STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285190	A. BUILDING _____ B. WING _____	**09/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALPINE VILLAGE RETIREMENT CENTER	**706 JAMES STREET VERDIGRE, NE 68783**

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 0608 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to ensure (1) employees report any suspicion of a crime against any resident, according to timelines; (2) post the notice of employee rights; and (3) prohibit and prevent retaliation for reporting.** Licensure Reference Number: 175 NAC 12-006.02 (8) Based on record reviews and interview, the facility failed to notify law enforcement of an allegation of resident to resident sexual abuse for 2 (Residents 5 and 29) of 2 sampled residents. The facility census was 34. Findings are: A. Review of a facility policy titled Reporting Suspicion of a Crime (revision date July 2017) revealed the Administrator, the Director of Nursing (DON) or any other designated individual was to report (within the required time frames) any reasonable suspicion of a crime against a resident to the State Agency and local law enforcement agency. Examples of crimes that would be reportable include but are not limited to: -rape; -assault and battery; and -sexual abuse. B. Review of a facility investigation report completed on 9/17/20, revealed the facility investigated an incident which occurred on 9/13/20. The report indicated at 10:45 PM, the staff were unable to find resident 29 in the resident's room. A search was conducted and the staff located Resident 29 in Resident 5's room. Staff witnessed Resident 29 in Resident 5's bed. Resident 29's buttocks were exposed and the resident was facing Resident 5. Resident 29 was asked by the staff to place on clothing and to leave Resident 5's room. Resident 5 was wide awake and without expression. Resident 5 was examined and found to have one side of pajama bottoms lowered and the resident's pajama top had been raised. The staff asked Resident 5 what had happened and the resident did not respond. The report further indicated the Administrator was notified of the incident on 9/13/20 at 11:05 PM. However, the report identified law enforcement was not notified and the report further identified law enforcement would be notified in the future. Review of Resident 29's Nursing Progress Notes dated 9/16/20 at 8:51 AM revealed the facility had contacted the Ombudsman regarding the incident between Residents 5 and 29 which had occurred on 9/13/20. The Ombudsman indicated Resident 29 had committed sexual abuse to another resident and Resident 29 was a danger to others. Interview with the Administrator and the DON on 9/16/20 at 10:44 AM confirmed the following: -Resident 5 and Resident 29 had developed a recent relationship. The residents would sit together in the front solarium and visit and staff had seen Resident 29 going into Resident 5's room as well; -staff had discouraged room visits due to the need for social distancing but also because Resident 5's family preferred staff were able to monitor the situation; -on 9/13/20 at 10:45 PM, staff found Resident 29 in Resident 5's room and in bed with Resident 5; -Resident 5 was not wearing any clothing to the lower torso; -Resident 29's clothing had been partially adjusted. Resident 5 was unable to tell staff what had occurred; and -the facility reported the incident to Adult Protective Services but failed to report the incident to local law enforcement.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09D7(a) (b) Based on interview and record review; the facility failed to develop and/or revise fall prevention interventions for the prevention of ongoing falls for Resident 11. The sample size was 2 and the facility census was 34. Findings are: Review of Resident 11's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 7/8/20 revealed the following: -severe cognitive impairment; -extensive assistance with bed mobility, transfers, dressing and toilet use; -unsteady and only able to stabilize with human assistance when moving from a seated to standing position, while walking, when turning around and facing the opposite direction while walking, when moving on and off the toilet, and during surface-to-surface transfers (between bed and chair or wheelchair); and -frequently incontinent of bowel and bladder. Review of the undated current Care Plan indicated Resident 11 was at risk for falls and had poor safety awareness. Nursing interventions included the following: -11/20/17 nonskid rug placed at bedside; and -4/29/18 automatic brakes applied to wheelchair. Review of a Post Fall assessment dated [DATE] at 4:30 AM revealed the resident had a fall out of bed. The fall was not witnessed and the resident indicated sliding out of bed. Currently identified fall prevention interventions included a nonskid rug at the bedside, automatic brakes to the resident's wheelchair, a defined edge mattress to the bed and the bedside table to be positioned by the closet. The report further revealed the resident had not been toileted since 10:00 PM. The resident indicated a need to use the bathroom and the report revealed the resident had not been toileted since 10:00 PM on 4/4/20. The resident was wearing one shoe and one sock. A new intervention was developed for the resident to wear gripper socks at all times. Further review revealed no evidence the staff had addressed the resident's toileting schedule as a potential causal factor for the fall. Review of a Post Fall assessment dated [DATE] at 8:20 PM revealed the resident was found on the floor next to the resident's bed. The resident was unable to identify a reason for the fall and stated I just rolled out of bed. Review of the report revealed no new interventions were identified and/or current fall interventions were not revised. Review of a Post Fall assessment dated [DATE] at 9:30 PM revealed the resident had a fall in the resident's room when self-transferring out of bed. A new intervention was put into place for a work order to fix the automatic brakes on the resident's wheelchair and for the staff to make sure the wheelchair was next to the bed when the resident was lying down. Review of a Post Fall assessment dated [DATE] at 2:25 PM revealed the resident had been self-propelling wheelchair in the corridor. The resident became stuck on the wall continued to try and move forward and then fell out of the chair face first. review of the resident's medical record revealed [REDACTED]. Review of a Post Fall assessment dated [DATE] at 7:45 AM revealed the resident was found on the floor of the resident's room and next to the bed. The assessment indicated the nonskid rug next to the bed had been removed so that housekeeping could mop the floor of the resident's room. However, staff failed to assure the floor was dry before returning the rug next to the resident's bed. Staff were educated to ensure the floor was completely dry before placing rug by the bed. Review of a Post Fall assessment dated [DATE] at 1:20 PM revealed the resident was found on the floor next to the resident's bed. review of the resident's medical record revealed [REDACTED]. Interview with the Director of Nursing on 9/17/20 at 11:30 AM revealed staff were to complete a Post Fall Assessment after each fall, identify causal factors and then either develop new interventions or revise current interventions to try and prevent further falls.
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.** **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.**

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 0801 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) Licensure Reference Number 175 NAC 12-006.04D2a Based on record review and interview the facility failed to ensure the Dietary Manager (DM) had the required qualifications. This had the potential to affect food service provided to all residents who were served food from the kitchen. The facility census was 34. Findings are: A. Review of the facility Job Description: Dietary Services Supervisor revised 7/2011 revealed the DM would carry out the assigned duties in accordance with current federal and state regulations. The DM would meet current requirements established by the regulatory agencies or be enrolled in a class to meet such requirements. Record review of the DM's personnel file revealed a job description signed and dated by the DM on 7/13/20 but no evidence that the DM had enrolled in or completed the required training. An Interview with the facility Administrator on 9/16/20 at 2:00 PM confirmed the DM had not been enrolled in or completed the required training.
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 including the spread of COVID-19 related to: 1) residents not wearing masks in common areas in which they were within 6 feet of others; 2) failure to implement transmission based precautions for Resident 6 after a leave of absence and to provide increased monitoring of resident 6 after appointments outside of the facility; 3) washing hands and changing gloves at appropriate intervals during the provision of wound care for Resident 2; and 4) failure to implement standard precautions during the administration of medications in resident rooms. These practices had the potential to affect all residents in the facility. The total sample size was 18 and the facility census was 34. Findings are: A. Review of Infection Control Assessment and Promotion Program (ICAP) with revision date 4/17/20 revealed the following regarding the need for a cohorting plan when a positive case of COVID-19 is confirmed or suspected: -identification of zones for placement of residents based on their symptoms and exposure risks; -red zone for all residents that have tested positive for COVID-19, who are symptomatic or are suspected positive. Healthcare workers to wear full Personal Protective Equipment (PPE- gloves, gowns, masks and eye protection); -yellow zone for all residents who are asymptomatic (showing no symptoms) but who may have been exposed to COVID-19. All residents in the Yellow Zone should be on COVID level precautions and should wear COVID level PPE; -if a resident has suspected positive or has tested positive for COVID-19 and has a roommate, the roommate should be transferred to a private room in the yellow zone; 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. B. Review of the CMS Center for Clinical Standards and Quality, Safety and Oversight Group dated 4/24/20 revealed the following guidance for infection control and prevention of Coronavirus Disease 2019 (COVID-19): -the facility should consider the necessity of appointments outside of the facility to the resident's health, whether it is critical for the resident to attend; -if attending the appointment is necessary, the facility should help arrange for the resident to attend the appointment by taking precautions to minimize the risk of transmission of COVID-19; and -the facility should monitor the resident upon return for fever and signs and symptoms of respiratory infection for 14 days after the outside appointment (preferably in a space dedicated for the observation of asymptomatic residents). C. Review of the Long-Term Care COVID-19 Phasing Guidance dated 6/15/20 revealed facilities could move to Phase 3 if they met certain criteria. Further review revealed certain mitigation steps were to be implemented in Phase 3. The guidance revealed universal source control pertained to everyone in the facility. Residents and visitors were to wear cloth face coverings or facemasks, if able to tolerate and wear safely. D. Review of the facility COVID-19 Cohorting Plan (revised 6/14/20) revealed resident monitoring was to be completed daily and was to include temperature and oxygen saturation checks as well as monitoring of potential symptoms. Symptoms were to include cough, fever, shortness of breath, fatigue, headache, and loss of taste or smell. If a confirmed or suspected case of COVID-19 was present in the facility, each resident was to be monitored and/or assessed twice a day or three times a day pending guidance from ICAP. E. Review of Resident 6's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 6/24/20 revealed active [DIAGNOSES REDACTED]. The following was assessed regarding the resident: -cognition was intact; -required extensive staff assistance with dressing, transfers, toilet use and personal hygiene; and -occasionally incontinent of bowel and bladder. Review of Nursing Progress Notes for Resident 6 revealed the following: -8/4/20 at 10:16 AM the resident was seen outside of the facility for a chiropractor appointment; -8/6/20 at 9:25 AM the resident left the facility for a chiropractor appointment; -8/6/20 at 9:15 PM the resident had an apathetic appearance. The resident reported a headache which the resident reported as an 8 out of 10 on the pain scale. In addition, the resident voiced a complaint of nasal drainage; -8/11/20 at 9:00 AM the resident left the facility for a chiropractor appointment; -8/13/20 at 9:25 AM the resident was out of the facility for a chiropractor appointment; and -8/18/20 at 9:25 AM the resident was out of the facility for a chiropractor appointment. Review of Resident screening logs dated 8/4/20 through 8/18/20 revealed the resident was screened for potential COVID-19 signs/symptoms only once a day. Review of Nursing Progress Notes revealed the following: -8/20/20 at 10:08 AM the resident was seen at the chiropractor office; and -8/25/20 at 9:19 AM the resident left the facility for a chiropractor appointment. Review of Resident screening log dated 8/26/20 revealed the resident was screened for potential COVID-19 signs/symptoms only once a day. Review of a Nursing Progress Note on 8/27/20 at 9:25 AM revealed the resident was seen at the chiropractor office. Review of a Social Service Progress Note dated 8/27/20 at 3:00 PM revealed the resident's family was notified that a facility staff member had tested positive for COVID-19. Review of Nursing Progress Notes revealed the following: -8/29/20 at 8:00 AM the resident want out on a leave of absence with spouse; and -8/30/20 at 8:11 PM the resident returned to the facility. Review of Resident 6's medical record revealed no evidence the resident was screened for potential COVID-19 signs/symptoms upon return to the facility on [DATE] after the resident's leave of absence. Review of a Nursing Progress Note dated 9/1/20 at 9:25 AM revealed the resident left the facility for a chiropractor appointment. Review of a Nursing Progress Note dated 9/3/20 at 9:25 AM revealed the resident was out of the facility for a chiropractor appointment. Review of a Nursing Progress Note revealed the following: -9/5/20 at 9:36 AM revealed the resident left the facility with spouse at 7:55 AM to go home for the day; and -9/5/20 at 8:10 PM the resident returned to the facility from outing with spouse. Review of a Nursing Progress Note dated 9/6/20 at 8:21 AM revealed the resident left the facility to go home with spouse for the day. Review of a Nursing Progress Note dated 9/8/20 at 10:07 AM revealed the resident was out of the facility for a chiropractor appointment. Review of a Nursing Progress Note dated 9/14/20 at 1:33 PM revealed the resident reported a severe headache, a slight increase in nasal drainage and fatigue. A COVID Rapid Test with a Point of Care device was done as the resident had been out on a recent leave of absence. The test result was negative. Review of a Nursing Progress Note dated 9/15/20 at 9:25 AM revealed the resident had left the facility for a chiropractor appointment. Review of a Nursing Progress Note dated 9/17/20 at 9:25 AM revealed the resident was out of the facility for a chiropractor appointment. Interview with the Director of Nursing (DON) on 9/17/20 at 10:24 PM confirmed the following: -residents who left the facility for frequent medically necessary appointments, should receive increased monitoring and were to be screened twice a day for signs and symptoms of COVID-19; -staff failed to screen Resident 6 twice a day from 8/4/20 to 8/18/20 and on 8/26/20 even though the resident had frequent appointments outside of the facility; -residents gone from the facility for a leave of absence should be placed in isolation for 14 days upon their return to the facility; -Resident 6 went home with spouse from 8/29/20 to 8/30/20 and again on 9/5/20 and 9/6/20; -Resident 6 was removed from isolation on 9/13/20; and -Resident 6 should have remained in isolation until 9/20/20. F. Observation on 9/15/20 at 11:35 AM revealed Resident 29 was seated in a wheelchair at the Nurse's Station. The resident was coughing and made no attempt to cover mouth. Resident 29 self-propelled wheelchair down the 200 corridor, to the front living room and back to the Nurse's Station. Resident 29 was not wearing a mask. Observations of Resident 29 on 9/16/20 from 9:00 AM to 11:49 AM revealed the following: -9:00 AM the resident was seated in a wheelchair and was self-propelling the chair in the 100 corridor. Resident 29 was not wearing a mask; -9:47 AM remained in wheelchair without benefit of a face covering. The resident was positioned at the Nurse's Station and Licensed Practical Nurse (LPN)-C and LPN-D were seated at the Nurse's Station. Neither of the staff provided the resident with cues to return to the resident's room or assisted the resident with putting on a mask; -10:14 AM the resident kicked open the door to the Social Service Director's office and propelled into the office. The resident then backed up the wheelchair and proceeded out to the front living room. Resident 29 remained without a face mask; and -11:21 AM to 11:49 AM the resident remained without a face covering, seated in the wheelchair and positioned in front of the Nurse's Station. Interview with LPN-C on 9/16/20 at 1:30 PM revealed the residents were to wear a mask whenever they were out of their rooms and in the corridors.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 2) G. Observations of Resident 2 revealed; On 9/15/20 at 7:59 AM the resident was sitting in the commons area near the Nurse's Station not wearing a face mask. Facility staff were present and did not encourage or remind the resident to wear a face mask. On 9/15/20 at 9:00 AM the resident was sitting in the commons area by the Nurse's Station not wearing a face mask. On 9/15/20 at 11:00 AM the resident was sitting in the commons area by the Nurse's Station with a face mask visible below the chin. Facility staff were present at the Nurse's Station and did not encouraged or remind the resident to put the face mask on. On 9/15/20 at 12:00 PM the resident was sitting in the commons area by the Nurse's Station with a face mask visible below the chin. Facility staff present at the Nurse's Station did not remind or encourage the resident to put the face mask on. On 9/15/20 at 12:10 PM the resident was sitting in the commons area by Nurse's Station with a face mask below the chin. Facility staff walked by and greeted the resident but did not remind or encourage the resident to put the face mask on. H. Review of the facility policy Handwashing/Hand Hygiene dated 8/2015 revealed that the facility considered hand hygiene the primary means to prevent the spread of infection and all personnel would follow handwashing/hand hygiene procedures to help prevent the spread of infection. Further review of the policy directives revealed that 1.) Handwashing with soap and water was indicated when hands were visibly soiled or following contact with a resident with infectious diarrhea, and 2.) the use of alcohol based hand rub (ABHR) was indicated before handling clean or soiled wound dressings, after handling used dressings, and after removing gloves. I. Review of the facility policy Personal Protective Equipment/Using Gloves dated 9/2010 revealed objectives to prevent the spread of infection, protect wounds from contamination, protect hands from potentially infectious material, prevent the spread of infection, prevent contamination of the patient, and to decrease the risk of infection when changing dressings. Further review revealed that gloves were to be used when touching excretions, secretions, body fluids, mucous membranes or non-intact skin. J. Review of the facility policy Dressings- Dry/Clean dated 9/2013 revealed directives for handwashing prior to procedures, prior to putting on clean gloves, following removal of soiled gloves, and prior to applying clean dressings. K. Observation of Resident 2's pressure ulcer (skin breakdown caused by prolonged pressure and lack of circulation to a skin area) dressing change on 9/16/20 at 1:10 PM revealed: -LPN-C entered the bathing area with a treatment cart and supplies needed for the dressing change located on top of the treatment cart. -LPN-C put on gloves and measured the open area then removed gloves (did not sanitize or wash hands), put on clean gloves and applied skin prep (adhesive liquid to aid in keeping the dressing intact) to the skin surrounding the pressure ulcer. -LPN-C opened the package to the dressing and removed the protective adhesive tabs from the dressing. -LPN-C noticed that the right glove was soiled with BM (bowel movement) and proceeded to remove the right glove while holding the clean dressing in the left gloved hand. The left glove was not removed and hands were not washed or sanitized. -LPN-C applied a clean glove to the right hand (without washing or sanitizing) and then applied the dressing to the pressure ulcer. -LPN-C removed gloves, sanitized the top of the treatment cart, and then sanitized hands with ABHR. L. Interview with the DON on 9/17/20 at 2:00 PM confirmed that staff should; 1.) encourage and/or assist residents who are out of their rooms to wear a face mask, and 2.) wash or sanitize their hands between all glove changes, and wash their hands with soap and water any time their hands are visibly soiled. M. On 9/15/20 at 11:58 AM, Nursing Assistant (NA)-I was observed to place their hand directly on the outside of their face mask and cough. NA-I then took an isolation gown and gloves and put them on without doing hand hygiene first. NA-I then entered Resident 186's room. N. On 9/15/20 at 12:02 PM Dining Assistant (DA)-J was observed in a room with Resident 3 and Resident 20. DA-J was setting up Resident 3's lunch and arranging the items on the bedside table wearing a gown, gloves, mask, and eye protection. The resident's roommate (Resident 20) was using a cordless phone. Resident 20 stated they were done with the phone. DA-J then took the cordless phone and exited the room. DA-J walked with the cordless phone while still wearing the same gown and gloves and placed the phone at the nurse's station. The phone was not cleaned after use. DA-J then changed gloves but did not complete hand hygiene prior to putting new gloves on and re-entered Resident 3's room to assist the resident with lunch. O. Observations with Registered Nurse (RN)-K on 9/17/20 revealed: - At 8:15 AM, RN-K exited Resident 15's room with a thermometer and a pulse oximeter. Prior to cleaning the items they were placed directly on a stool in the hallway outside of Resident 15's room. The stool was not cleaned afterwards. -At 8:25 AM, RN-K prepared Resident 8's medications. RN-K went to put on an isolation gown and placed RN-K's face shield face down on the same stool in the hallway (outside of Resident 15's room). After getting the gown on RN-K picked up the face shield and put it on without completing hand hygiene. RN-K then put gloves on, picked up Resident 8's medication cup and entered Resident 8's room without completing hand hygiene. - At 8:35 AM, RN-K prepared Resident 32's medications. Prior to entering Resident 32's room RN-K took the clean medication cup with medication in it and placed it directly on one side of the night stand in the hallway (that had isolation equipment on it) then removed the staff's face shield and placed it face down on the other side of the night stand. RN-K put on an isolation gown, picked up the face shield and put it back on and donned gloves. At no time was hand hygiene completed and the face shield and the night stand were not cleaned. RN-K then picked up the medication cup and entered Resident 32's room. -At 8:45 AM, RN-K (while still in Resident 32's room) removed the face shield and placed it on a table/dresser in the resident's room face down while doffing the RN's gown and gloves. RN-K then picked up the face shield and put it back on. Neither the resident's dresser/table nor the staff's face shield were cleaned afterwards.