STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285238	A. BUILDING _____ B. WING _____	07/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KEYSTONE RIDGE POST ACUTE NURSING AND REHAB	7501 KEYSTONE DRIVE OMAHA, NE 68134

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

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F 0553 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Allow resident to participate in the development and implementation of his or her person-centered plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.05(3) Based on interview, record review and review of the policy and procedures, the facility failed to ensure residents' right to participate in care planning. This affected three (Residents 22, 36 and 53) of five sampled residents. Care conferences for Residents 22, 36 and 53 were not conducted on a quarterly basis. Findings are: 1. Review of the clinical record for Resident 22 revealed an admission history form dated 10/31/19 with a readmission date of [DATE]. Resident 22 was admitted to the facility on [DATE] with left hip [DIAGNOSES REDACTED] and weakness. The quarterly Minimum Data Set (MDS) assessment, dated 05/26/20, documented the resident had a Brief Interview for Mental Status (BIMS) of 12 out of 15, indicating minimal cognitive impairment. Resident 22 needed extensive assistance for transfers, toileting, and personal hygiene. On 07/20/20 at 3:50 PM, Resident 22 was interviewed. Resident 22 was not familiar with the purpose of a care plan meeting and could not recall being invited to attend a care plan meeting. Review of the clinical record on 07/21/20 at 1:52 PM, indicated the only care conference Resident 22 attended and was invited to was conducted on 11/14/19. The clinical record documented a Special Instruction to invite Resident 22's spouse to care conference meetings. On 07/21/20 at 4:09 PM, the MDS coordinator was interviewed. The MDS coordinator reviewed the clinical record and stated the last documented care conference was 11/14/19. The MDS coordinator stated social services documented care conferences on paper, and possibly had a copy. On 07/21/20 at 4:40 PM, Social Services was interviewed. Social Services was unable to locate any documentation of a care conference being conducted since 11/14/19. 2. Review of the clinical record, for Resident 36, revealed an admission history form dated 03/11/14. Resident 36 was admitted to the facility on [DATE] with dementia and difficulty in walking. The quarterly MDS assessment, dated 06/12/20, documented the resident had a BIMS of 0 out of 15, indicating extensive cognitive impairment. Resident 36 needed extensive assistance for all Activities of Daily Living (ADLs). Review of the clinical record documented care conferences being conducted on 06/09/20 and 03/24/20. No documentation of a care conference being conducted was identified prior to 03/24/20. On 07/23/20 at 2:14 PM, the MDS coordinator was interviewed. The MDS coordinator reviewed the clinical record and stated there were no care conferences documented prior to 03/24/20. On 07/23/20 at 2:33 PM, Social Services was interviewed. Social Services stated no care conferences were conducted between 8/28/19 and 03/24/20. Social Services stated (gender) was struggling with keeping up with the required documentation. 3. Review of the clinical record for Resident 53 revealed an admission history form dated 01/11/19 with a readmission date of [DATE]. Resident 53 was admitted to the facility on [DATE] with [MEDICAL CONDITIONS], [DIAGNOSES REDACTED] and major [MEDICAL CONDITION]. The quarterly MDS assessment, dated 06/26/20, documented the resident had a BIMS of 15 out of 15, indicating no cognitive impairment. Resident 53 needed supervised assistance for most activities of daily living. Review of the clinical record revealed no evidence of care conferences being conducted. The clinical record documented a Special Instruction to invite Resident 53's daughter/child to care conference meetings. On 07/23/20 at 2:16 PM, the MDS coordinator was interviewed. The MDS coordinator reviewed the clinical record and stated a care conference was conducted on 06/30/20 but the documentation was not completed and had not been entered into the clinical record. Prior to 06/30/20, the MDS coordinator stated the last documented care conference was on 09/24/19. On 07/23/20 at 3:23 PM, Social Services was interviewed. Social Services stated, I need to get better organized. Social Services was unable to locate any written care conference notes. The facility's policy and procedure titled, Comprehensive Person-Centered Care Planning, dated 08/2017, documented the following under the section Procedures: .6. The resident's comprehensive plan of care will be reviewed and/or revised by the IDT (interdisciplinary team) after each assessment. 7. The facility IDT includes, but it not limited to the following professionals: A. Attending physician or non-physician practitioner (NPP) designee involved in resident's care; B. Registered nurse responsible for the resident; C. Nurse aide responsible for the resident; D. Member of the food and nutrition services staff; E. To the extent possible, resident and resident representative; F. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
F 0576 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure residents have reasonable access to and privacy in their use of communication methods.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews and review of policy and procedures, it was determined the facility failed to ensure one hearing impaired resident (Resident 214) was provided a means of communication with persons outside the facility. Three residents in the facility were hearing impaired. Findings are: On 07/15/20, Resident 214 was admitted to the facility from a hospital. An entry Minimum Data Set (MDS) assessment, dated 07/15/20, documented the resident was alert and cognitively intact in skills for daily decision making. A Baseline Care Plan, dated 07/15/20, indicated the resident was hard of hearing, had cochlear implants, and needed a white board/paper for communication. Physician orders [REDACTED].Audiological Care PRN (as needed) . A nurse's note, dated 07/15/20 at 7:02 PM, indicated the resident was deaf and communicated by reading lips and writing. On 07/20/20 at 12:00 PM, Resident 214 was observed sitting in a chair, beside a table, on which a tablet of paper and pen were kept for communication. To conduct the interview, the surveyor wrote a question on the paper, and the resident answered verbally. When asked if the resident had been able to talk with their family since admission to the facility's COVID-19 quarantine unit, Resident 214 stated they had not been able to communicate with their family as they needed a computer to communicate, and they did not have access to one. The resident stated they had not been able to talk with their family since the day before they admitted to the facility. The resident stated there was a computer in the library that they had been able to use when they lived at the assisted living facility (ALF), but because they had been admitted from the hospital to a COVID-19 quarantine unit, they were not allowed to go to the library anymore. On 07/21/20 at 2:05 PM, Social Services-F was asked if a means of communication had been provided so the resident could speak with their family. Social Services-F had not thought the resident would be at the facility very long. Social Services-F said, So, honestly, I have not addressed this. On 07/22/20 at 9:00 AM, the resident was asked if the facility had provided a way for them to communicate with their family. The resident said, No. I have to wait another week. The resident had been told they would have to wait until they got out of the COVID-19 unit. The resident stated the last time they spoke with a family member was on 07/14/20 before admitting to the facility. Resident 214 said, I want to speak with my son. I don't know if he is still traveling. I don't know where he is or how he is. On 07/22/20 at 11:36 AM, the Administrator stated social services was responsible for making sure resident's communication needs were met. A facility policy titled, Federal Residents Rights, documented: As a resident of this nursing facility, you have the right to

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0576 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) .communication with and access to persons and services inside and outside the facility .
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.05(3) Based on staff and resident interviews and policy review, the facility failed to resolve a report of missing property for one (Resident 56) of two residents reporting missing property. Findings are: Resident 56 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A grievance policy, dated 11/23/16, was reviewed. The policy revealed that the grievance official is the Social Worker, (SW)-F. 4. The Grievance Official evaluates and investigates the concern and takes immediate action to resolve the concern and prevent further potential violations of any resident's right. 7. The Grievance official/Designee completes the Grievance Resolution Form, takes appropriate corrective action. Review of grievance records revealed that on 07/16/20, Resident 56 reported that all of (gender) underwear was missing. Resident 56 reported that they have days that (gender) goes without underwear and (gender) doesn't like it. Under Steps Taken to Investigate the Grievance, SW-F wrote that Resident 56's underwear was found in the laundry. Under Conclusion, SW-F wrote, Underwear returned from laundry. Under Corrective Action Taken, SW-F wrote that on 07/16/20, three pair of underwear were returned to Resident 56. The correction completion date was 07/17/20 and was signed and dated by SW-F and the Administrator on 07/17/20. On 07/20/20 at 12:39, PM, an interview was completed with Resident 56. Resident 56 stated that 15 pair of underwear were missing. It was reported to SW-F. SW-F said a search would be conducted. The items were noted missing over the last two months. An interview was completed with SW-F on 07/21/20 at 1:41 PM. SW-F was reported finding some underwear in the laundry. I went down to the laundry and found some. I haven't taken it to (Resident 56) yet to see if it's (gender). SW-F said that if what was found didn't belong to Resident 56, underwear would be purchased. SW-F explained the procedure, after missing clothes were reported, was to search the resident's room and the laundry. If we can't find it, we will see how they want to go about replacing. On 07/21/20 at 2:00 PM, the Administrator reviewed the grievance dated 07/16/20. The Administrator stated that, according to the grievance, three pair of underwear were returned to Resident 56 on 07/16/20 and that she signed off as reviewing the grievance on 07/17/20. A follow up interview was completed with SW-F on 07/21/20 at 3:30 PM. SW-F stated that underwear was returned to Resident 56, but SW-F did not verify if the underwear actually belonged to Resident 56 because Resident 56 was in the bathroom when the underwear was returned. SW-F said the underwear was the correct size for Resident 56. After the interview on 07/21/20 at 1:41 PM, SW-F said that Resident 56 was asked if the correct underwear was returned. One of the three pair were confirmed as belonging to Resident 56.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09C(1) Based on record review and staff interview, the facility failed to create a comprehensive care plan for one (Resident 11) of two residents with pressure ulcers. Findings are: Resident 11 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) assessment, 05/05/20, indicated Resident 11's Brief Interview for Mental Status (BIMS) score was 15, indicating no cognitive impairment. Resident 11 was noted to need extensive assistance from two staff to transfer and to be frequently incontinent of bowel and bladder. Review of Resident 11's care plan revealed an entry, dated 05/08/20, Resident 11 had the potential for pressure ulcer development related to immobility. The care plan did not mention incontinence or other moisture concerns or concerns about Resident 11 refusing to get out of the chair and in bed. The care plan did not note an active pressure ulcer. An update, dated 05/20/20, noted a moisture related area to the right buttock. No abnormalities were noted to the left buttock. A second entry on the care plan, dated 05/08/20, noted Resident 11 had bowel and bladder incontinence related to impaired mobility. The goal was for Resident 11 to remain free from any skin breakdown. Review of the nursing assistants' documentation from 7/08/20 thru 7/21/20 revealed two episodes of bladder incontinence out of 39 entries. On 07/17/20, Resident 11 had a Weekly Non-pressure form completed by Nurse-S on 07/17/20. Nurse-S documented Resident 11 had open areas to both the left and right buttock. The area was noted to be Moisture Associated Skin Damage (MASD). An interview was completed with Resident 11 on 07/20/20 at 11:54 AM. Resident 11 stated there were two open places on the buttocks. I'm supposed to lay down in the afternoons, but sometimes I don't. A follow up interview was completed with Resident 11 on 07/20/20 at 3:03 PM. Resident 11 denied incontinent episodes and stated that transfers and ambulating to the bathroom were done independently. Resident 11 also reported sitting in the recliner constantly since 7:30 AM. On 07/20/20 at 3:07 PM, an interview was completed with Certified Nursing Assistant (CNA)-T. CNA-T reported working with Resident 11 for the last two months. CNA-T said Resident 11 went to the bathroom independently and had not required incontinent care. An interview was completed with Nurse Practitioner (NP)-U on 07/21/20 at 3:39 PM. NP-U was questioned about Resident 11's skin. NP-U reported Resident 11 has recurrent issues with incontinence and has periods of time where (gender) doesn't let the staff know (Resident 11) needs changed. NP-U also stated Resident 11 sat in a chair most of the time, including to sleep. NP-U stated the left buttock wound appeared to be trauma related from removing a dressing or shearing, but pressure was not the primary concern. NP-U stated there was an order written [REDACTED]. NP-U reported becoming aware of a newly open area to the left buttocks on Resident 11 on 07/17/20. On 07/22/20 at 9:16 AM, an interview was completed with CNA-V. CNA-V reported being familiar with Resident 11. CNA-V reported Resident 11 was never found wet and Resident 11 independently went to the toilet. An interview was completed with Nurse-K on 07/23/20 at 9:09 AM. Nurse-K reported being familiar with Resident 11 and being one of the staff who would update care plans. Nurse-K stated she was aware Resident 11 had wounds to the left and right buttock and verified the area on the left buttock was not documented on the care plan. Nurse K also verified the care plan for Resident 11 did not reflect that Resident 11 was resistive to having a brief changed or laying down during the day. Nurse-K said Resident 11 had been residing in the assisted living area of the center and they were aware that Resident 11 lived in the recliner. Nurse-K said Resident 11 would sit most of the day and sleep in the chair. Resident 11 was encouraged to lay down 2-3 times a day. Nurse-K agreed that the extended length of time Resident 11 sat in the chair had contributed to the skin issues.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12.0069D2a Based on observation, record reviews and staff interviews, the facility failed to implement measures to prevent a facility acquired pressure ulcer (a localized injury to skin an or underlying tissue over a bony prominence, a result of pressure or pressure in combination with shear and /or friction) or follow physician's orders [REDACTED]. Findings are: Resident 11 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS), dated [DATE], indicated Resident 11's Brief Interview for Mental Status (BIMS) score was 15, indicating no cognitive impairment. Resident 11 was noted to need extensive assistance from two staff to transfer and to be frequently incontinent of bowel and bladder. Review of Resident 11's care plan revealed an entry, dated 05/08/20, that Resident 11 had the potential for pressure ulcer development related to immobility. The care plan did not mention incontinence or other moisture concerns or concerns about Resident 11 refusing to get out of the chair and in bed. The care plan did not note an active pressure ulcer. An update, dated 05/20/20, noted a moisture related area to the right buttock. No abnormalities were noted to the left buttock. A second entry on the care plan, dated 05/08/20, noted Resident 11 had bowel and bladder incontinence related to impaired mobility. The goal was for Resident 11 to remain free from any skin breakdown. Review of the nursing assistants' documentation from 07/08/20 thru 07/21/20, revealed two episodes of bladder incontinence out of 39 entries. A review of treatment records noted a treatment order dated 07/17/20. The order noted Resident 11 should have A&D ointment (a barrier ointment) and a foam dressing applied to the left and right buttocks daily. An interview was completed with Resident 11 on 07/20/20 at 10:54 AM. Resident 11 stated that (gender) had two areas on the buttocks that were being treated. The dressing came off during a shower on 07/18/20 and had not been replaced. Resident 11 also stated (gender) did not follow the recommendation to get out of the recliner and back to bed in the afternoons. On 07/20/20 at 11:10 AM, an

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) observation of wound care for Resident 11 was completed. Nurse-W completed the dressing and was interviewed. There was no dressing in place before the dressing change began. Resident 11 was noted to have an open area, approximately 1.5 centimeters in diameter, to the base of the left buttock. A&D ointment and a foam dressing were applied to the left buttock. No treatment was applied to the right buttock. A follow up interview was completed with Nurse-W on 07/20/20 at 12:55 PM. Nurse-W was asked to review the treatment order for Resident 11. Nurse-W acknowledged the treatment needed to be done to the right buttock. A review of a Nurse Practitioner note, dated 07/17/20, documented a wound to the left buttock measuring 0.5 cm (centimeters) x 0.56 cm x 0.1 cm in depth. An interview was completed with Nurse Practitioner (NP)-U on 07/21/20 at 3:39 PM. NP-U was questioned about Resident 11's skin. NP-U reported that Resident 11, has recurrent issues with incontinence and has periods of time where (gender) doesn't let the staff know (Resident 11) needs changed. NP-U also stated that Resident 11 sits in a chair most of the time, including to sleep. NP-U stated the left buttock wound appeared to be trauma related from removing a dressing or shearing, but pressure was not the primary concern. NP-U stated there was an order written [REDACTED]. NP-U reported becoming aware of a newly open area to the left buttocks on Resident 11 on 07/17/20. On 07/22/20 at 8:51 AM, an interview was completed with Nurse-S. Nurse-S said they made weekly rounds with the wound Nurse Practitioner. Nurse-S said staff report skin changes verbally or through a message board that staff can post on. Nurse-S said the electronic medical record had a texting option that staff could use, but Nurse-S hadn't figured out how to use it yet. Nurse-S reported Resident 11 had skin issues to the right and left buttock. Resident 11 was encouraged to lay down between meals, but Resident 11 was noncompliant and frequently slept in the recliner. I don't know if it's (the left buttock wound) pressure. I believe it's mostly moisture related. That's why we encourage (Resident 11) to lay in bed, to get the circulation back in it. Moisture comes from sweat mostly. Nurse-S stated the wound was found on 02/17/20 during wound rounds with the Nurse Practitioner. Nurse-S stated the normal procedure when discovering a new wound would be to fill out a progress note that would notify risk management and that would get entered onto the 24-hour report. Nurse-S said (gender) did not do the progress note or risk management notification. Nurse-S said the only documentation to show when the wound was discovered came from the Nurse Practitioner. On 07/22/20 at 9:33 AM, an interview was completed with Certified Nursing Assistant (CNA)-X. CNA-X reported being the CNA who assisted Resident 11 with a shower on 07/18/20. CNA-X said an open wound was seen on Resident 11's buttocks. The dressing came off during the shower, and was reported to the nurse. An interview was completed with the Director of Nurses (DON) on 07/22/20 at 9:51 AM. The DON said if a new wound was found, the nurse would make a progress note and they would use the text feature in the electronic medical record to notify Nurse-S. An interview was completed with Nurse-K on 07/23/20 at 9:09 AM. Nurse-K reported being familiar with Resident 11 and being one of the staff who would update care plans. Nurse-K stated she was aware that Resident 11 had wounds to the left and right buttock and verified the area on the left buttock was not documented on the care plan. Nurse-K also verified the care plan for Resident 11 did not reflect that Resident 11 was resistive to having a brief changed or laying down during the day. Nurse-K said Resident 11 had been residing in the assisted living area of the center and they were aware Resident 11 lived in the recliner. Nurse-K said Resident 11 would sit most of the day and sleep in the chair. Resident 11 was encouraged to lay down 2-3 times a day. Nurse-K agreed the extended length of time Resident 11 sat in the chair had contributed to the skin issues.
F 0800 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.** LICENSURE REFERENCE NUMBER 175 NAC 12-006.11D, 12-006.11E Based on observation, interview, and review of policy and procedures, the facility failed to ensure cold food was held at 41 degrees Fahrenheit (F) or lower and hot pureed food was held at 135 degrees F or higher. This affected 4 out of 4 residents who had requested cold food and 3 of 3 residents who were on pureed food. Findings are: On 07/22/20 at 11:05 AM, the lunch tray line service was observed. Due to COVID-19 precautions, the facility was serving meals on disposable dinnerware. The Cook was placing the hot food on the steam table. The steam table was not operable and was in need of repair. The Cook was observed taking four Chef salads and one fruit plate out of the refrigerator and were placed on a side table. At 11:18 AM, the Cook began plating food without taking temperatures. At 11:20 AM, the Cook was asked to pause service and take food temperatures. The Cook stated since the steam table was broken, they try to get the food out and served as quickly as possible. The Cook stated food temperatures were taken once the food was finished cooking and before the food goes into the hot box for holding. The Cook stated it was not routine for them to take temperatures on the steam table. At 11:25 AM, the food temperatures were as follows: - Pureed ham was 130 degrees F - Ground textured ham was 158 degrees F - Pureed green beans were 135 degrees F - Pureed scalloped potatoes were 130 degrees F - Regular ham was 169 degrees F - Regular green beans were 168 degrees F - Regular scalloped potatoes were 172 degrees F The Chef Salads were temped at 12:07 PM. The temperature was 47.7 degrees F. The Cook served the salads. The Certified Dietary Manager (CDM) was interviewed at 11:30 AM. The CDM confirmed temperatures were not routinely being taken on the steam table. The CDM stated it was the expectation that food would be at a minimum temperature of 168 degrees F at the time it was being plated. The CDM stated random temperature checks were done at the end of the meal service to make sure the hot food had not fallen below 135 degrees F, but there was no documentation. A test tray of regular textured food was assembled at 11:57 AM in a Styrofoam clam shell disposable container. The test tray was temped at 12:17 PM. The food temperatures were as follows: Regular ham - 94 degrees F Green beans - 120 degrees F Scalloped potatoes - 122 degrees F The CDM stated the temperatures were OK to serve because it had not been off the steam table for over two hours. An undated dietary services policy titled, Food, Reheating and Cooling during Tray line, indicated: It is the policy of this facility that potentially hazardous foods shall be served and held at the required temperatures on the tray line or during meal service. If cold food is above 41 degrees Fahrenheit (F) or hot food is below 140 degrees F, corrective action shall be taken. Procedures: 1. Cold foods when not being prepared shall be kept at least 41 degrees F. Utilize the cooling procedure as needed. Measure internal temperature periodically on the tray line or during meal service. 2. Hot foods will be prepared per recipe and cooked to specified temperature. Food will be kept for service at greater 140 degrees F. If the temperature drops below 140 degrees F, stop service and reheat. 3. (not part of the deficient practice) omitted 4. Temperature of the food when the resident receives it is based on palatability. The goal is to serve cold food cold and hot food hot. Recommended temperature at delivery to Resident: in part, Hot Entre - greater or equal to 120 degrees F Starch - greater or equal to 120 degrees F Vegetables - greater or equal to 140 degrees F
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** LICENSURE REFERENCE NUMBER 175 NAC 12-006.11D, 12-006.11E Based on observation, interview and record review, the facility failed to distribute food in accordance with professional standards for food service safety by failing to ensure food placed on the steam table during tray line was held on an operable steam table. This affected 33 out of 62 residents on the H floor. Findings are: On 07/22/20 at 11:05 AM, this surveyor entered the kitchen to observe the lunch tray line service. This surveyor's initial observation was there was no water in the steam table and the burners were not turned on. On 07/22/20 at 11:25 AM, the Cook was interviewed. The Cook stated, the table hasn't worked in a long time. The Cook stated the kitchen staff take the food from the hot box, place it on the non-functioning steam table and try to get it plated as quickly as possible. Temperatures, according to the Cook, were recorded after the food was cooked and not at the steam table prior to serving. On 07/22/20 at 11:30 AM, Certified Dietary Manager (CDM) was interviewed. The CDM stated the steam table had not been working for a while. CDM had inquired about getting the steam table used for the assisted living dining room, but the request was denied due to not wanting to relocate equipment at the risk of COVID-19. Records review of TELS workorder software, revealed a workorder input for 06/17/20. The work order request was for the Garden level steam table no longer heating up. The work order was submitted by the CDM on 06/17/20 at 10:11 AM. During an interview on 07/22/20 at 12:30 PM, the Administrator indicated (gender) was informed of the steam table issue on 7/17/20. On 07/22/20 at 2:30 PM, the Maintenance Supervisor was interviewed. The Maintenance Supervisor stated the work order was for the steam table on the G floor and not for the steam table on the H floor. The Maintenance Supervisor was not aware the steam table on the H floor was not heating up. On 07/22/20 at 2:50 PM, Dietary Supervisor was interviewed. The Dietary Supervisor explained access to

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) TELS had not been provided since beginning employment in April 2020 and the expectation was all work orders were to go through TELS. The Dietary Supervisor had verbally notified the Maintenance Supervisor. In June, the Maintenance Supervisor looked at the steam table and mentioned it needed new heating coils. The Dietary Supervisor brought it up several times in the morning department head meeting.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.17 Based on observations, interviews, record reviews and review of policy and procedures, it was determined the facility failed to implement use of proper PPE (personal protective equipment) for one resident (Resident 57) who regularly received medical treatments outside the facility. Five residents left the facility for regularly scheduled medical treatments. Findings are: Resident 57 had medical [DIAGNOSES REDACTED]. While independent or needing supervision with most activities of daily living (ADL's) the resident did require help from staff with bathing. A care plan, dated 05/15/20, documented the resident received [MEDICAL CONDITION] treatments related to [MEDICAL CONDITION] every three weeks at a local oncology center. The care plan documented the resident was at risk for contracting infections due to [MEDICAL CONDITION]. The care plan indicated [MEDICAL CONDITION] complications or side effects included chills, diarrhea, fatigue, nausea/vomiting, flu-like symptoms, malaise, muscle soreness, weakness, and sore throat. From 07/20/20 through 07/22/20, observations were made of multiple staff providing care to the resident. Staff donned surgical masks and gloves, but staff did not don face shields or gowns to care for the resident. On 07/22/20 at 11:13 AM, the Director of Nurses (DON) was asked what kind of PPE staff used when caring for Resident 57. The DON stated staff donned masks and gloves. The DON was asked why the resident was not treated like a [MEDICAL TREATMENT] resident who would go out of the facility and would require PPE, including gown and a face shield. The DON stated the resident's situation was different because the facility drove the resident to the appointment. The DON stated the resident did not have to wait in a waiting room, and the resident was in a private room for the treatment. On 07/23/20 at 10:38 AM, the Nurse Manager from [MEDICAL CONDITION] center stated, while Resident 57 generally had early appointments, [MEDICAL CONDITION] center had a waiting room and it was likely the resident would be in the waiting room with others, but socially distanced. The Nurse Manager indicated there was no policy to enable a patient an exemption from being in the waiting room. From the waiting area, the resident would go to an open infusion room with other patients, socially distanced and masked. The Nurse Manager indicated the nurses worked with multiple patients and donned PPE. The Nurse Manager stated, (Named Resident) should be treated like a resident who goes to [MEDICAL TREATMENT]. On 07/23/20 at 3:15 PM, the resident was asked if they ever waited in a waiting room at their [MEDICAL CONDITION] appointment. The resident answered, Yes, there are other people in there. The resident was asked if there were other patients in the infusion room, and the resident said, Yes. The resident was asked if the nurses take care of more than one patient, and the resident answered, Yes. On 07/27/20 at 8:10 AM, the DON was asked if the facility had enough PPE, and she stated they had enough PPE. She stated they were part of a coalition that ensured they could obtain the PPE needed. A facility form titled, Gateway Nebraska COVID-19 Response Plan, documented: .PPE required by Zone: Refer to Cohorting Zones document for list of PPE for staff and residents based on Zone . A facility form titled, Cohorting Plan For LTCF (Long Term Care Facilities) (to be implemented when a COVID-19 infection is suspected or identified), documented: .Establishing Transitional (Gray) Zones: 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 [MEDICAL TREATMENT]). 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 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 .PPE for Gray Zone rooms: ALL TIMES N95 or KN-95 mast (at all times) Gloves Face Shield Gown (low risk option) Low contact gown option: entering room but not touching resident or having a high contact with surfaces .