STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285304	A. BUILDING _____ B. WING _____	**09/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROCK COUNTY HOSPITAL LONG TERM CARE	**100 EAST SOUTH STREET BASSETT, NE 68714**

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 0880 **Level of harm -** Actual harm **Residents Affected -** Many	**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 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: 1) symptomatic residents without ongoing monitoring and isolation not initiated at the time that symptoms were first identified for 5 (Residents 1, 2, 3, 5 and 6) of 9 sampled residents; 2) staff failure to wear appropriate PPE (Personal Protective Equipment- can include items such as gowns, gloves, masks, goggles, face shields, and foot coverings) when in resident's rooms and corridors; 3) staff failure to ensure staff/visitor screening logs had all areas completed and logs were reviewed to assure symptomatic staff/visitors were not allowed into the facility; and 4) facility staff received education regarding screening/monitoring of residents and use of PPE. This had the ability to affect all residents. The total sample size was 9 and the facility census was 18. 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): -CMS was responsible for ensuring the health and safety of nursing home residents by enforcing the standards required to help each resident attain or maintain their highest level of well-being. In light of the recent spread of COVID-19 CMS took several steps to help prevent the spread of [MEDICAL CONDITION]; -prompt detection, triage, and isolation of potentially infectious residents was essential to prevent unnecessary exposures among residents, healthcare personnel, and visitors at the facility; -facilities should be vigilant in identifying any possible infected individuals and preform frequent monitoring for symptoms of respiratory infections throughout the day; -for individuals allowed in the facility, provide instructions on hand hygiene, limiting surfaces touched and use of PPE; -if possible, create a dedicated visiting area near the entrance of the facility where residents can meet with visitors in a sanitized environment with the facility disinfecting rooms after each visit; B. Review of Long Term Care COVID-19 Phasing Guidance dated 6/15/20 revealed the following regarding 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; -all residents to be screened at least daily with a temperature check, questions and observations for other signs and symptoms of COVID-19; -facility policy should clearly identify when the daily screenings should occur and how they are tracked; -all persons to be entering the facility are to be screened and all staff at the beginning of their shift. Screening to include temperature checks, questionnaire regarding symptoms and potential exposure and observations of any signs or symptoms; and -if a staff member becomes symptomatic, they must notify their supervisor immediately. C. 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 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); and -ideally, all zones should have dedicated staff but if staff have to work in multiple zones, it is preferred that they plan ahead and batch all the care-giving activities together in a way to finish the work in one zone, before moving to the next zone. D. Review of Resident 1's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 8/11/20 revealed active [DIAGNOSES REDACTED]. The following was assessed regarding the resident: -cognition was severely impaired; -required extensive staff assistance with dressing, transfers, toilet use and personal hygiene; and -occasionally incontinent of bladder. Review of a Nursing Progress Note dated 8/12/20 at 4:42 PM revealed the resident had a visit from a family member. Review of a Nursing Progress Note dated 8/15/20 at 5:43 PM revealed the resident's family and a grandchild was at the facility to visit. Review of a Nursing Progress Note dated 8/20/20 at 3:18 PM revealed the resident's family had called to cancel visitation. Family was unable to come to the facility as a grandchild had been sent home from school with a sore throat. The note further indicated family were hoping to get results back tomorrow from the testing. Review of Resident 1's medical record revealed no evidence of the testing Resident 1's grandchild had received related to the sore throat or of the results regarding this test. Review of a Nursing Progress Note dated 8/24/20 at 4:19 PM revealed the resident had a family member visiting at the facility. Review of a Nursing Progress Note dated 8/25/20 at 3:43 AM revealed the resident was in the bathroom. The resident was confused and started to urinate in pants which upset the resident. The resident was very confused and once back in bed, the resident was noted to be restless'. The resident kept indicating the resident did not feel good. Review of a Nursing Progress Note dated 8/25/20 at 4:25 PM and on 8/26/20 at 4:10 PM revealed the resident's family was at the facility for a visit. Review of a Nursing Progress Note dated 8/30/20 at 9:45 AM revealed the resident had a slight fever. The resident and the resident's roommate were kept in their room for the breakfast meal. Review of the resident's Weights and Vital Signs Summary Sheet dated 8/30/20 revealed at 6:19 AM the resident had a temperature of 99.5 degrees Fahrenheit (F) with an oxygen saturation level of 88 percent (%). Further review revealed no documentation of the resident's respiration rate. Review of a Nursing Progress Note dated 8/30/20 at 1:30 PM revealed the Charge Nurse notified the Director of Nursing (DON) the resident had a low grade temperature with no other signs or symptoms (staff failed to identify the resident's decreased oxygen saturation rate or the resident's increased confusion). The resident reported feeling tired but indicated the resident's roommate (spouse) had been up throughout the previous night. The Charge Nurse was instructed to continue monitoring the resident and if other symptoms were noted, the facility should think COVID. If the resident's condition deteriorated staff were to notify the provider. Review of the resident's Weights and Vital Signs Summary Sheet dated 8/30/20 at 4:15 PM revealed the resident's temperature was 100.3 degrees F. review of the resident's medical record revealed [REDACTED]. Review of a Nursing Progress Note dated 8/31/20 at 3:28 AM revealed the resident's temperature had been around 100.3 degrees F. most of the shift. No further assessment was completed of the resident. Review of a Nursing Progress Note dated 9/1/20 at 12:40 AM revealed the resident was incontinent of urine. The resident had shortness of breath with exertion, an occasional cough and audible wheezing. Review of a Nursing Progress Note dated 9/1/20 at 2:38 AM revealed the resident was again incontinent of urine, had a notable cough and required increased assistance with cares from usual level. Review of a Nursing Progress Note dated 9/1/20 (7 days after the resident first started to show potential symptoms of COVID-19) at 3:05 PM revealed the resident was placed in red zone isolation due to a temperature of 100.4 degrees F. and other mild symptoms. Review of a Nursing Progress Note dated 9/2/20 at 10:33 AM revealed a discussion was held with staff regarding moving Resident 1's roommate (Resident 3) out of Resident 1's room. The note indicated the staff had decided not to move Resident 3 due to the trauma and the risk it would subject Resident 3 to as well as the whole facility. The staff agreed to keep both residents in the room. Review of a Nursing Progress Note dated 9/3/20 at 8:00 PM revealed Resident 1's COVID-19 test had returned positive. Review of a Nursing Progress Note dated 9/4/20 at 5:52 PM revealed the facility had contacted ICAP for recommendations and were advised to separate Resident 1 and Resident 3 to the extent possible. ICAP advised if unable to move into separate rooms, to separate

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

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

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F 0880 **Level of harm -** Actual harm **Residents Affected -** Many	(continued... from page 1) beds/chairs in room, have one resident use the bathroom and the other a bedside commode and to have both residents wear N95 masks. The note indicated when the residents were first admitted , the facility had attempted mask use with the residents and the residents were not compliant. In addition, moving beds, recliners and bringing a commode into the room would increase safety hazard. During an interview with the Social Service Director (SSD) on 9/8/20 at 11:45 PM the SSD indicated when the facility went into Phase III, Resident 1 and 3's family were allowed to visit on a daily basis. The resident's family were allowed to come into the facility and to visit in the resident's room. The resident's room door was frequently closed during these visits and the staff were unable to monitor these visit to assure masks were worn and social distancing was maintained. During an interview with the DON on 9/8/20 at 1:10 PM the following was revealed: -Resident 1 had increased confusion and restlessness on 8/25/20 and the resident reported not feeling well; -resident screening on 8/30/20 at 6:19 AM revealed the resident had a temperature of 99.5 degrees F and an oxygen saturation level of 88%; -resident screening on 8/30/20 at 4:15 PM revealed the resident's temperature was 100.3 degrees F. There was no evidence the staff assessed the resident further to determine signs and symptoms of potential COVID-19; -9/1/20 at 12:40 AM the resident was incontinent of urine. The resident had shortness of breath with exertion, an occasional cough and audible wheezing; -9/1/20 at 3:05 PM the resident had a temperature of 100.4 degrees F. and was placed in red zone isolation; -9/3/20 the resident's COVID-19 test was positive; and -the facility did not move Resident 3 from Resident 1's room despite the positive COVID test and ICAP recommendations as the facility felt it would be too traumatic for Resident 3. E. Observations on 9/8/20 from 11:58 AM to 12:25 PM in the yellow zone revealed the following: -Nursing Assistant (NA)-C positioned a dietary cart in the corridor outside of resident room [ROOM NUMBER]. Without washing hands or using hand sanitizer, NA-C placed on goggles, a disposable gown and disposable gloves. NA-C was already wearing an N-95 mask. NA-C entered the room carrying a meal tray. NA-C positioned the bedside table in front of the resident, moved a box of Kleenex and a water glass to the side of the table and then placed the meal tray on the table. NA-C proceeded to put a clothing protector on the resident and to assist with meal set-up. NA-C removed gown and gloves and placed in a trash receptacle in the resident's room, washed hands in the bathroom and exited the resident's room. NA-C removed goggles and placed on a table in the corridor. NA-C failed to disinfect/sanitize goggles after they were removed; -NA-C removed a pair of disposable gloves from a pocket of NA-C's uniform and donned. While wearing disposable gloves and mask, NA-C entered room [ROOM NUMBER], positioned the bedside table in front of the resident and assisted the resident with putting on a clothing protector. NA-C exited into the corridor and returned to room [ROOM NUMBER] with a meal tray. The meal tray was placed on the bedside table and NA-C assisted the resident with opening silverware packet and removing the cover from the resident's meal. NA-C removed gloves and used hand sanitizer in the corridor; and -NA-C removed another pair of disposable gloves from a uniform pocket, placed on and then proceeded to continue the meal service. During an interview on 9/8/20 at 12:30 PM, NA-C confirmed the following: -staff had been trained to cleanse/disinfect goggles after each use; -staff were to wash hands or use hand sanitizer before putting on clean gloves; -all residents were either in the red zone or in the yellow zone. When entering rooms in the yellow zone, staff were to put on clean gloves, gown and goggles. Staff were able to wear the same N-95 mask in all rooms in the yellow zone. Goggles were to be cleaned between each use in the resident rooms with Super Sani disposable cleansing cloths; and -staff were to wear masks, gowns, gloves and goggles in each of the resident's room when passing the meal trays if the residents required assistance or if staff touched any of the surfaces in the resident's room. F. Review of Resident 5's MDS dated [DATE] revealed the resident; 1.) had dementia, diabetes, and hypertension, 2.) was severely impaired cognitively, 3.) received hospice services, and 4.) received extensive assistance with bed mobility, transfers, dressing and toileting. Review of Resident 5's Weights and Vitals Summary revealed the residents body temperature; -on 9/2/20 at 1:59 PM was 100.1, -on 9/3/20 at 6:13 AM was 101.8, and -on 9/3/20 at 8:30 AM was 100.1. Review of Resident 5's Nursing Progress Notes dated 9/2/20, and 9/3/20 revealed no indication of nursing assessment of the residents condition related to the identified elevated body temperatures. Review of residents Nursing Progress Note dated 9/5/20 at 3:14 PM revealed that the resident was tested for COVID-19 (due to roommate). Review of Resident 5's Care Plan with a revision date of 9/5/20 revealed the resident was in a yellow zone and required transmission based precautions. Further review of the resident's Weights and Vitals Summary revealed the resident's body temperature; -on 9/7/20 at 1:03 AM was 99.1 -on 9/7/20 at 8:00 PM was 100 -on 9/8/20 at 6:57 PM was 100.4 -on 9/8/20 at 11:25 PM was 99.9 Further review of the resident's Progress Notes dated 9/7/20, and 9/8/20 revealed no indication of nursing assessment of the resident condition related to the identified elevated body temperatures. Further review of the resident's Care Plan with a revision date of 9/8/20 revealed the resident was in a red zone and required transmission based precautions. Interview with the DON at 1: 50 PM on 9/8/20 confirmed the facility protocol for resident screening is to obtain daily temperature, pulse, respiration and oxygen saturation. If those vital signs were abnormal and resident was coughing, short of breath, complained of a sore throat, or any abnormal upper respiratory symptoms were noted, the staff was to keep the resident and the resident's roommate in their room and report to the Charge Nurse immediately for further assessment of the resident's condition. G. Observations on 9/8/20 at 11:00 AM revealed the Dietary Manager walked down the resident care hallway of the facility wearing a cloth face covering and proceeded past the open doors of rooms the facility designated as Red Zone where COVID-19 positive and presumed positive residents resided. H. An observation on 9/8/20 from 11:05 AM to 11:20 AM of the Housekeeper, (HK) revealed the following: -HK mopped the floor in room [ROOM NUMBER] (a room that was actively used for testing staff and residents for Covid-19) immediately after a resident had exited the room; -HK was wearing an isolation gown, gloves, N95 mask and eye glasses, then removed the isolation gown and gloves, exited room [ROOM NUMBER] and had not been wearing goggles or a protective face shield over the N95 mask; and -HK then sanitized hands, donned a pair of gloves, touched the outside of the N95 mask with the gloved hand a couple of times and entered a room across the hall (room [ROOM NUMBER]) to clean it and touched several surfaces while the resident was inside the room. An interview with HK on 9/8/20 at 11:20 AM, confirmed HK had been wearing the same N95 mask for an entire shift while cleaning the rooms of residents that had been on isolation precautions. HK also confirmed protective goggles or face shields had not been worn. I. An observation on 9/8/20 from 10:45 AM to 11:05 AM of the SSD revealed the following: -a yellow colored sign on the door of room [ROOM NUMBER] instructed persons to see the charge nurse first and everyone was to wear an isolation gown, gloves, N95 mask, and goggles before entering; -a resident was sitting in the room in a recliner and the SSD entered the room wearing a fabric hat, isolation gown, gloves, N95 mask, and goggles; -SSD, put linens on bed 1 first, then removed the gown and gloves and discarded them in the room and washed hands in the bathroom; -SSD exited the room, donned a new gown and gloves while wearing the same N95 mask and goggles (not a protective face shield), adjusted the goggles and mask with gloved hands, then entered the same room and put linens on the second resident's bed in the same room. An interview on 9/8/20 at 11:05 AM with the SSD confirmed SSD was unaware of the need to disinfect the goggles between entering each resident's room, who were on isolation precautions, and SSD had worn the N95 mask for the entire shift. J. Review of Resident 2's Progress Notes from 8/28/20 to 9/9/20 revealed: - On 8/28/20 at 9:58 AM the resident's vital signs were taken by a Nursing Assistant and the resident had a temperature of 100.6 degrees. The resident then took a whirl pool bath. The resident had a [MEDICAL CONDITION] type episode and was assisted back to the resident's room. The resident also appeared tired. - On 8/28/20 at 9:41 PM the resident's temperature was 100.5 degrees, after taking Tylenol (a medication used for pain and fever reduction). - On 9/1/20 the resident was taken by van to an appointment in another state. - There were no further nursing Progress Notes after 9/1/20 until 9/7/20. - On 9/7/20 the resident had a temperature of 99.5 degrees and was then moved to red zone transmission based precautions. - There was no indication in the Progress Notes to indicate (prior to 9/4/20) Resident 2 had been placed on transmission based precautions related to an elevated temperature that started on 8/28/20 and no indication that the resident was put on transmission based precautions and/or increased monitoring related to an out of state appointment on 9/1/20. Review of Resident 2's COVID screenings from 8/28/20 to 9/4/20 revealed the screenings were completed in the Point of Care system (documentation completed by the Nursing Assistants). Further review revealed the screening forms had instruction for the Nursing Assistants to report to the nurse if the resident had abnormal vital signs. There were no parameters identified. Interview with Licensed Practical Nurse (LPN)-A on 9/8/20 at 11:29 AM confirmed Resident 2 was not put on transmission based precautions from 8/28/20 to 9/4/20. On 9/4/20 the resident along with all other residents (except one red zone transmission based precautions resident) had been placed in yellow zone transmission based precautions. Resident 2 was then moved to a private room and placed on red zone

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F 0880 **Level of harm** - Actual harm **Residents Affected** - Many	(continued... from page 2) transmission based precautions on 9/7/20. Until 9/7/20, Resident 2 had shared a room with Resident 6. K. Review of the Staff/Visitor Screening Logs dated 8/1/20 to 9/8/20 revealed: - On 8/3/20 Staff Member(SM)-N reported a cough and nasal congestion due to a head cold. SM-N continued to report a cough through 9/4/20. There was no indication that the staff member had been seen by a medical provider to rule out COVID. - On 8/7/20 LPN-Q and NA-P reported nasal congestion and there was no evidence the cause was investigated prior to the staff members working. - On 8/9/20 a visitor signed the screening log but there was no indication the visitor had been screened for COVID signs/symptoms, potential exposure, or an elevated temperature. It is unknown what staff member potentially screened the visitor. - On 8/10/20 Registered Nurse (RN)-B and Dietary Staff (DS)-R reported allergies [REDACTED]. - On 8/11/20 RN-B reported a head cold. There was no indication that the staff member had been seen by a medical provider to rule out COVID. - On 8/14/20 NA-S reported a cough and nasal congestion and identified it as a head cold. There was no indication that the staff member had been seen by a medical provider to rule out COVID. - On 8/14/20 and 8/15/20 DS-T reported a known COVID exposure. On 8/16/20 DS-T reported body aches and the known COVID exposure. On 8/17/20 DS-T had been tested for COVID and the results were unknown. DS-T worked but did wear an N-95 mask for that shift. - On 8/19/20 Staff Member-X reported a known COVID exposure. There was no evidence the details of that exposure were reviewed prior to the staff member working. - On 8/20/20 two visitors did not have a documented temperature check completed. - On 8/24/20 LPN-U reported a sore throat due to allergies [REDACTED]. - On 8/27/20 NA-V reported a cough and sore throat from allergies [REDACTED]. - On 8/28/20 RN-G reported a loss of smell and reported it as a head cold (with nasal congestion marked as no). There was no indication that the staff member had been seen by a medical provider to rule out COVID. - On 8/30/20 a visitor did not have a documented temperature check completed. - On 9/5/20 and 9/6/20 NA-W reported body aches and abdominal pain. There was no indication that the staff member had been seen by a medical provider to rule out COVID. L. Interviews on 9/8/20 from 9:50 AM to 10:30 AM with LPN-A, NA-C, and NA-D revealed (prior to 9/3/20) the staff had been self-screening for signs/symptoms of COVID prior to working. Interviews with the DON on 9/8/20 from 10:10 AM to 3:20 PM and 9/9/20 at 4:15 PM confirmed the facility was in phase 3 prior to Resident 1's confirmed positive COVID results on 9/3/20 (the source of Resident 1's COVID infection was unknown). Phase 3 had allowed for some communal dining, activities, and visitors. Visitors, after being screened, were allowed to visit in an outdoor setting, in a designated room, or in the residents' rooms if the resident had a private room. The DON reported now 4 additional residents were being observed on red zone transmission based precautions due to suspected COVID infections. The DON confirmed Resident 2 had roomed with Resident 6 until 9/7/20. The DON confirmed no additional precautions/monitoring were put in place for Resident 2 after returning from an out of state appointment. The DON confirmed the area of the appointment had community spread COVID cases. Further interview revealed the Nursing Assistants had been doing the resident COVID screening. The DON confirmed the NAs had not received any training on how to screen the residents for signs/symptoms of COVID (including vital signs parameters). In addition, The DON confirmed the facility staff had been self-screening (prior to 9/3/20) for signs/symptoms of COVID. The DON confirmed any potential signs or symptoms were not reviewed by a nurse prior to the staff member working with the residents. The DON was unsure what the details of Staff Member-X's COVID exposure was and confirmed the staff member was allowed to work. The DON confirmed DS-T had a known exposure and was allowed to continue to work while awaiting test results. The DON confirmed over the last month no employee's had been sent home or to the physician related to reported signs/symptoms.