STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285263	A. BUILDING _____ B. WING _____	09/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTFIELD QUALITY CARE OF AURORA	**PO BOX 166, 1313 1ST STREET AURORA, NE 68818**

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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E 0004 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Develop and maintain an Emergency Preparedness Program (EP).** Licensure Reference Number 175 NAC 12-006.18F Based on record reviews and interview, the facility failed to ensure that the Emergency Preparedness Plan policies and procedures were reviewed and updated annually. This failure had the potential to affect all residents residing in the facility in the event of an emergency. The facility census was 41. Findings are: Record review of the facility Emergency Preparedness Plan policies and procedures revealed an absence of documentation related to the last time the plan and polices had been reviewed or updated. The date of review line on the policies were left blank. Interview on 9/17/20 at 12:20 PM with the facility Administrator confirmed there was no evidence of Emergency Preparedness policy annual review or updates and that the date of review had been left blank on the Emergency Preparedness policies.
E 0031 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide emergency officials' contact information.** Licensure Reference Number 175 NAC 12-006.18F Based on record review and interview, the facility failed to ensure that the Emergency Preparedness Plan included contact information for the State Licensing and Certification agency and the office of the State Ombudsman. The had the potential to affect all residents that resided in the facility in the event of an emergency. The facility census was 41. Findings are: Record review of the facility Emergency Preparedness Plan revealed that the plan did not include contact information for the State Licensing and Certification agency or the office of the State Ombudsman. Interview on 9/17/20 at 1:40 PM with the facility Administrator confirmed that the facility Emergency Preparedness Plan did not include contact information for the State Licensing and Certification agency or the office of the State Ombudsman.
F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** Licensure reference Number 175 NAC 12-006.05 (6) Based on observations, record reviews and interviews the facility failed to ensure residents dignity and respect was provided to residents related to 1) staff standing while assisting residents to eat and 2) Hoyer (mechanical lift) sling straps visible for Residents 27 and 42. 3) Calling Resident 42 by a name other than (his/her) given name, 4) not providing privacy to Resident 31's groin area. The total sample size was 12. The facility census was 41. Findings are: 1) An observation on 9/16/20 at 12:09 PM revealed NA (Nursing Assistant) -A was standing and assisted Resident 27 to eat; NA - A gave Resident 27, two bites of food and then walked away. An observation on 9/16/20 at 12:11 PM revealed LPN (Licensed Practical Nurse) -B was standing and assisted Resident 42 to eat few bits of food and then walked away. According to The American Health Care Association Facilities are to Ensure there is adequate space and furniture to allow direct care staff to sit comfortably next to residents to enhance proper feeding techniques. Staff should be seated at eye level when possible and in a manner to promote socialization, even for those residents who have limitations with cognition and/or communication. An interview on 9/22/20 at 12:45 PM with DON (Director of Nursing) confirmed staff should not be standing while assisting residents to eat. 2) An observation on 9/16/20 at 11:45 AM in Unit 400 dining area revealed Resident 27 and 42's were sitting in wheel chairs at dining room table and both residents Hoyer slings straps were visible. An observation on 9/17/20 at 11:45 AM revealed Resident 27 Hoyer sling including red straps were showing and hanging down the back of Resident 27's wheelchair. An observation on 9/22/20 at 9:30 AM revealed Resident 42 and 27's slings were showing. Record review of Resident 42's Care Plan dated 8/14/19 revealed documentation about leaving Hoyer sling in place while resident is up in wheelchair to decrease friction to skin, but did not address leaving straps dangling and hanging out of wheelchair. Record review of Resident 27 Care Plan dated 9/16/2020 revealed no documentation about leaving Hoyer sling in place; while resident is up in wheelchair or addressing leaving hoyers straps dangling and hanging out of wheelchair. An interview on 9/22/20 at 12:45 PM with DON confirmed residents Hoyer slings should not be showing and this is a dignity/ respect issue. 3) According to The American Health Care Association Staff are to address the resident by his/her given name, in an adult manner. Speaking to the residents in baby language and calling them names such as Granny, Sweetie, Honey, etc. would be considered disrespectful. An observation on 9/16/20 at 11:45 AM in 400 unit dining room revealed Resident 42 was sitting at table with Residents 2 and 22. Resident 42 was crying out and yelling help fix my glasses I need to poop AA (Activity Aide) -C sat next to Resident 42 and called Resident 42 Resident - Name Poo. An observation on 9/16/20 at 11:55 AM revealed AA -C sat next to Resident 42 and called Resident 42 Sweet Heart. An observation on 9/16/20 at 11:56 AM revealed AA-C was sitting next to Resident 42 and called Resident 42 Resident Name-Poo. An observation on 9/16/20 at 12:00PM revealed AA-C sat next to Resident 42 and called Resident 42 Sweet heart. An observation on 9/16/20 at 12:01 AM revealed AA-C sat next to Resident 42 told Resident 42 I Love You. Record review of Resident 42's Care plan dated 6/13/20 revealed Residents is to be treated with respect and dignity; no documentation for Resident 42 to be called Resident Name -Poo, Sweet Heart or I love you. An interview on 9/22/20 at 12:45 PM with DON confirmed Residents are to be called by their given name or specific name directed by Resident and/ or POA and documented on Care Plan. . 4) An interview on 9/16/20 at 10:20 AM with Resident 31 revealed (gender) is told can't wear clothing because of catheter bag. Resident 31 says I wear this blue gown. Resident stated I used to wear overhalls but now I would just be happy with wearing sweat pants and shirt I have let staff know this is what i want. An observation on 09/16/20 at 10:20 AM revealed Resident 31 was sitting in recliner in (gender) room wearing a blue gown and bottom of gown was at resident thigh level and residents white pull - up brief was visible along with catheter tubing tube (a tube that drains urine from bladder). Catheter bag was not covered. An observation on 09/17/20 at 10:00AM revealed Resident 31 sitting in recliner with a white and blue gown on; gown was short and ended at resident's thigh level and resident's catheter strap, catheter tubing, and pull- up brief. Catheter tubing that was dangling from residents leg and hook to bed , catheter bag was not covered. An observation on 9/17/20 at 11:54 AM revealed Resident 31 was in Bath chair in the SPA with a blue gown on, gown was pulled up around Resident 31's waist exposing resident 31's genital area. Record review of policy titled Promoting/Maintaining Resident Dignity dated 3/8/20 revealed Residents are to be groomed and dressed according to resident's preferences. An interview on 9/22/20 at 12:45 PM with DON (Director of Nursing) confirmed Resident 31 should have a sheet or drape covering residents groin area when resident is wearing a gown.
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) State Licensure Reference Number 175 NAC 12-006.04C3a(6) Based on interview and record review, the facility failed to ensure the physician was updated related to a change of condition for Resident 19. The sample size was 12. The facility had a total census of 41 residents. The findings are: A review of a progress note dated 8/21/20 at 10:05 PM revealed Resident 19 had blood in (gender) urine and was not a good drinker. Resident 19's urine was dark in color and had a foul odor. The progress note stated Resident 19's physician was updated via fax. A review of Resident 19's EHR (Electronic Health Record) and paper medical record did not reveal any documentation of a physician update or follow-up from the physician related to the progress note dated 8/21/20. In an interview on 9/21/20 at 4:28 PM, the Director of Nursing (DON) stated (gender) called over to Resident 19's physician's office and they had no record of a fax sent related to Resident 19's progress note on 8/21/20. The DON confirmed no follow-up was done for the progress note written on 8/21/20 regarding Resident 19's urine. A review of the facility's undated Notification of Changes policy revealed the following: Definitions: -Clinical Complications: Examples - Development of stage 2 pressure injury, recurrent episodes of [MEDICAL CONDITION], recurrent UTIs (Urinary Tract Infections) or onset of depression. -Need to alter treatment significantly: Means a need to stop a form of treatment because of adverse consequences (such as adverse drug reaction), or commence a new form of treatment to deal with a problem (for example, the use of any medical procedure, or therapy that has not been used on that resident before). -The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. -Circumstances requiring notification include: -2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: -a. Life-threatening conditions, or -b. Clinical complications. -3. Circumstances that require a need to alter treatment. This may include: -a. New treatment -b. Discontinuation of current treatment due to: -i. Adverse consequences. -ii. Acute condition. -iii. Exacerbation of a chronic condition.
F 0582 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** Licensure Reference Number 175 NAC 12-006.05(1) Based on record review and interview, the facility failed to ensure that 2 (Resident 25 and 29) of 3 residents reviewed for Skilled Nursing Facility Advanced Beneficiary Notices (SNFABN) were offered a choice to have a Medicare Fiscal Intermediary review performed to determine if Medicare would continue to pay for skilled services received. The facility census was 41. Findings are: Record review of Resident 25's SNFABN notice dated 8/20/20 indicated that Medicare part A services for skilled care were planned to end on 8/22/20. A review of the form revealed that no option box had been marked by the resident to indicate whether the resident wanted an independent review the denial of the skilled care received and a decision made by the Medicare Fiscal Intermediary. Record review of Resident 29's SNFABN notice dated 8/12/20 indicated that Medicare part A services for skilled care were planned to end on an unknown date. A review of the form revealed that no option box had been marked by the resident to indicate whether the resident wanted an independent review the denial of the skilled care received and a decision made by the Medicare Fiscal Intermediary. Interview on 9/21/20 at 9:04 AM with the facility Social Services Director confirmed that the choice boxes on Resident 25 and 29's SNFABN should have been marked to indicate their decision whether or not to have the Medicare Fiscal Intermediary review the denial of skilled services received. Interview on 09/21/20 at 01:37 PM with the facility Administrator confirmed that there was no policy related to how to fill out the SNFABN forms.
F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** Licensure Reference Number 175 NAC 12-006.05(7) Based on observations, record reviews and interviews, the facility failed to implement a method where grievances could be lodged on an anonymous basis and failed to have a grievance policy that explained grievance rights to residents and / or personal representatives. This had the potential to affect all residents that resided in the facility. The facility census was 41. Findings are: Observation on 09/21/20 at 10:50 AM revealed a set of forms entitled Concern / Compliment Forms were located in a wall folder on the side of the receptionist desk in the lobby of the facility. There was no sign or information posted that indicated that the forms were to be used for grievances or where to put the form if filled out. There was no box or place that grievance forms could be filed anonymously without having to give it to someone. There was no Grievance policy or information posted that explained grievance rights to residents or personal representatives. Record review of the facility Admission Packet revealed that residents have the right to voice complaints and grievances without discrimination or reprisal and the nursing facility has a responsibility to provide prompt efforts to resolve grievances. The information did not address how to file a grievance or how to ensure grievances could be submitted anonymously. Interview on 9/21/20 at 10:54 AM with the facility Social Services Director (SSD) confirmed that grievance forms are located at the front desk and are called Concern / Compliment Forms. The SSD stated that when a resident is admitted the SSD shows them where the forms are and the resident can come up and get one at anytime. The SSD stated that, when completed, the resident can give the form to the SSD or the charge nurse or whoever they want. The SSD confirmed that there was no box or any method a grievance could be filed anonymously. The SSD confirmed that the facility did not have a policy on grievances to the knowledge of the SSD. Interview on 09/21/20 at 01:38 PM with the facility Administrator confirmed that there was no box or method to file grievances anonymously and that the facility did not have a policy related to grievances that included: The right to file a grievance in writing. The right to file a grievance anonymously. The reasonable timeframe the resident can expect a completed review of the grievance. The right to obtain the review in writing. The required contact information of the grievance official. The contact information of independent entities with whom grievances may also be filed.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09B The facility failed to ensure the Minimum Data Set (MDS: A federally mandated comprehensive assessment tool used for care planning) was coded to reflect the resident's status related to Anticoagulant (a medication used to thin the blood) medication use for 2 (Residents 25 and 35) of 13 sampled residents reviewed. The facility census was 41. Findings are: A. Record review of Resident 25's MDS dated [DATE] section N: Medications Received during the last 7 days revealed 7 days of Anticoagulant use by Resident 25. Record review of Resident 25's Physician order [REDACTED]. Record review of Resident 25's August 2020 Medication Administration Record [REDACTED]. interview on 09/21/20 at 02:47 PM with the facility MDS Coordinator confirmed that Resident 25 did not have an order for [REDACTED]. Record review of the MDS 3.0 Manual N0410E, Anticoagulant, revealed the following instructions related to the coding of Anticoagulant medications - Record the number of days an anticoagulant medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Do not code antiplatelet medications such as Aspirin/extended release, [MEDICATION NAME], or [MEDICATION NAME] here. Record review of Resident 35's MDS dated [DATE] section N: Medications Received during the last 7 days revealed 7 days of Anticoagulant use by Resident 35. Record review of Resident 35's MAR indicated [REDACTED]. The start date on this medication was 3/24/20. Interview on 09/21/20 at 02:46 PM with the MDS Coordinator confirmed that the [MEDICATION NAME] had been coded as an Anticoagulant and that it should not have been counted per the directions in the MDS 3.0 manual.
F 0644 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews the facility failed to ensure a level 2 PASARR for Resident 31 was completed related to new mental health diagnoses. The sample size was 12. The facility census was 41. Findings are: Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. . Offered all applicants the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings). Record review of Resident 31's PASRR revealed a PASRR was completed on

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F 0644 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) 6/10/19. No mental health illness /intellectual/developmental disability or serious behavioral health condition was listed for Resident 31. Review of all of Resident 31's MDS (The Minimum Data Set) (is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems) dated 9/16/19 Section I (Active Diagnosis) Revealed Resident 31 has [DIAGNOSES REDACTED]. Anxiety was not check as a current diagnosis. Record review of Resident 31's [DIAGNOSES REDACTED]. Resident anxiety was not checked on MDS. Record review of Resident 31's Electronic Medical Record Revealed Resident 31 was diagnosed on [DATE] with anxiety. An interview on 9/22/20 at 1:52 PM with DON (Director of Nursing) confirmed a level II PASRR should have been completed due to resident being admitted with [MEDICAL CONDITION] and [MEDICAL CONDITION] and Resident 31 new mental health [DIAGNOSES REDACTED].
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** State Licensure Reference Number 175 NAC 12-006.10D Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5% for 2 (Residents 23 and 25) of 4 residents reviewed for medication administration. The med error rate was 16%. The facility had a total census of 41 residents. The findings are: A. Observations of medication administration on 9/21/20 and 9/22/20 revealed 4 medication errors out of 25 opportunities for error. This resulted in an error rate of 16%. B. An observation on 9/21/20 at 9:15 AM revealed Medication Aide (MA)-M administered the following oral medications to Resident 25: -[MEDICATION NAME] 5mg (a medication used to treat type 2 diabetes) -Pantoprazole 40mg (a medication used to decrease the amount of acid produced by the stomach) -[MEDICATION NAME] 500mg (a medication used to treat type 2 diabetes) An interview with MA-M at this time revealed Resident 25 had already eaten breakfast. A review of Resident 25's September 2020 MAR (Medication Administration Record) revealed the following medication orders [REDACTED]. Compare medication source (bubble pack, vial, etc.) with MAR indicated [REDACTED]. a. Refer to drug reference material if unfamiliar with the medication, including its mechanism of action or common side effects. b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. -Medications requiring administration on an empty stomach: *[MEDICATION NAME] *Time-Sensitive medications In an interview on 09/22/20 at 12:35 PM, the Director of Nursing (DON) confirmed the [MEDICATION NAME] and pantoprazole scheduled at 7:30 AM for Resident 25 should have been given prior to Resident 25 eating breakfast. The DON also confirmed the [MEDICATION NAME] scheduled at 8:00 AM for Resident 25 should have been given with breakfast. C. An observation on 9/22/20 at 8:02 AM revealed MA-N administered the following oral medication to Resident 23: -[MEDICATION NAME] 0.25mg (a medication used to treat [MEDICAL CONDITION] (an abnormal heart rhythm) by controlling the heart rate and rhythm) MA-N did not check any of Resident 23's vital signs prior to administering the [MEDICATION NAME] A review of Resident 23's September 2020 MAR indicated [REDACTED]*[MEDICATION NAME] *Anti-Hypertensives In an interview on 09/22/20 at 12:35 PM, the DON confirmed an apical pulse (auscultated over the left chest with a stethoscope for a full minute) should have been taken prior to MA-N administering [MEDICATION NAME] to Resident 23.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** State Licensure Reference Number 175 NAC 12-006.12E1 Based on observation, interview, and record review, the facility failed to ensure a medication cart was secured in the 200 hallway when no staff were present. This had the potential to affect all 15 residents on the 200 hallway. The facility had a total census of 41 residents. The findings are: An observation on 9/22/20 at 7:58 AM revealed a medication cart located in the 200 hallway of the facility was unlocked and no staff were present. An observation on 9/22/20 at 8:00 AM revealed MA (Medication Aide)-N exited room [ROOM NUMBER]. An interview with MA-N at this time confirmed the medication cart was unlocked and should not have been. A review of the facility's undated Medication Storage Policy revealed the following: -1. General guidelines: -a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. -b. Only authorized personnel will have access to the keys to locked compartments (see attached listing). -c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. In an interview on 9/22/20 at 12:50 PM, the Director of Nursing confirmed the medication cart should not have been left unlocked in the 200 hallway.
F 0801 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.** Licensure reference Number 175 NAC 12-006.04D2a Based on observations, interviews and record reviews the facility failed to ensure the dietary manger was certified. The facility census was 41. Findings are: Per the Nebraska Food Code 2-102.20 Food Protection Manager Certification. A PERSON IN CHARGE who demonstrates knowledge by being a FOOD protection manager that is certified by a FOOD protection manager certification program that is evaluated and listed by a Conference for Food Protection-recognized accrediting agency as conforming to the Conference for Food Protection Standards for Accreditation of Food Protection Manager Certification Programs is deemed to comply with 2-102.11(B). An interview on 9/16/20 at 8:30 with staff member - O introduced (her/him) self as DM (Dietary Manager). Another staff member -P introduced self as Dietician. Dietician explained (he/she) comes to facility once a week on Wednesdays and is available by phone any time. An interview on 9/21/20 at 1:28 PM with DM confirmed (he/she) does not have a dietary manager certification yet but, is working on it. Record review of DM Employee File revealed no completed dietary manager certification or additional education relevant to Dietary manager position.
F 0810 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide special eating equipment and utensils for residents who need them and appropriate assistance.** State Licensure Reference Number 175 NAC 12-006.09D8c Based on observation, interview and record review, the facility failed to ensure Resident 28 was provided weighted silverware with meals. The sample size was 12. The facility had a total census of 41 residents. The findings are: An observation on 9/16/20 at 8:54 AM revealed Resident 28 was sitting up in bed eating breakfast. Resident 28 was using weighted silverware to eat. A tremor was noted in Resident 28's right hand as (gender) ate. An observation on 9/16/20 at 12:10 PM revealed Resident 28 was sitting up in bed eating lunch. Resident 28 was using regular silverware to eat. A tremor was noted in Resident 28's hand as (gender) ate. An observation on 9/17/20 at 12:12 PM revealed Resident 28 was sitting up in bed eating lunch. Resident 28 was using regular silverware to eat. A tremor was noted in Resident 28's hand as (gender) ate. A review of Resident 28's care plan indicated Resident 28 was to use weighted silverware at meals due to hand tremors. In an interview on 9/22/20 at 1:44 PM, the Dietary Manager confirmed Resident 28 was to use weighted silverware at meals.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Licensure Reference Number 175 12-006.11 E Based on observations, interviews and record review the facility failed to 1)ensure hair was completely covered during food preparation and service, 2)food temperatures were in accordance with the state food code requirements, 3)maintain a complete log of food and 4) refrigerator temperatures on the 400 unit dining area. This had the potential to affect all residents in the building. The facility census was 41. Findings are: 1) Record review of The Nebraska Food Code dated March 2012 Section 2-402.11 revealed the following related to Hair Restraints

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 3) effectiveness: Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils and linens and unwrapped single service and single use articles. An observation 9/21/20 at 9:00 AM during lunch preparation noted DA (Dietary Aides) Q and R had lots of hair exposed outside of the hairnet. An observation on 9/21/20 at 9:00 AM revealed DM (Dietary Manager) had multiple strands of hair not enclosed in hair net while in kitchen and assisting with lunch prep. An interview on 9/21/20 at 12:00 PM with DM confirmed all hair should be enclosed in hairnets. 2) According to the Nebraska State Food code 81-2,272.01 Time/ Temperature Control for Safety Food, Hot and Cold Holding. (A) At one hundred thirty-five degrees Fahrenheit or above. (B) Forty-one degrees Fahrenheit or less. An observation on 9/21/20 at 11:45 AM Cook -T checked temperatures on steam table; Chicken 154, Mixed Veggies, Ground and pureed chicken 128- cook acknowledged needed to be at least 135 - both placed back in oven. Gravy temperature was 170. An Observation on 9/21/20 at 12:30 PM revealed steam table had lids off all foods, Cook -T took food temperatures, by placing a cleaned thermometer into each food, cleaning thermometer in between as well. The temperatures of food on the steam table were: Chicken breasts 140 Mixed veggies 154 Purred chicken 119 Mechanical Chicken 134 Gravy 137 Mashed Cauliflower 133 An interview on 9/21/20 at 12:40 PM with DM (Dietary Manager) confirmed temperatures were too low and needed to be at least 135. 3) Record review of undated Facility Policy Titled Record of Food Temperatures -400 hall Unit revealed ready to eat foods that require heating before consumption should be taken directly from sealed container or an intact package from an approved food processing source and heated to at least 135 degrees F for holding for hot service. An interview on 9/21/20 at 9:30 AM with DM confirmed nursing staff is to take temperatures of 1st and last tray of each meal and document it. Record review of Temp log for assist dinning- Last tray for 400 unit revealed only 5 days of supper meal tray temperature for the month of September 2020 were documented. Breakfast and Lunch temperatures range from 99 to 136. Today's (9/21/20) temperatures for lunch 116.8 for first tray and 123.6 for last. An interview on 9/21/20 at 12:40 PM with DM revealed the nursing staff in the 400 hallway know the temperatures need to be 135 or higher. To correct temperature issue nursing is to call dietary or use microwave on unit to heat food to safe temperature. Record review of sign posted on refrigerator in Unit 400 dining room revealed the following information- use the thermometer provided, must take internal temperature of last plate in hot cart and document it on form provided. Holding temperature for food in Hot cart is 140 Degrees. This process must be repeated for every meal. Record Review of Sign posted on refrigerator in Unit 400 dining room revealed PLEASE MAKE SURE YOU ARE TEMPING THE FIRST AND LAST PLATE COMING OUT OF THE HOT CART EACH MEAL Signed by DM on 1/15/2020. An interview on 9/21/20 at 12:40 PM with DM revealed (gender) was unaware of the missing temperatures and confirmed the temperatures were not at safe temperature. 4) Record review of Cooler/Freezer Temperature Chart for the month of September 2020. This chart was on the side of the 400 unit dining snack/drink refrigerator. The chart is blank. No temperatures have been completed for the month of September. Record review of undated facility policy title Monitoring of Cooler/Freezer Temperature - 400 hall Unit revealed logs for recording temperatures for each refrigerator or freezer will be posted in a visible location outside the freezer or refrigerator unit. Temperatures will be checked and logged at least twice per day by designated personnel. An interview on 9/21/20 at 9:30 AM with DM revealed dietary department is responsible for performing refrigerator temperatures in the 400 hall dining room fridge. DM confirmed refrigerator temperature have not been done for most of September.
F 0880 **Level of harm** - Minimal harm or potential for 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 Numbers 175 NAC 12-006.17, 12-006.17B, and 12-006.17D Based on observation, interview, and record review, the facility failed to ensure staff, visitors, and residents that resided on the 400 hall wore masks in accordance with CDC (Centers for Disease Control and Prevention) and CMS (Centers for Medicare and Medicaid Services) guidelines and residents located on the 400 hall practiced social-distancing during meals to prevent the potential spread of COVID-19. This failure had the potential to affect all residents residing in the facility. The facility also failed to perform catheter care and hand hygiene in a manner to prevent potential cross contamination for 1 (Resident 31) of 2 residents reviewed for catheter care. The facility had a total census of 41 residents. The findings are: A. An observation on 9/16/20 at 8:54 AM revealed Housekeeper (HK)-Q cleaning in resident room [ROOM NUMBER] and wore a surgical mask covering HK-Q's mouth, but not the nose. The resident in room [ROOM NUMBER] was present while HK-Q was cleaning. An observation on 9/16/20 at 9:05 AM revealed HK-Q cleaning in resident room [ROOM NUMBER] and wore a surgical mask covering HK-Q's mouth, but not the nose. Two residents were present in room [ROOM NUMBER] while HK-Q was cleaning. In an interview on 9/16/20 at 9:11 AM, HK-Q acknowledged (gender) mask was not covering (gender) nose. HK-Q stated the mask kept slipping. An observation on 9/17/20 at 12:02 PM revealed Receptionist-S walked through the main dining area wearing a surgical mask. Receptionist-S's surgical mask covered only the mouth and not the nose. An observation on 9/17/20 at 12:04 PM revealed Receptionist-S walked through the main dining area wearing a surgical mask. Receptionist-S's surgical mask covered only the mouth and not the nose. An observation on 9/17/20 at 12:20 PM revealed Receptionist-S sat at the front desk wearing a surgical mask covering only (gender) mouth. An observation on 9/17/20 at 12:35 PM revealed Receptionist-S at the nurses' desk wearing a surgical mask covering only (gender) mouth. An observation on 9/21/20 at 12:45 PM revealed Receptionist-S sat at the front desk wearing a surgical mask covering only (gender) mouth. An observation on 9/21/20 at 3:11 PM revealed the Administrator walked out of the Administrator's office and to the nurses' station with no face covering. The Administrator had a surgical mask hanging from (gender) ear. An observation on 9/22/20 at 9:53 AM revealed a visitor in the facility in street clothes walking down the main hallway towards the front doors of the building. The visitor wore no face covering. An interview with the Director of Nursing (DON) at this time revealed the visitor was in the facility for a job interview. In an interview on 9/22/20 at 1:00 PM, the DON reported the visitor was at the facility for a job interview for a housekeeping position. The visitor had been in the Administrator's office for the interview (located in the center of the building). The DON stated the visitor refused a face covering due to a medical condition. The DON reported the DON was not informed of the visitor's refusal to wear a face covering when the visitor arrived for the job interview. The DON stated if the DON had been aware of the visitor's refusal to wear a face covering, the DON would not have let the visitor into the building and would have instructed staff to conduct the job interview outside. A review of an undated COVID19 - Facility Re-Opening Plan revealed the following: Universal Source Control of PPE: -Residents and visitors wear (a) facemask, if able to tolerate and wear safely. -All facility staff, regardless of their position, will wear a surgical/procedural facemask. In an interview on 9/22/20 at 9:27 AM, the Infection Preventionist reported staff are expected to wear a surgical mask at all times in the facility unless they are in an office with the door closed for eating or drinking. B) An observation on 9/16/20 at 9:07 AM revealed the following residents in activity area with no social distancing or masks on. Residents 27, 18, 3, 21, 37 and 22. An interview on 9/16/20 at 9:20 AM with CNA (Certified Nursing Assistant) - A revealed residents in the 400 hall do not have masks and are not required to wear them. An observation on 9/17/20 at 11:43 AM revealed Resident 2, 27, 24, 21 18 and 7 sitting in the activity room with no masks on and no social distancing. An interview on 9/22/20 at 9:21 AM with Infection Preventionist confirmed unit 400 is its one little area and masks have been tried but they did not work. IP Confirmed masks should be offered and encouraged to be worn by residents when gathered together and social distancing of 6 feet apart should be followed as well. Record review of Facility Policy undated Titled Covid-19 -Facility Re-Opening Plan Revealed that during group activities residents will be sat at least 6' feet apart for the following the social distancing recommendations. All will wear approved masks (provided by the facility (this includes the residents and staff. Residents will receive instructions on proper hand hygiene and staff will assist to ensure cleanliness. C. An observation on 9/16/20 at 9:30 AM revealed the following residents were in the 400 dining hall dining room: Sitting at table 1 were Resident 42, 22, Sitting at Table 2 were Resident 27 and 3, staff member CNA - D Sitting at Table 3 were Resident 24 and 21 Sitting at Table 4 were Residents 7, 1, 2 and 36. Dining room table do not have barriers and tables are not spaced 6 feet apart. An observation on 9/22/20 at 9:30 AM revealed in the 400 hall dining area revealed the following residents were sitting at table 1-Residents 42, 22, 36, 37 and 3 staff members MA-F, CNA-E and CAN-G. Sitting at Table 2 were Residents 27 and 3 and staff member MA-H. Sitting at Table 3 were Residents 21 and 24. Sitting at Table 4 were Residents 7, 1, 2 and 36. No barrier between residents and tables were not spaced 6 feet apart. An interview/ observation on 9/22/20 at 9:15 AM with Physical Plant Manager confirmed the dining room tables in the 400 hall dining were not 6 feet apart and each tables measurements were 42x 42. . Record review of the a Facility policy undated Titled Covid-19- Facility Re-Opening Plan does not address communal dining in the 400 unit hall way; this area is also referred to as the memory care area. An interview on 9/22/20 at 12:45 PM with DON confirmed residents on the 400 hallway need to be 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285263	A. BUILDING _____ B. WING _____	**09/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTFIELD QUALITY CARE OF AURORA	**PO BOX 166, 1313 1ST STREET AURORA, NE 68818**

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 4) feet apart and following social distancing recommendations to prevent spread of Covid-19. 3) An interview on 9/16/20 at 10:20 AM with Resident 31 revealed Resident has [MEDICAL CONDITION] and that's why (gender) has a catheter (tube that drains urine from the bladder). An observation on 9/17/20 at 11:54 AM revealed Resident 31 was in Bath chair in the SPA with a blue gown on. CNA (Certified Nursing Assistant) -E preformed hand hygiene, by applying soap to one hand, turning on water faucets, ran hands underwater, washed hands for 10 seconds, rinsed with water, dried hands with paper towel, applied gloves. CNA-E walked over to supply rack and picked up package of peri -wipes (disposable wipes used to wash genital area), CNA-E did not remove gloves or perform hand hygiene; CNA-E lifted Resident 31 gown up; expose genital area. Resident was sitting a few feet from the entrance to the SPA, privacy curtain was not pulled and a drape was not placed over Resident 31's groin area for privacy. CNA-E then removed peri wipe from package, wiped Resident 31's right side of groin in an upward motion, discarded wipe, used a new wipe, CNA-E then wiped Resident 31's left groin area in a upward motion, then discarded wipe. CNA-E stated it's kind of hard to do this when you're sitting Resident 31 responded They usually do this when I'm laying down in my recliner. CNA-E removed a new wipe from peri- wipe package then pushing back foreskin, wiped penis and catheter tube cleaning 1 cm from insertion site (urinary meatus) (on male resident this is the opening of the penis) in one circular motion, discarded wipe. Catheter tube was not wiped down. CNA-E removed gloves. Resident 31's foreskin was not returned to normal position. CAN-E left Resident 31 gown up and genital area exposed; another staff member entered bath house 3 times with door open. CNA-E preformed hand hygiene, by applying soap to one hand, turning on water faucets, ran hand underwater, washed hands for 10 seconds, rinsed with water, dried hands with paper towel, applied gloves, Assisted Resident 31 to apply new pull- up brief to legs(disposable incontinent underwear) and non- skid socks. CNA-E removed gloves and preformed hand hygiene by washing hand with soap and water for 10 seconds and dried hands with paper towel, applied new gloves. Bath chair and Resident 31 was reposition in SPA so that Resident 31 was in front of a grab bar. Resident 31 was then assisted to stand up with assistance of CNA-E and another Aide. CNA-E performed back perineal care (cleaning of buttocks and anus) with a disposable wipe. CNA-E noted a small sore to Residents right buttocks. Resident was assisted to sit down. CNA-E called for MA (Medication Aide). An observation on 9/17/20 at 12:01 PM MA entered spa, performed hand hygiene by turning on water faucet, applying soap and washing for 12 seconds. Applied gloves, lifted Resident 31's gown and applied cream to the head of Resident 31's Penis. MA - U removed gloved. CNA-E then asked if Resident 31 had cream for sore on buttocks. MA-U replied - no I will get the nurse. MA- U left SPA without performing hand hygiene. An observation on 9/17/20 at 12:06 PM revealed IP (Infection Preventionist) entered room performed hand hygiene for 20 seconds, dried hands, and applied gloves. Resident 31 was assisted to standing position and IP assessed sore on Resident 31's right buttocks, a nonprescription barrier cream was applied. IP removed gloves and preformed hand hygiene with soap and water for 20 seconds. Resident 31 was assisted in pulling up brief and sitting down into wheelchair. Record review of policy dated 2/26/20 Titled Catheter Care Policy revealed staff are to ensure privacy by closing the door, closing the blinds/ curtains, assist resident to a lying position or the most comfortable position for the resident. Drape the resident to expose only the perineal area. For a male resident - gently grasp penis, draw foreskin back, use circular motion, cleanse meatus, new wipe starting at urinary meatus moving down, cleanse the shaft of the penis, with new wipe starting at the urinary meatus moving outward, wipe the catheter making sure to hold the catheter in place as to not pull on the catheter. Record review of undated policy Titled Hand Hygiene revealed hand hygiene technique when using soap and water by wet hands with water, avoid using hot water to prevent drying of skin, apply to hands the amount of soap recommended by the manufacturer, Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers, rinse hands with water, dry thoroughly with a single-use towel, use clean towel to turn off the faucet. An interview on 9/22/20 at 12:45 PM with DON (Director of Nursing) confirmed when performing catheter care hand hygiene needs to be 20 seconds, and follow facility policy and CDC guidelines are hand hygiene. When performing catheter care the foreskin should be returned to normal position, the catheter tube needs to be wiped down ward away from urinary meatus and the groin should be wiped in a downward motion front to back.