STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285278	A. BUILDING _____ B. WING _____	09/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NYE LEGACY HEALTH & REHABILITATION CENTER	**3210 N CLARKSON FREMONT, NE 68025**

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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, it was determined the facility failed to transmit the five-day abuse investigation results to the Nebraska State Department of Health and Human Services (DHHS) for 1 of 3 sampled residents (Resident 44) reviewed for abuse reporting. The facility census was 73. Findings are: The facility abuse policy related to injuries of unknown origin documented by the fifth day of the investigatory period (from date of report), the facility will report the results of the investigation to the appropriate agencies, as required by state statutes. Resident 44 had [DIAGNOSES REDACTED]. The resident's quarterly Minimum Data Set, dated dated [DATE], documented the resident was rarely/never understood and was moderately impaired in cognition. The resident also required extensive assistance with activities of daily living. The medical record documented the resident was observed with a bruise of unknown origin on the back of the left hand. The medical record documented the resident was taking an anticoagulation medication and was being treated for [REDACTED]. The facility provided documentation of an investigation conducted related to possible abuse. The results of the investigation were that the resident was not a victim of abuse. The facility provided documentation, dated 06/05/20, that the five-day investigatory results had been sent to Adult Protective Services (APS). It was not sent to DHHS. The facility investigation documented there had been no abuse to the resident. On 09/01/20 at 1:08 PM, the Corporate Nurse, the Director of Nurses, and the Social Services Director were interviewed. The Social Services Director stated she had tried multiple times to fax the 5-day investigation report to the DHHS, but the faxes didn't transmit properly; so, she decided to send the report to the APS.
F 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the facility failed to transmit a completed admission Minimum Data Set assessment (MDS: a federally mandated comprehensive assessment tool used for care planning), within 14 days following completion for 1 of 21 residents (Resident 2) reviewed for submission of MDS assessments. The facility census was 73. Findings are: Resident 2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A record review revealed an admission MDS assessment, dated on 03/02/20, with a status of completed. Resident 2 was discharged home on[DATE]. A record review revealed the facility did not transmit the admission MDS for Resident 2 until 08/27/20 when it was brought to the attention of the MDS Coordinator-C's attention. After MDS Coordinator-C transmitted Resident 2's admission MDS, the status changed to accepted. On 09/01/20 at 8:35 AM, the MDS Coordinator-C indicated it was probably a computer system glitch and moving forward the MDS status will be doubled checked for accuracy. On 09/01/20 at 2:07 PM, the Director of Nursing indicated moving forward the facility will do weekly audits to make sure that all MDS are transmitted within 14 days. On 09/01/20 at 2:46 PM, the Administrator indicated going forward the facility will do weekly audits to make sure that all MDS are transmitted within 14 days.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to implement and maintain infection control practices during the COVID-19 pandemic, when a cognitively impaired resident (Resident 61), was allowed to wander into the room of a resident (Resident 9) who was a person under investigation (PUI) for COVID-19. This affected 1 of 7 residents reviewed who had wandering behaviors. The facility identified 8 residents as PUIs. The facility census was 73. Findings are: Resident 61 was admitted [DATE] with [DIAGNOSES REDACTED]. The annual Minimum Data Set Assessment, dated 05/18/20, documented the resident was unable to participate in the Brief Interview for Mental Status and required 1-2 assist with all activities of daily living. The resident was independent with ambulating in the wheelchair. Resident 61's care plan indicated the resident was at risk of wandering into other residents' rooms. At the time of the survey, Resident 61 was not on any transmission based precautions for any exposure to COVID-19. Resident 9 was admitted on [DATE] to a gray zone room for potential exposure to COVID-19, requiring staff to don (PPE) personal protective equipment including mask, face shield and protective gown. The initial nursing assessment, completed 08/22/20, revealed the resident did not have signs or symptoms of COVID-19 at that time. The baseline care plan directed the restriction of visitors, included hand hygiene for residents and staff and to encourage social distancing. Resident 9 remained under isolation for potential exposure to COVID-19. However, Resident 9 did not reside on a PUI unit. The resident's door to (gender) room was not always kept closed. During an observation with Nurse-A on 08/31/20 at 8:45 AM, Resident 61 was observed exiting Resident 9's room, without a mask or other personal protective equipment. Resident 61 was observed self-propelling the wheelchair. Resident 61 did not reside in the same room as Resident 9. Resident 61 resided across the hall, and down one room from Resident 9. An interview with the Administrator, Director of Nursing and Nurse Consultant-B on 08/31/20 at 9:10 AM confirmed Resident 61 was not wearing a mask and had a history of [REDACTED]. During an interview on 08/31/20 at 11:09 AM, Resident 9 indicated (gender) was sitting in the wheelchair in (gender) room when Resident 61 entered the room in (gender) wheelchair. Resident 61 started messing with (gender) breakfast meal tray. Resident 9 told Resident 61 to stop. Resident 61 took Resident 9's call bell and started chewing on the red button. Resident 9 said when he/she saw a nurse or CNA walk by, (gender) called for help. Resident 9 indicated (gender) was not wearing a mask and (gender)could not remember whether Resident 61 was wearing a mask. Resident 61 was positioned very close to Resident 9 and was in (gender) room for 4 to 5 minutes. Resident 9 said residents had went into (gender) room before but could not remember if it was Resident 61. Resident 9 further indicated that he/she had complained to the facility staff previously about residents wandering in his/her room unannounced. Review of the facility's, COVID-19 Guidelines, updated 08/13/20, directs staff that, 7. All admissions will self-quarantine in their room . and 9. SNF (skilled nursing facility) admissions will initiate droplet precautions at all times.

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.