STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285157	A. BUILDING _____ B. WING _____	**10/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PREMIER ESTATES OF PAWNEE, LLC	**P O BOX 513, 438 12TH STREET PAWNEE CITY, NE 68420**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** Licensure Reference Number 175 NAC 12-006.17B Based on observation, interview and record review the facility failed to ensure staff properly prevent cross contamination including COVID-19 (mild to severe respiratory illness caused by Coronavirus) by not wearing an N95 mask in designated yellow zone resident rooms to be cleaned . This had the potential to affect 26 residents in the yellow zone. The facility census was 27. Findings are: Observation on 10/28/20 at 10:15 am with Housekeeper A revealed a surgical mask worn in designated yellow zone rooms that were cleaned. Interview on 10/28/20 at 11:15 am with Housekeeper A revealed surgical mask was worn to clean resident rooms in the yellow zone. Housekeeper A revealed an N95 mask is worn to clean the designated red zone room. Record review on 10/28/20 at 2:50 pm of facility protocol for zones and PPE (personal protective equipment) dated 4/20/20 revealed all staff that work in a yellow zone are to wear gown, gloves, eye protection and N95 mask. Interview on 10/28/20 at 3:00 pm with Nurse Consultant confirmed that Housekeeping is expected to wear an N95 mask in the designated yellow zone when rooms are cleaned, just like nursing staff and not a surgical mask.

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.