

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 28E199	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2020
NAME OF PROVIDER OF SUPPLIER GOLDEN OURS CONVALESCENT HOME		STREET ADDRESS, CITY, STATE, ZIP 902 CENTRAL AVENUE GRANT, NE 69140	
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 0885 Level of harm - Potential for minimal harm Residents Affected - Many	<p>Based on interviews and record review the facility failed to notify residents and their representatives when confirmed COVID-19 infections were identified in the building. This had the potential to impact all residents. Census was 17. Sample included 2 current residents (Residents 1, and 2) and 3 former residents (Residents 3,4, and 5). Findings are: On 8/4/2020 at 3:45 PM, an interview with Resident 1 revealed that the resident could not recall being notified by the facility when new COVID-19 infections were identified in the facility but did report being told the results of their own test. Record review for Resident 1 and Resident 2 showed no evidence that these individuals or their representatives had been notified when new cases of COVID-19 were identified in the facility. On 8/4/2020 at 3:55 PM an interview with the facility's Administrator and DON (Director of Nursing) revealed that the facility had been notifying residents and their representatives regarding each individual's COVID testing results but had not notified anyone regarding positive cases being identified in the building. Review of the facility's policies with the Infection Preventionist showed that neither the Response to Positive COVID-19 Testing policy or the Protocol for Positive COVID-19 in the Building policy indicated a plan or procedure to notify residents or their representatives when cases of COVID-19 were confirmed. On 8/4/2020 at 5:45 PM during an exit conference, the facility's Administrator, DON, Infection Preventionist, and CEO verified that the facility did not have any plan in place to notify residents and their representatives when confirmed cases of COVID-19 were identified in the facility unless that specific individual was the one who had tested positive.</p>		

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.