Civil Remedies Division" form.
At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for

hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. The DAB will set the location for the hearing. Counsel may represent you at a hearing at your own expense.

All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions for using DAB E-File in cases before the DAB's Civil Remedies Division can be found by clicking the button marked E-Filing Instructions after logging-in to DAB E-File.

For questions regarding the E-Filing system, please contact E-File System Support at OSDABImmediateOffice@hhs.gov.

Please note that all hearing requests must be filed electronically unless you have no access to the internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. Such a request should be made to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

A request for a hearing must be filed no later than 60 days from the date of receipt of this notice.

A copy of the hearing request shall be submitted electronically to:
kevin.wright@cms.hhs.gov

If you believe you have achieved substantial compliance, you should contact the CMS RO. In addition, if substantial compliance has not been achieved within six (6) months after the last date of the survey identifying noncompliance, June 2, 2020, we will terminate your Medicare provider agreement effective December 2, 2020.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at QIO Program Website. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at Locate Your QIO.

CONTACT INFORMATION

Thank you for the time and courtesy extended to our surveyors during the survey. If you have any

questions regarding the survey, please contact Amanda Spicer, Nurse Consultant. For questions regarding enforcement, Kevin Wright, Health Insurance Specialist. Both can be reached in our Kansas City Regional Office at (816) 426-2011.

Sincerely,

Lisa Hauptman
Acting Long Term Care Branch Manager
Survey & Operations Group
Center for Clinical Standards & Quality

CMS Kansas City

Enclosures
CMS 2567

Copies via e-mail to:
NE DHHS
Hauptman/Grimes
WPS
OGC

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285263	A. BUILDING _____ B. WING _____	C 05/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTFIELD QUALITY CARE OF AURORA	**PO BOX 166, 1313 1ST STREET AURORA, NE 68818**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS References to Title 175 of the Nebraska Administrative Code, Chapter 12- "Regulations Governing Licensure of Skilled Nursing Facilities, Nursing Facilities, and Intermediate Care Facilities" have been included in survey report as they apply to deficient practices identified.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		7/20/20

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/14/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285263	A. BUILDING _____ B. WING _____	C 05/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTFIELD QUALITY CARE OF AURORA	**PO BOX 166, 1313 1ST STREET AURORA, NE 68818**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 1 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Licensure Reference Number 175 NAC 12-006B	F 880	The facility denies that the alleged facts as set forth constitute a deficiency under	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285263	A. BUILDING _____ B. WING _____	C 05/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTFIELD QUALITY CARE OF AURORA	**PO BOX 166, 1313 1ST STREET AURORA, NE 68818**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observation, interview, and record review the facility failed; to follow implemented infection control practices and CMS (Centers for Medicare and Medicaid Services) guidelines to prevent potential cross contamination including the spread of COVID 19 (a highly contagious virus primarily spread from person to person through respiratory droplets, which can lead to serious illness and even death) related to lab personnel that were not screened upon facility entry and did not have PPE (Personnel Protective Equipment) masks in place per the facility practice. This had the potential to affect 1 resident 2 sampled (Resident 5). The facility census was 44. Findings are: AN observation on 5/29/20 at 1.50 PM revealed; LP (Lab Personnel) E and LP F had come to the nurse's desk after entering the building. LP E and F stood next to the screening station. It was observed that neither LP E nor LP F had a face mask during entry. LP-E gained information lab that required completion. LP E and F left the nurses station and entered the hallway for resident. Record review of Laboratory Results for Resident 5 revealed; the lab was drawn at 1:58 PM. Record review of Screening for LP (Lab Personnel) E dated 5/29/20 revealed; LP E had been screened at 2:00 PM. LP E had traveled from Omaha, had no symptoms, and was afebrile. LP E had contact with Covid 19. Record review of Screening for LP F dated	F 880	the interpretations of federal and state law. The preparation of the following plan of correction should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged, or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provision of state and federal law. Without waiving the forgoing statement, the facility states that regards to this citation: The Laboratory Personnel, in question, had been screened for COVID19 symptoms and known exposure that vary morning at Memorial Hospital prior to performing lab rounds at Westfield Quality Care of Aurora. Therefore, an extremely rare chance of any potential exposure to any residents of Westfield Quality Care of Aurora existed, which is the intent of all screening. All other records indicated that appropriate screening had taken place. To date, as of the receipt of this alleged deficiency 7-8-20, there are no new symptoms or positive tests of COVID19 at Westfield Quality Care of Aurora and since ALL residents and staff have been cleared of COVID19. The screening process in place has proven effective. The Laboratory Personnel were screened prior to the leaving the facility. They were screened by Westfield Quality Care of Aurora staff at 2:00PM. Many of the observations made by the survey team were made following the time that the laboratorians were screened.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285263	A. BUILDING _____ B. WING _____	C 05/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTFIELD QUALITY CARE OF AURORA	**PO BOX 166, 1313 1ST STREET AURORA, NE 68818**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 3 5/29/20 revealed; LP F had been screened at 2:00 PM. LP F had not traveled, had no symptoms, and was afebrile. LP F had contact with Covid 19. Record review of Laboratory Result for Resident 4 revealed; the lab had been drawn at 2:22 PM. An observation on 5/29/20 at 2:02 PM of LP-E and LP-F in the front of the nurse's station without masks that were required in the resident areas. An interview on 5/29/20 at 2:02 PM with LP E confirmed; both LP-E and LP-F had not screened prior to drawing lab on a resident. They were unaware that there was a screening station and where the station was located. An interview on 5/29/20 at 2:03 PM with LPN (Licensed Practical Nurse) G revealed; LPN G was unaware that the lab personnel needed to fill out the paperwork on entry and be screened. The LPN reported there was a book for the Hospice and one for therapy, but was unaware if there was a book for the lab. An observation on 5/29/20 at 2:04 PM of the Screening station revealed; there was a binder that had Hospice and a binder for Therapy. An interview on 5/29/20 at 2:05 PM with the Interim DON (Director of Nurses) confirmed; lab personnel were to be screened on entry to the building. An observation on 5/29/20 at 2:30 PM of the 300 hall revealed; the hall had resident doors closed, staff had the N95 masks donned.	F 880	A laboratory personnel binder was prepared at the time of the incident where laboratorians are to sign-in upon arrival to the facility. Signs were posted at both entrances to the facility indicating that ANYONE entering the facility must be screened. Masks and hand sanitizer are available at both entrances to the facility. Nursing staff and laboratory staff have been educated on the need for and the process of screening the laboratory staff at the time of the incident. Additional education will be presented to staff on 7-15-20. Audits are being performed on the screening tools and follow-up by nursing should any outlier symptoms exist or reported travel present as a concern. These results are reporting to QA monthly.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285263	A. BUILDING _____ B. WING _____	C 05/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTFIELD QUALITY CARE OF AURORA	**PO BOX 166, 1313 1ST STREET AURORA, NE 68818**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 4 An interview on 5/29/20 at 3:07 PM with Interim DON confirmed that the lab personnel had screened prior to leaving the facility. The interim DON reported that the previous lab personnel should have been screening and the staff were searching for that documentation. The Interim DON reported that there was not a binder for the Lab personnel. An interview on 5/29/20 at 4:15 PM with RN (Registered Nurse) H confirmed; lab personnel had come on 05/29/20 were not the normal lab personnel and the normal lab personnel that came was aware of the process and would stop and screen. RN H reported they were aware of the screening process and they had not remember to complete this with the lab personnel. Additional information provided by the facility: An interview on 6/2/20 at 2:36 PM with the Administrator revealed; the facility was unable to locate any past documentation related to Lab staff screening. Additional information provided by the facility	F 880		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285127	A. BUILDING _____ B. WING _____	06/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AMBASSADOR OMAHA	1540 NORTH 72ND STREET OMAHA, NE 68114

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 6/2/2020. The facility was found to not be in compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total residents: 80	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/13/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285127	A. BUILDING _____ B. WING _____	06/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AMBASSADOR OMAHA	1540 NORTH 72ND STREET OMAHA, NE 68114

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 1 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285127	A. BUILDING _____ B. WING _____	06/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AMBASSADOR OMAHA	1540 NORTH 72ND STREET OMAHA, NE 68114

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement CMS and CDC recommendations in order to prepare for COVID-19. The facility failed to thoroughly screen visitors, when the Federal surveyor entered the facility and was not screened by staff. Additionally, the facility failed to screen staff, when the facility failed to ask CDC-recommended screening questions prior to staff caring for residents. The facility failed to ensure that staff correctly wore facemasks at all times while in the facility, and while within six feet of residents. Findings included: - On 6/2/20 at 11:30am, Registered Nurse (RN1) and RN2 sat at the 3R, or pediatric floor, nursing station. RN1 and RN2 wore disposable surgical facemasks, but failed to wear the masks appropriately. RN1 and RN2 each had their mask beneath their nose, leaving their noses exposed. Upon seeing the Federal surveyor, RN1 and RN2 pulled their facemasks over their noses. On 6/2/20 at 12:03pm, the Pediatrics Supervisor indicated that facemasks must be worn over the mouth and nose. The Pediatric Supervisor indicated that she was not aware of any issues with staff wearing facemasks inappropriately. On 6/2/20 at 12:17pm, RN1 and RN2 indicated that their facemasks had slipped beneath their noses. On 6/2/20 at 12:37pm, a housekeeper (H1)	F 880		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285127	A. BUILDING _____ B. WING _____	06/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AMBASSADOR OMAHA	1540 NORTH 72ND STREET OMAHA, NE 68114

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 3	F 880		

cleaned R1's room while R1 watched TV in the common area. H1 wore a disposable surgical facemask, however, H1's mask was pulled beneath her chin, leaving her mouth and nose exposed while she cleaned the room.

On 6/2/20 at 12:47pm, H1 indicated that she was too hot, so she pulled her mask down beneath her chin. H1 indicated that this was not appropriate mask wearing, and fixed her mask.

On 6/2/20 at 12:58pm, H1 swept R2's room, while R2 was present. H1 stood directly next to R2 and looked in the direction of R2's television, which played cartoons. H1's facemask was again pulled beneath her chin, leaving her mouth and nose exposed. H1 then exited the room and retrieved a dustpan, collected some floor debris, then exited R2's room. H1 failed to sanitize her hands after leaving the room and beginning to vacuum the hallway.

On 6/2/20 at 1:05pm, RN3 stood in R3's room and talked with the resident. RN3 wore a disposable surgical facemask, however, the mask was pulled down, leaving R3's nose exposed. Upon seeing the Federal surveyor, RN3 pulled her facemask over her nose.

On 6/2/20 at 1:22pm, RN3 indicated that her mask had slipped down, and that she had not fixed it yet. RN3 indicated that masks must be worn over the mouth and nose.

On 6/2/20 at 2:30pm, Licensed Practical Nurse (LPN1) indicated that facemasks must be worn over the mouth and nose at all times. LPN1 indicated that in the past, she had observed staff not wearing facemasks appropriately. This

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285127	A. BUILDING _____ B. WING _____	06/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AMBASSADOR OMAHA	1540 NORTH 72ND STREET OMAHA, NE 68114

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 4	F 880		

happened occasionally, and LPN1 would complete on-the-spot education for staff who did not correctly wear their masks.

- Review of CMS guidance, dated 3/4/20, documented the following:

"How should facilities monitor or limit visitors? Facilities should screen visitors for the following:

1. International travel within the last 14 days to restricted countries. For updated information on restricted countries visit: https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html

2. Signs or symptoms of a respiratory infection, such as a fever, cough, and sore throat.

3. Has had contact with someone with or under investigation for COVID-19."

The guidance then stated:

"How should facilities monitor or restrict health care facility staff?

The same screening performed for visitors should be performed for facility staff (numbers 1, 2, and 3 above)."

On 6/2/20 at 11:15am, the Federal surveyor entered the facility. A receptionist sat at the desk. The Federal surveyor gave the reason and purpose for the visit, and the receptionist called the Director of Nursing (DON). The receptionist failed to screen the Federal surveyor. Approximately five minutes later, the DON arrived, and escorted the Federal surveyor to

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285127	A. BUILDING _____ B. WING _____	06/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AMBASSADOR OMAHA	1540 NORTH 72ND STREET OMAHA, NE 68114

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 5 floor 3R. The DON failed to screen the Federal surveyor. On 6/2/20 at 12:17pm, RN2 indicated that the facility screening process consisted of staff taking their own temperatures and logging the result. There were no screening questions to complete. On 6/2/20 at 12:28pm, the DON indicated that all floors in the facility were locked, so staff were either screened there or at the nursing stations, which were directly by the entry doors. Facility staff were to take their own temperatures and log them. The DON indicated that there were also screening questions staff were to complete. On 6/2/20 at 1:22pm, RN3 indicated that the facility screening process consisted of staff taking their temperatures and logging the result. Staff were asked if they had signs or symptoms of COVID-19, but there were no further screening questions. Review of staff screening sheets, dated 3/15/20 through the recent ones, documented facility staff had their temperatures taken, and answered a single question as to if they had signs or symptoms of a respiratory infection. There were no other screening questions present. The facility failed to provide any staff screening forms prior to 3/15/20.	F 880		

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 2, 2020

Brody Chandler, Administrator
The Lighthouse At Lakeside Village
17600 Arbor Street
Omaha, NE 68130

CMS CERTIFICATION NUMBER: 285280

Dear Mr. Chandler:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 18, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Kansas City Regional Office
601 East 12th Street, Room 355
Kansas City, Missouri 64106

MIDWEST DIVISION OF SURVEY AND CERTIFICATION

June 30, 2020

Mikayla Wengler, Administrator
Tiffany Square
3119 West Faidley Avenue
Grand Island, NE 68803

CMS Certification No: 285087

Dear Ms. Wengler:

SUBJECT: SURVEY RESULTS
Cycle Start Date: June 22, 2020

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES
The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-20-All*, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS
On June 22, 2020, the Centers for Medicare & Medicaid Services (CMS) completed a COVID-19 Focused Survey at Tiffany Square to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was in substantial compliance with participation requirements and no deficiencies were cited. The findings from this survey are documented on the enclosed form CMS 2567.

No additional action is required on the facility's part.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES
The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at QIO Program Website. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at Locate Your QIO.

CONTACT INFORMATION
If you have any questions please contact Kevin Wright, Principal Program Representative at (816) 426-2011.

Sincerely,

Kevin Wright
Long Term Care Branch
Survey & Operations Group
Center for Clinical Standards & Quality
CMS Kansas City

cc:
NE DHHS
Powers/Grimes

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 23, 2020

Jodi Dethlefs, Administrator
Valley View Senior Village
220 South 26th Street
Ord, NE 68862

CMS CERTIFICATION NUMBER: 285294

Dear Ms. Dethlefs:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 21, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 23, 2020

Traci Haglund, Administrator
Wakefield Health Care Center
306 Ash Street
Wakefield, NE 68784

CMS CERTIFICATION NUMBER: 285209

Dear Ms. Haglund:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 16, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 22, 2020

Lisa Kisinger, Administrator
Wauneta Care And Therapy Center
Po Box 520, 427 Legion Street
Wauneta, NE 69045-0520

CMS CERTIFICATION NUMBER: 285220

Dear Ms. Kisinger:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 13, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
CMS Kansas City - Survey & Operations Group
601 East 12th Street, Room 355
Kansas City, Missouri 64106

July 17, 2020

Cheri Wingert, Administrator
Wayne Countryview Care and Rehabilitation
811 East 14th Street
Wayne, NE 68787

CMS Certification Number: 285135

Dear Ms. Wingert:

SUBJECT: SURVEY RESULTS
Cycle Start Date: July 14, 2020

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES
The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-20-All*, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS
On July 14, 2020, the Centers for Medicare & Medicaid Services (CMS) completed a COVID-19 Focused Survey at Wayne Countryview Care and Rehabilitation to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was in substantial compliance with participation requirements and no deficiencies were cited. The findings from this survey are documented on the enclosed form CMS 2567.

No additional action is required on the facility's part.

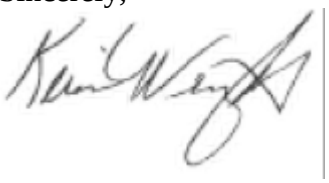
QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES
The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities

in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at QIO Program Website: https://qioprogram.org/covid-19. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at Locate Your QIO: https://qioprogram.org/locate-your-qio.

CONTACT INFORMATION

If you have any questions please contact Kevin Wright, Principal Program Representative at (816) 426-2011.

Sincerely,



Kevin Wright
Long Term Care Branch
Survey & Operations Group
Center for Clinical Standards & Quality
CMS Kansas City

cc:
NE DHHS
Powers/Grimes

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 15, 2020

Allen Pannell, Administrator
Western Nebraska Veterans Home
1102 West 42nd Street
Scottsbluff, NE 69361

Dear Mr. Pannell:

This is to acknowledge the results of the Infection Control survey conducted at your facility on June 17, 2020 by representatives of this Department. Your facility was found in compliance with Skilled Nursing Facility, Nursing Facility and Intermediate Care Facilities.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E. Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/ls

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 8, 2020

Christopher Young, Administrator
Westfield Quality Care Of Aurora
Po Box 166, 1313 1st Street
Aurora, NE 68818

Dear Mr. Young:

An unannounced visit was conducted to investigate a complaint at Westfield Quality Care Of Aurora on May 29, 2020, by representatives of the Department of Health and Human Services Division of Public Health. To complete this investigation, a representative sample of the residents who reside in the facility or had resided in the facility was selected. The investigative process included review of resident records; observation of the provision of care and services; and interviews with residents, family members and staff.

ALLEGATION:
The facility fails to implement infection control procedures to prevent the spread of infection.

FINDINGS:
The facility failed to implement infection control procedures to prevent the spread of infection per CMS directives related to COVID -19. To make this determination; record review of residents records and observations revealed, laboratory staff were not screened upon entering the facility or before resident contact. Interviews revealed laboratory staff were unaware of requirements in place to prevent infection transmission of COVID-19. Record reviews confirmed laboratory staff had not been screened prior to providing services to a resident. This facility failure is a violation of F880 Infection Control and Licensure Reference Number 175 NAC 12-006.17B.

These findings are related to regulations under the Licensure Unit's regulatory authority. Since each division has unique statutory and regulatory obligations and guidelines, it may be possible that your facility will receive additional findings from other divisions who have also participated in the investigation/assessment of these same or similar allegations.

Please contact this office if you have questions.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 8, 2020

Christopher Young, Administrator
Westfield Quality Care Of Aurora
Po Box 166, 1313 1st Street
Aurora, NE 68818 **CMS Certification No. 285263**

Subject: Survey Results
Cycle Start Date: May 29, 2020

Dear Administrator,

UNANNOUNCED COVID-19 SURVEY

The Secretary of the U.S. Department of Health and Human Services (DHHS) has the duty and responsibility to protect the health, safety, welfare and rights of Medicare/Medicaid beneficiaries. The Secretary has delegated authority to administer and provide oversight of the Medicare program to Centers for Medicare & Medicaid Services (CMS).

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-31-All*, CMS and the State Survey Agency are conducting unannounced onsite surveys at certain Medicare certified provider and supplier types.

SURVEY RESULTS

On May 29, 2020, a survey was completed at Westfield Quality Care Of Aurora by the State Survey Agency to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the CMS 2567 and will be posted on the ePOC system.

PLAN OF CORRECTION

A Plan of Correction (PoC) for the deficiencies must be submitted **by July 18, 2020**, to the State Survey Agency Contact. **Failure to submit an acceptable PoC by July 18, 2020 may result in the imposition of additional remedies.**

The PoC must contain the following:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
3. Address what measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of the quality assurance being implemented, the earliest correction date will be the date of the revisit; and
5. Include dates when corrective action will be completed. **The corrective action completion dates must be written in the completion date column within acceptable time frames.** If the PoC is unacceptable for any reason, you will be notified in writing by this office. If the PoC is acceptable, you will be notified via ePOC. Please note that the facility is ultimately accountable for compliance, and that responsibility is not alleviated in cases where notification regarding the acceptability of the facility's PoC is not made timely. **The PoC will serve as the facility's allegation of compliance.**

ENFORCEMENT REMEDIES

Based on the Statement of Deficiencies (Form CMS-2567), the following remedies are imposed:

- **Directed Plan of Correction:**

  In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction is imposed on the facility. In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. The effective date is not a deadline for completion of the DPOC. However, the State Agency will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice.

  Training option(s) which are the most appropriate for the type of noncompliance cited. For examp

  Sparkling Surfaces - https://youtu.be/t7OH8ORr5Ig
  Clean Hands - https://youtu.be/xmYMUly7qiE
  Closely Monitor Residents - https://youtu.be/1ZbT1Njv6xA
  Keep COVID-19 Out! - https://youtu.be/7srwrF9MGdw
  Lessons - https://youtu.be/YYTATw9yav4

  Please send all documentation to the State Agency at the following:

Connie Vogt, RN, BSN

Email: dhhs.healthcarefacilities@Nebraska.gov

In the Subject Line please put: DPOC

For states participating in the ePOC program, the DPOC may be added as an attachment.

Please note, if documentation includes any resident personal identifiable information (PII) or personal health information (PHI) it must be sent encrypted.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies, within 10 days after receipt of the Form CMS 2567. Please see the attached instructions (DPOC attachment) for detailed guidance.

- **Imposition of Denial of Payment for New Admissions (DPNA):**

Payment will be denied for all NEW Medicare and Medicaid admissions, beginning August 8, 2020 of the date the denial of payment begins. DPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated.

INFORMAL DISPUTE RESOLUTION (IDR)

You have one opportunity to dispute the deficiencies cited on the survey date through (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Connie Vogt, RN, BSN
Email: dhhs.healthcarefacilities@Nebraska.gov
In the Subject Line please type: Request IDR

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by

counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

This request must be submitted within 10 days from the date of the enforcement letter. An incomplete Informal Dispute Resolution process will not delay the effective date of any enforcement action.

Informal Dispute Resolution is in no way to be construed as a formal evidentiary hearing. It is an informal internal process to review additional information submitted by the facility. You will be advised of our decision relative to the informal dispute.

APPEAL RIGHTS

If you disagree with the determination to impose remedies made on the basis of noncompliance identified at the May 29, 2020 survey, you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board (DAB). The appeal rights are set forth at 42 C.F.R. § 498.5 and the procedures for requesting a hearing are set forth at §498.40, et seq. You must file your hearing request electronically by using the DAB's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov/, unless you obtain a waiver from the DAB (*see* DAB Civil Remedies Division Procedures, § 6(a)(i)(1)). Your appeal must be filed no later than 60 days from the date of receipt of this letter.

We request that you provide an electronic copy of the request for appeal to: ROkcm
and to the CMS Regional Chief Counsel at:
OGCKansasCityGeneralInbox@hhs.gov

If you elect to dispute deficiencies through the Informal Dispute Resolution (IDR) process, this will not extend the 60 day period to file your appeal before the Departmental Appeals Board. Filing an appeal will not stop the imposition of any enforcement remedy.

If you experience problems with, or have questions about DAB e-File, please contact e-File System Support at OSDABImmediateOffice@hhs.gov. If you have questions about using the DAB e-file System, please visit: https://dab.efile.hhs.gov/appeals/to_crd_instructions?locale=en.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at QIO Program Website. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at Locate Your QIO.

CONTACT INFORMATION

If you have any questions please contact this office.

Sincerely,



Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

Enclosures: CMS 2567

Copies via e-mail to: CMS-RO
DHHS - State Medicaid Agency
DHHS - Nursing Support

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285263	A. BUILDING _____ B. WING _____	05/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTFIELD QUALITY CARE OF AURORA	**PO BOX 166, 1313 1ST STREET AURORA, NE 68818**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		7/20/20

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/14/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285263	A. BUILDING _____ B. WING _____	05/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTFIELD QUALITY CARE OF AURORA	**PO BOX 166, 1313 1ST STREET AURORA, NE 68818**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 1 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Licensure Reference Number 175 NAC 12-006B Based on observation, interview, and record review the facility failed; to follow implemented infection control practices and CMS (Centers for Medicare and Medicaid Services) guidelines to prevent potential cross contamination including the spread of COVID 19 (a highly contagious virus primarily spread from person to person through respiratory droplets, which can lead to serious illness and even death) related to lab	F 880	The facility denies that the alleged facts as set forth constitute a deficiency under the interpretations of federal and state law. The preparation of the following plan of correction should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged, or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provision	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285263	A. BUILDING _____ B. WING _____	05/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTFIELD QUALITY CARE OF AURORA	**PO BOX 166, 1313 1ST STREET AURORA, NE 68818**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 personnel that were not screened upon facility entry and did not have PPE (Personnel Protective Equipment) masks in place per the facility practice. This had the potential to affect 1 resident 2 sampled (Resident 5). The facility census was 44. Findings are: AN observation on 5/29/20 at 1.50 PM revealed; LP (Lab Personnel) E and LP F had come to the nurse's desk after entering the building. LP E and F stood next to the screening station. It was observed that neither LP E nor LP F had a face mask during entry. LP-E gained information lab that required completion. LP E and F left the nurses station and entered the hallway for resident. Record review of Laboratory Results for Resident 5 revealed; the lab was drawn at 1:58 PM. Record review of Screening for LP (Lab Personnel) E dated 5/29/20 revealed; LP E had been screened at 2:00 PM. LP E had traveled from Omaha, had no symptoms, and was afebrile. LP E had contact with Covid 19. Record review of Screening for LP F dated 5/29/20 revealed; LP F had been screened at 2:00 PM. LP F had not traveled, had no symptoms, and was afebrile. LP F had contact with Covid 19. Record review of Laboratory Result for Resident 4 revealed; the lab had been drawn at 2:22 PM. An observation on 5/29/20 at 2:02 PM of LP-E	F 880	of state and federal law. Without waiving the forgoing statement, the facility states that regards to this citation: The Laboratory Personnel, in question, had been screened for COVID19 symptoms and known exposure that vary morning at Memorial Hospital prior to performing lab rounds at Westfield Quality Care of Aurora. Therefore, an extremely rare chance of any potential exposure to any residents of Westfield Quality Care of Aurora existed, which is the intent of all screening. All other records indicated that appropriate screening had taken place. To date, as of the receipt of this alleged deficiency 7-8-20, there are no new symptoms or positive tests of COVID19 at Westfield Quality Care of Aurora and since ALL residents and staff have been cleared of COVID19. The screening process in place has proven effective. The Laboratory Personnel were screened prior to the leaving the facility. They were screened by Westfield Quality Care of Aurora staff at 2:00PM. Many of the observations made by the survey team were made following the time that the laboratorians were screened. A laboratory personnel binder was prepared at the time of the incident where laboratorians are to sign-in upon arrival to the facility. Signs were posted at both entrances to the facility indicating that ANYONE entering the facility must be screened.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285263	A. BUILDING _____ B. WING _____	05/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTFIELD QUALITY CARE OF AURORA	**PO BOX 166, 1313 1ST STREET AURORA, NE 68818**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 3 and LP-F in the front of the nurse's station without masks that were required in the resident areas. An interview on 5/29/20 at 2:02 PM with LP E confirmed; both LP-E and LP-F had not screened prior to drawing lab on a resident. They were unaware that there was a screening station and where the station was located. An interview on 5/29/20 at 2:03 PM with LPN (Licensed Practical Nurse) G revealed; LPN G was unaware that the lab personnel needed to fill out the paperwork on entry and be screened. The LPN reported there was a book for the Hospice and one for therapy, but was unaware if there was a book for the lab. An observation on 5/29/20 at 2:04 PM of the Screening station revealed; there was a binder that had Hospice and a binder for Therapy. An interview on 5/29/20 at 2:05 PM with the Interim DON (Director of Nurses) confirmed; lab personnel were to be screened on entry to the building. An observation on 5/29/20 at 2:30 PM of the 300 hall revealed; the hall had resident doors closed, staff had the N95 masks donned. An interview on 5/29/20 at 3:07 PM with Interim DON confirmed that the lab personnel had screened prior to leaving the facility. The interim DON reported that the previous lab personnel should have been screening and the staff were searching for that documentation. The Interim DON reported that there was not a binder for the Lab personnel.	F 880	Masks and hand sanitizer are available at both entrances to the facility. Nursing staff and laboratory staff have been educated on the need for and the process of screening the laboratory staff at the time of the incident. Additional education will be presented to staff on 7-15-20. Audits are being performed on the screening tools and follow-up by nursing should any outlier symptoms exist or reported travel present as a concern. These results are reporting to QA monthly.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285263	A. BUILDING _____ B. WING _____	05/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTFIELD QUALITY CARE OF AURORA	**PO BOX 166, 1313 1ST STREET AURORA, NE 68818**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 4 An interview on 5/29/20 at 4:15 PM with RN (Registered Nurse) H confirmed; lab personnel had come on 05/29/20 were not the normal lab personnel and the normal lab personnel that came was aware of the process and would stop and screen. RN H reported they were aware of the screening process and they had not remember to complete this with the lab personnel. Additional information provided by the facility: An interview on 6/2/20 at 2:36 PM with the Administrator revealed; the facility was unable to locate any past documentation related to Lab staff screening. Additional information provided by the facility	F 880		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285263	A. BUILDING _____ B. WING _____	C 05/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTFIELD QUALITY CARE OF AURORA	**PO BOX 166, 1313 1ST STREET AURORA, NE 68818**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS References to Title 175 of the Nebraska Administrative Code, Chapter 12- "Regulations Governing Licensure of Skilled Nursing Facilities, Nursing Facilities, and Intermediate Care Facilities" have been included in survey report as they apply to deficient practices identified.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		7/20/20

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/14/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285263	A. BUILDING _____ B. WING _____	C 05/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTFIELD QUALITY CARE OF AURORA	PO BOX 166, 1313 1ST STREET AURORA, NE 68818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 1 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Licensure Reference Number 175 NAC 12-006B	F 880	The facility denies that the alleged facts as set forth constitute a deficiency under	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285263	A. BUILDING _____ B. WING _____	C 05/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTFIELD QUALITY CARE OF AURORA	**PO BOX 166, 1313 1ST STREET AURORA, NE 68818**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 Based on observation, interview, and record review the facility failed; to follow implemented infection control practices and CMS (Centers for Medicare and Medicaid Services) guidelines to prevent potential cross contamination including the spread of COVID 19 (a highly contagious virus primarily spread from person to person through respiratory droplets, which can lead to serious illness and even death) related to lab personnel that were not screened upon facility entry and did not have PPE (Personnel Protective Equipment) masks in place per the facility practice. This had the potential to affect 1 resident 2 sampled (Resident 5). The facility census was 44. Findings are: AN observation on 5/29/20 at 1.50 PM revealed; LP (Lab Personnel) E and LP F had come to the nurse's desk after entering the building. LP E and F stood next to the screening station. It was observed that neither LP E nor LP F had a face mask during entry. LP-E gained information lab that required completion. LP E and F left the nurses station and entered the hallway for resident. Record review of Laboratory Results for Resident 5 revealed; the lab was drawn at 1:58 PM. Record review of Screening for LP (Lab Personnel) E dated 5/29/20 revealed; LP E had been screened at 2:00 PM. LP E had traveled from Omaha, had no symptoms, and was afebrile. LP E had contact with Covid 19. Record review of Screening for LP F dated	F 880	the interpretations of federal and state law. The preparation of the following plan of correction should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged, or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provision of state and federal law. Without waiving the forgoing statement, the facility states that regards to this citation: The Laboratory Personnel, in question, had been screened for COVID19 symptoms and known exposure that vary morning at Memorial Hospital prior to performing lab rounds at Westfield Quality Care of Aurora. Therefore, an extremely rare chance of any potential exposure to any residents of Westfield Quality Care of Aurora existed, which is the intent of all screening. All other records indicated that appropriate screening had taken place. To date, as of the receipt of this alleged deficiency 7-8-20, there are no new symptoms or positive tests of COVID19 at Westfield Quality Care of Aurora and since ALL residents and staff have been cleared of COVID19. The screening process in place has proven effective. The Laboratory Personnel were screened prior to the leaving the facility. They were screened by Westfield Quality Care of Aurora staff at 2:00PM. Many of the observations made by the survey team were made following the time that the laboratorians were screened.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285263	A. BUILDING _____ B. WING _____	C 05/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTFIELD QUALITY CARE OF AURORA	**PO BOX 166, 1313 1ST STREET AURORA, NE 68818**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 3 5/29/20 revealed; LP F had been screened at 2:00 PM. LP F had not traveled, had no symptoms, and was afebrile. LP F had contact with Covid 19. Record review of Laboratory Result for Resident 4 revealed; the lab had been drawn at 2:22 PM. An observation on 5/29/20 at 2:02 PM of LP-E and LP-F in the front of the nurse's station without masks that were required in the resident areas. An interview on 5/29/20 at 2:02 PM with LP E confirmed; both LP-E and LP-F had not screened prior to drawing lab on a resident. They were unaware that there was a screening station and where the station was located. An interview on 5/29/20 at 2:03 PM with LPN (Licensed Practical Nurse) G revealed; LPN G was unaware that the lab personnel needed to fill out the paperwork on entry and be screened. The LPN reported there was a book for the Hospice and one for therapy, but was unaware if there was a book for the lab. An observation on 5/29/20 at 2:04 PM of the Screening station revealed; there was a binder that had Hospice and a binder for Therapy. An interview on 5/29/20 at 2:05 PM with the Interim DON (Director of Nurses) confirmed; lab personnel were to be screened on entry to the building. An observation on 5/29/20 at 2:30 PM of the 300 hall revealed; the hall had resident doors closed, staff had the N95 masks donned.	F 880	A laboratory personnel binder was prepared at the time of the incident where laboratorians are to sign-in upon arrival to the facility. Signs were posted at both entrances to the facility indicating that ANYONE entering the facility must be screened. Masks and hand sanitizer are available at both entrances to the facility. Nursing staff and laboratory staff have been educated on the need for and the process of screening the laboratory staff at the time of the incident. Additional education will be presented to staff on 7-15-20. Audits are being performed on the screening tools and follow-up by nursing should any outlier symptoms exist or reported travel present as a concern. These results are reporting to QA monthly.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285263	A. BUILDING _____ B. WING _____	C 05/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTFIELD QUALITY CARE OF AURORA	**PO BOX 166, 1313 1ST STREET AURORA, NE 68818**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 4 An interview on 5/29/20 at 3:07 PM with Interim DON confirmed that the lab personnel had screened prior to leaving the facility. The interim DON reported that the previous lab personnel should have been screening and the staff were searching for that documentation. The Interim DON reported that there was not a binder for the Lab personnel. An interview on 5/29/20 at 4:15 PM with RN (Registered Nurse) H confirmed; lab personnel had come on 05/29/20 were not the normal lab personnel and the normal lab personnel that came was aware of the process and would stop and screen. RN H reported they were aware of the screening process and they had not remember to complete this with the lab personnel. Additional information provided by the facility: An interview on 6/2/20 at 2:36 PM with the Administrator revealed; the facility was unable to locate any past documentation related to Lab staff screening. Additional information provided by the facility	F 880		

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 16, 2020

Barbara Dreyer, Administrator
Wilber Care Center
611 North Main
Wilber, NE 68465

CMS CERTIFICATION NUMBER: 285172

Dear Ms. Dreyer:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 6, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

July 16, 2020

Jonathan Brandow, Administrator
Wisner Care Center
1105 9th Street
Wisner, NE 68791

CMS CERTIFICATION NUMBER: 285151

Dear Mr. Brandow:

This is to acknowledge the results of the Infection Control survey conducted at your facility on July 6, 2020 by representatives of this Department. Your facility was found in compliance with Emergency Preparedness - E0024 and Long Term Care regulation at F880.

The results of the Infection Control survey are commendable and we applaud your efforts to maintain compliance with the regulations.

If you have any questions in the future, please contact me.

Sincerely,

Connie E Vogt RN,BSN

Connie Vogt, RN, BSN, Program Manager - Office of LTC Facilities - Licensure Unit - Division of Public Health - DHHS
PO Box 94986, 301 Centennial Mall South, Lincoln, Nebraska 68509-4986
(402) 471-3324, FAX: (402) 471-0555

CV/kd

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Kansas City Regional Office
601 East 12th Street, Room 355
Kansas City, Missouri 64106

MIDWEST DIVISION OF SURVEY AND CERTIFICATION

July 15, 2020

Joseph Jay Colburn, Administrator
York General Hearthstone
P O Box 159, 2600 North Lincoln Avenue
York, NE 68467-0159

CMS Certification No: 285131

Dear Mr. Colburn:

SUBJECT: SURVEY RESULTS
Cycle Start Date: June 26, 2020

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES
The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-20-All*, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS
On June 26, 2020, the Centers for Medicare & Medicaid Services (CMS) completed a COVID-19 Focused Survey at York General Hearthstone to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was in substantial compliance with participation requirements and no deficiencies were cited. The findings from this survey are documented on the enclosed form CMS 2567.

No additional action is required on the facility's part.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES
The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at QIO Program Website: https://qioprogram.org/covid-19. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance

related to infection control. QIOs per state can be found at Locate Your QIO: https://qioprogram.org/locate-your-qio.

CONTACT INFORMATION
If you have any questions please contact Lisa Hauptman, Principal Program Representative at (816) 426-2011.

Sincerely,

Lisa Hauptman

Lisa Hauptman
Long Term Care Branch
Survey & Operations Group
Center for Clinical Standards & Quality
CMS Kansas City

cc:
NE DHHS
Power/Grimes