STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285166	A. BUILDING _____ B. WING _____	10/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PREMIER ESTATES OF KENESAW, LLC	P O BOX 10, 100 WEST ELM AVENUE KENESAW, NE 68956

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 0695 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure reference number 175 NAC 12-006.0906 Based on record review and interview, the facility failed to provide comfort cares to include oxygen for one resident (Resident 4). The facility sample size was 4. The facility identified a census of 41. Findings are: A record review of the Progress Notes dated 09/18/20 through 10/5/20 revealed that Resident 4 had received a Covid-19 (a mild to severe respiratory illness that is caused by a coronavirus) test with a negative result on 9/19/20. The record review revealed that Resident 4 had been tested for Covid-19 again on 9/23/20 with positive results. The record review of the Progress Notes revealed that an order for [REDACTED]. The record review of the assessments also noted intermittent symptoms to include a non-productive cough, labored respirations, abnormal lung sounds and cyanotic (a bluish or purplish discoloration due to deficient oxygenation of the blood) nail beds. A record review of the vital signs documented from 9/6/20 through 10/5/20 revealed that Resident 4 had SaO2 (Oxygen saturation which is a measurement of the percentage of how much oxygenation is in the blood, The normal level is 95-100% on room air. Older adults typically have lower oxygen saturation levels than younger adults. For example, someone older than [AGE] years of age may have an oxygen saturation level of about 90-95%, which is an acceptable level) levels below 90% daily with the lowest documented level being 80% on 10/4/20. A record review of the active orders list for Resident 4 as of 10/5/20 revealed that Resident 4 had not been given any supplemental oxygen to aide in maintaining comfort. An interview on 10/7/20 at 01:10 PM with LPN-A revealed that hospitalization had been discussed with Resident 4 and the guardian and declined. The interview confirmed that no oxygen order had been obtained for Resident 4 during the illness or time of comfort cares.
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 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 to include the spread of COVID-19 (a mild to severe respiratory illness that is caused by a coronavirus) related to failing to verify screening results for facility employees, failure to ensure follow up of symptoms indicated on screening sheets, failure to ensure the screening sheets contained full staff identifying information including first and last names and titles, failure to prevent self screening, failure to use PPE (Personal Protective Equipment used to protect healthcare workers, patients, and others from potentially contacting and/or spreading potential infections) in its intended manner and failure to ensure isolation gowns were not contaminated prior to use or removed appropriately. The facility failure had the potential to affect all residents in the building. The facility identified a census of 41. Findings are: A: A record review of the facility Covid-19 screening logs (CSL) revealed that on 10/4/20 and 10/5/20, LPN-F answered yes to living with someone that had symptoms of or tested positive for Covid-19 and answered yes to having shortness of breath and muscle aches on 10/5/20 and 10/6/20. The record review revealed that the screening for LPN-F on 10/7/20 contained only a temperature and did not address the symptoms of Covid-19. Further review of the CSL for LPN-F revealed that there was no evidence of a follow up evaluation prior to allowing LPN-F to work. A record review of the facility CSL revealed that on 10/5/20 Employee H answered yes to living with someone that had symptoms of or tested positive for Covid-19 and on 10/2/20 and 10/5/20 answered yes to having close contact with someone with symptoms of Covid-19. Further review of the CSL for Employee H revealed that there was no evidence of a follow up evaluation prior to allowing Employee H to work. A record review of the facility CSL revealed that on 10/5/20 Employee I answered yes to providing cares to a patient with Covid-19 without PPE and on 10/1/20 and 10/5/20 Employee I answered yes to being in contact with a person who had tested positive for Covid-19. The record review revealed that on 10/1/20, Employee I answered yes to having current symptoms of Covid-19. Further review of the CSL for Employee I revealed that there was no evidence of a follow up evaluation prior to allowing Employee I to work. A record review of the facility CSL revealed that on 10/6/20 NA-D answered yes to having close contact with someone with symptoms of Covid-19. Further review of the CSL for NA-D revealed that there was no evidence of a follow up evaluation prior to allowing NA-D to work. An interview with the facility Administrator and the facility ICP (Infection Control Preventionist), after review of the CSL's, revealed that Employee I had not been inside the facility since 10/5/20. During the interview with the facility Administrator and the facility ICP, it was confirmed that the facility CSL's were not being addressed at the time of the screening and that staff were being allowed to screen themselves but were expected to verify each other's temperatures. An observation on 10/7/20 revealed NA-G to be restocking isolation gowns kept outside of resident rooms on the Red Zone (isolation rooms designated for residents with positive Covid-19 test results). The observation revealed NA-G had dropped an isolation gown onto the floor and then pick up isolation gown and place it into the drawer with other clean isolation gowns. An interview on 10/7/20 at 11:58 AM with NA-G confirmed that the gown did land on the floor and was placed into the drawer containing other clean isolation gowns. The interview with NA-G revealed that NA-G was a contract staff member just beginning at this facility today. The interview with NA-G revealed that NA-G denied having any previous education related to working on a Red zone. A record review of Employee Information for NA-G dated 8/7/20 revealed that NA-G was educated and found to be proficient in infection control to include the use of PPE and the different types of isolation precautions. An observation on 10/6/20 revealed RN-B to have no straps on the bottom of the N95 (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) mask being worn on the red zone. An interview with the facility ICP confirmed that the use of a N95 mask without bottom straps was not an acceptable practice on the red zone. B. On 10/06/2020 at 9:36 AM Observation of the DON (Director of Nursing) revealed the DON sitting behind the desk at the nurses station, in the entry way between the units, the DON had no face shield or goggles on and had the N95 mask pulled down under his nose. The mask was only covering the DON's mouth. On 10/06/2020 at 10:12 AM an interview with the ADM (Administrator) revealed that while the interim Infection Preventionist was off work, due to being on quarantine, the random checks for compliance for PPE (Personal Protective Equipment) and training was being done by the DON (Director of Nursing) and the Regional Consultant. On 10/06/2020 at 10:23 AM Observation of the DON (Director of Nursing) revealed that the DON was sitting at the nurses station between the hallways and was drinking a Gatorade drink. The nurse's station was located at the center point of the Yellow Zone. On 10/06/2020 at 11:15 AM an interview with the Regional Consultant, who was the acting Infection Preventionist, revealed it was the expectation of the infection control process that N95 mask (a piece of personal protective equipment to prevent the wearer from coming into contact the the [MEDICAL CONDITION]) be worn in the Yellow and Red Zone with the mask covering both the nose and mouth. Food and Drinks are not to be in the Yellow and Red Zone areas and are to be consumed in the break room off the units. C. On 10/07/2020 at 11:45 AM observation of the DON (Director of Nursing) who was working as the Charge Nurse, revealed while completing a glucometer test (a test using a machine to determine the sugar level in the blood) on Resident 5 revealed that the DON used hand sanitizer and applied

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** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) gloves. The DON placed a disinfectant wipe down on top of the treatment cart and entered the room with the glucometer, a test strip, cotton ball and an alcohol wipe. The DON sat the glucometer down on the bedside table and asked the resident which finger he wanted the test done on. The DON then cleaned the finger off with the alcohol pad and using a clean unused lancet punctured the skin of the left index finger. The test strip had already been inserted into the machine and the sample of blood was placed on the strip. The DON then obtained the results and the resident was given his insulin with the RN priming the insulin pen before giving the insulin. The DON removed the isolation gown in the room and gloves then walked across the room to place the gown into the trash can by the roommate's bed. The roommate was sitting on a walker between the sink and the bed. The DON washed the DON's hands for 20 seconds in the resident's sink with the roommate being less than 6 feet from the DON. The face shield did not get cleaned between residents. The DON exited the room and cleaned the glucometer with a disinfectant wipe followed by a second disinfectant wipe letting the glucometer air dry before placing it into the container belonging to the resident. Each resident hah their own glucometer with cleaning of the glucometer noted between residents. The DON did not remove the isolation gown close to the door of the room. Review of the Nebraska Medicine COVID-19 PPE (Personal Protective Equipment) Guidance updated 3.19.20 revealed that when doffing the gown it is to be removed close to the doorway. Review of the CDC (Centers for Disease Control) Guidelines dated 8/7/2020 Coronavirus Disease 2019 (COVID-19): How to Wear Masks, revealed that to wear a mask to protect others. -Wear a mask that covers your nose and mouth to help protect others in case you're infected with COVID-19 but don't have symptoms -Wear a mask in public settings when around people who don't live in your household, especially when it may be difficult for you to say six feet apart -Wear a mask correctly for maximum protection -Don't put the mask around your neck or up on your forehead -Don't touch the mask, and, if you do, wash your hands or use hand sanitizer to disinfect