STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285095	A. BUILDING _____ B. WING _____	**08/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONUMENT REHABILITATION AND CARE CENTER	**111 WEST 36TH STREET SCOTTSBLUFF, NE 69361**

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 0039 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Conduct testing and exercise requirements.** Based on record review and staff interviews, the facility failed to conduct exercises to test the emergency plan annually. Findings are: Record review of Wildfire Whole Community Tabletop Exercise, dated 09/07/18, and Emergency Evacuation, dated 08/07/19, revealed the last time the facility conducted an emergency event drills identified by the risk assessment. There are no current emergency event drills identified by the risk assessment conducted by the facility. During an interview on 08/19/20 at 2:32 PM, the Director of Maintenance stated when COVID-19 came in: We had to deal with it. It was put on hold. During an interview on 08/19/20 at 3:00 PM, the Administrator stated that he/she did realize that COVID-19 was an issue, however agreed that the emergency drills need to be done annually.
F 0685 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Assist a resident in gaining access to vision and hearing services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number: 175 NAC 12-006.09D Based on observation, interview and record review, the facility failed to ensure a resident's hearing aids were sent out to be repaired for one of one resident (Resident 76) with a hearing aid. The facility census was 85, Findings are: Resident 76 had [DIAGNOSES REDACTED]. The resident's quarterly Minimum Data Set (MDS) assessment, dated 5/22/20, documented the resident was interviewable, required extensive assistance for activities of daily living, and was coded as requiring hearing aids to have adequate hearing. The resident's care plan documented the resident was at risk for impaired communication and wore hearing aids. Interventions included: to ensure availability and functioning of adaptive communication equipment such as hearing aids. On 08/17/20 at 12:33 PM, an interview with Resident 76 revealed it was hard to hear and that the hearing aids had been sent out to be repaired about a month ago. The resident stated staff had taken both hearing aids to be repaired and that it was very hard to hear without having everyone yell out for him/her to hear them. On 08/18/20 at 2:16 PM, Certified Nursing Assistant (CNA)-A was interviewed and stated he/she had worked with the resident the past weekend and the resident had told CNA-A he/she had not used Resident 76 hearing aids in a few weeks. On 08/20/20 at 7:41 AM, the Director of Nursing (DON) was interviewed and stated on 08/12/20, the resident had informed the DON that the hearing aids had been taken and the resident had been waiting a month for the hearing aids to be repaired. The DON stated on 08/17/20 the hearing aids were found and were sent out for repair and that the resident had been informed.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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.** Based on observation, interview and review of facility policy, the facility failed to ensure medications were not left unattended at residents' bedsides for 2 of 2 residents (Residents 34 and 81). The census was 85. The facility's Medication Administration policy, revised 05/2020, documented: .Remain with the resident/patient until all medication is taken. On 08/19/20 at 7:54 AM, upon entering the room of Resident 34 with Licensed Practical Nurse (LPN)-A, medications were observed in a medication cup on the resident's overbed table. LPN-A was asked if LPN-A had left the medication unattended in the room. LPN-A stated, (Resident 34) takes (Resident 34) (medications) with breakfast. The nurse was asked if the medication should be brought in after the resident's breakfast was served to Resident 34. LPN-A stated, Well, it pops up (on the computer) now. LPN-A left the room and medications were observed on the breakfast tray of Resident 34's roommate, Resident 81. When asked if his/her medications were routinely left for the resident to take on his/her own, LPN-A replied, Exactly and nodded his/her head affirmatively. On 08/19/20 at 11:12 AM, LPN-A was interviewed. When asked if LPN-A had left medications unattended at the bedside for Residents 34 and 81 to take, LPN-A stated LPN-A had left the medications for Resident 34 to take. When asked about the medication for Resident 81, LPN-A stated LPN-A had taken his/her medications to the resident, and he/she was still in bed. LPN-A stated LPN-A had not waited to observe the resident take his/her medications. When asked if the facility's medication administration policy allowed the nurses to leave medications unattended in residents' rooms, LPN-A did not know the facility's policy on this. On 08/19/20 at 11:32 AM, the above observations were reviewed with the Director of Nursing (DON) and the Assistant Director of Nursing. When asked if the facility's policy allowed staff to leave medications unattended at a resident's bedside, the DON stated, No.
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 NAC12-006.11E Based on observation, interviews and facility policy review, the facility failed to ensure safe food handling practices by not covering the smores bars for 84 residents who received food trays in their rooms. Findings are: Observed a test tray on 08/19/20 from Unit 400, which was the last unit to be served lunch. The residents' food trays had plate covers that were used to cover the plate containing a boneless pork chop, mashed potatoes and mixed vegetables. The tray also contained a single piece of bread, which was wrapped in plastic wrap. The smores bars were placed in a separate bowl without any covering. During an interview on 08/19/20, the Consultant Registered Dietitian stated they was under the when the resident's food trays were in the enclosed food carts, they were protected from the outside. Consultant Registered Dietitian also stated the staff members would serve the food trays one at a time, which would protect the uncovered smores bars. Review of the facility's policy on Assisting the Resident with in-Room Meals, under Section One, Steps in the Procedure, that single room trays will have all items covered.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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, 12.006.17D, 12-006.18C Based on observation, interview, record review and review of facility policy, the facility failed to ensure:1. Proper hand hygiene, glove use and use of a clean barrier were implemented to prevent cross contamination between wounds for one (Resident 34) of two sampled residents for whom wound care was observed; 2. Personal Protective Equipment was utilized while handling soiled linens; this had the potential to affect all of the residents 3. Appropriate PPE was utilized on the Persons Under Investigation (PUI) unit;4. Ice pitchers from the PUI unit were handled in a manner to prevent potential cross-contamination; 5. Oxygen tubing was kept off the floor for one resident (Resident 15) . The facility census was 85, Findings are: 1. The facility's Dressing Change Policy, revised 05/22/19, documented: Policy: To ensure dressings are changed as ordered while maintaining the highest level of

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** - Some	(continued... from page 1) infection control standards to reduce risk for wound infection and negative outcomes for our residents .Procedure: 1. Place a clean paper towel on the over the bed table. Set up needed supplies. 2. Complete hand hygiene and apply clean gloves. 3. Remove soiled dressing and discard in appropriate receptacle. 4. Remove dirty gloves, complete hand hygiene, then apply clean gloves. 5. Clean area as ordered and pat dry. 6. Remove dirty gloves, complete hand hygiene, then apply clean gloves. 7. Apply and creams or wound care item as ordered. 8. Apply outside dressing. Resident 34 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission nursing assessment, dated 08/14/20, (re-admission from a hospital stay) documented the resident had the following wounds: a Stage III pressure ulcer to the right lower leg, an unstageable pressure injury to the right heel, vascular ulcers to the right toes and a surgical incision to coccyx. On 08/19/20 at 7:54 AM, Licensed Practical Nurse (LPN)-A was observed performing wound treatments for Resident 34's wounds. Upon entering the room, LPN-A set supplies on the resident's bed. Surgical wound to coccyx: LPN-A removed the foam dressing from the buttocks and then removed the packing from the wound. The nurse irrigated the wound with normal saline (NS), dried the area, re-packed the wound, and applied the foam dressing. During the process, the nurse did not change gloves or perform hand hygiene. Wound to the right lateral lower leg: LPN-A removed her/his gloves and washed her/his hands. The nurse removed the foam dressing from the wound, cleaned the wound with NS gauze, set the foam dressing on the bed, applied [MEDICATION NAME] over the wound, applied foam dressing, and wrapped the foam dressing to hold it in place. During the process, the nurse did not change gloves or perform hand hygiene. When cutting the [MEDICATION NAME], the nurse removed scissors from the cargo pocket of her/his pants and then replaced it back into the pocket. The nurse did not clean the scissors before or after use. Right heel wound: Without changing gloves or performing hand hygiene, LPN-A prepared the dressing for the right heel wound and set it on the overbed table without a clean barrier. The nurse then removed her/his soiled gloves, washed her/his hands, and donned clean gloves. The nurse removed the dressing over the right heel, cleaned the unstageable wound (eschar) with a [MEDICATION NAME] swab and applied the clean dressing. The nurse did not change gloves or perform hand hygiene during the process. Wounds to right toes: Without changing gloves or performing hand hygiene, LPN-A removed the dressing from between the resident's third and fourth toes of the right foot. The nurse changed gloves, but did not perform hand hygiene, and set supplies on the overbed table without a clean barrier. The nurse removed [MEDICATION NAME] from between the toes, cleaned between the toes with NS gauze, irrigated with NS between the toes, dried the area, applied clean [MEDICATION NAME] between the toes, removed gloves, donned clean gloves but did not perform hand hygiene. LPN-A then wrapped the toes with a clean dressing. The nurse cut the [MEDICATION NAME] with scissors removed from the cargo pocket of her/his pants. The nurse did not clean the scissors before or after use. On 08/19/20 at 11:51 AM, the above observations of wound care by LPN-A for Resident 34 was reviewed with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON). They were asked to identify problems with the wound care observations. The DON stated the LPN should have made a clean barrier on which to set supplies, should have performed hand hygiene and change gloves when she/he went from dirty to clean with each wound and between wounds. The DON stated LPN-A should have cleaned the scissors before and after use. The DON stated there was usually three hand hygiene/glove changes with each wound treatment. 08/19/20 at 4:30 PM, the above observations of the wound care for Resident 34 were reviewed with LPN-A. When asked if the wound care supplies were supposed to be set onto a clean barrier, she/he stated, Yes and acknowledged she/he had set supplies on the bed and on the overbed table. When asked at what times during a wound treatment that hand hygiene and glove changes were required, LPN-A stated, When they are visibly soiled or when I move to a different wound. The nurse acknowledged she/he had not changed gloves or performed hand hygiene when going from dirty to clean with each wound or between wounds. When asked if scissors should be disinfected before and after use if being stored in her/his pocket, LPN-A replied, Yes. When asked if she/he agreed with the observation as recounted above, she/he stated she/he did. 2. Review of the undated facility's policy titled, Laundry and Bedding, Soiled read in part, Soiled laundry/bedding shall be handled in a manner that prevents gross microbial contamination of the air and person handling the linen. 4. Anyone who handles soiled laundry must wear protective gloves and other appropriate protective equipment (e.g. gowns if soiling of clothing is likely). An observation of the laundry facilities on 08/19/20 at 10:01 AM, revealed an area where soiled laundry came into the laundry area. There were no face shields or gowns observed in the soiled laundry area. During an interview on 08/19/20 at 10:05 AM, Laundry Aide-A stated the laundry was pickup up by the laundry staff and sorted three times per day. He/she stated if the laundry was coming in from the PUI (Persons Under Investigation) area or in a yellow bag (precautions) the staff wore a gown and gloves, in addition to their mask to sort the laundry. The aid further stated if the laundry was not from the PUI area or bagged for precautions, the laundry staff did not wear a gown to sort dirty laundry. During an interview on 08/19/20 at 10:32 AM, the Director of Housekeeping stated that staff only wore gloves and a mask when sorting laundry, unless the laundry came in a yellow bag. He/she further stated if a gown was needed, then the staff could get one from a hallway cart. During an observation on 08/19/20 at 1:34 PM, Laundry Aide-A, wearing a mask and gloves, took two empty barrels from the laundry area and dropped one at the hall 200 soiled linen room (outside the door). Laundry Aide-A took the 2nd barrel to hall 400 and switched it out with the half-full barrel; then took the half-full barrel to hall 300. The aide bent over the soiled barrel in the 300 hall linen room and removed the bags of soiled linen. He/she visibly touched the dirty barrel with his/her shirt and then went on to hall 200 and collected the dirty linen barrel. Both barrels were then taken to the laundry room soiled entry door. Laundry Aide-A put on a gown and face shield and sorted the laundry, removing each bag and opening them one by one. He/she shook each piece of laundry, some visibly soiled with stool, to check for cell phones, hearing aids and dentures. The aide stated he/she always did this to check for these items. After sorting the laundry, the aide rolled the laundry to the machines, grabbing the laundry and touching his/her gown, and tossed it into the machine. The aide was asked why he/she was wearing the face shield and gown, and the aide replied he/she was told to do this. During an interview on 08/19/20 at 4:06 PM, the Administrator stated that it was expected that the laundry staff would wear a gown, gloves and mask while transporting laundry from one unit to another and on to the laundry room, and also to wear appropriate PPE while sorting the dirty laundry. 3. Review of the facility's policy titled, Infection Control, dated 03/01/20, read in part, Policy: To limit the risk of spread of the Coronavirus Disease (COVID-19) in the event of exposure and to follow CDC (Centers for Disease Control) and DOH (Department of Health) recommendations/guidelines in the event of an outbreak while decreasing the risk of social stigma against any person or group of people. Procedure: 4. Ensure staff adhere to appropriate PPE per CDC recommendations. Review of the Coronavirus information sheet read, in part, How [MEDICAL CONDITION] spreads: [MEDICAL CONDITION] is thought to spread mainly from person-to-person. 4. It may be possible that a person can get COVID-19 by touching a surface or object that has [MEDICAL CONDITION] on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way [MEDICAL CONDITION] spreads. During an observation on 08/18/20 at 11:55 AM, the sign taped to the PUI (Persons Under Investigation) entrance stated to wear a face shield and face mask when entering and don a gown and gloves when doing direct resident care. During an interview on 08/18/20 at 1:35 PM, the Director of Nursing stated CNA-B should not have left the zipper open when going in and coming out and he/she clearly should have been wearing a face shield. 4. Review of the facility's policy titled, Ice Machines and Ice Storage Chests, dated 03/01/20, read in part, Ice machines and ice storage/distribution container will be used and maintained to assure a safe and sanitary supply of ice. 1. Ice-making machines, ice storage chests/containers, and ice can all become contaminated by: d. Improper storage or handling of ice and 2. To help prevent contamination of ice machines, ice storage chest/containers or ice, staff shall follow these precautions:. If another receptacle such as a small chest or bin is used to transport ice from the source to another point of distribution, follow the same steps as above. Do not distribute ice directly from an open container. Further observation on 08/18/20 at 11:57 AM, revealed Certified Nursing Assistant (CNA)-B entered the PUI area. CNA-B left the zippered entrance unzipped (opened) and then exited the PUI unit with two water pitchers to fill with ice on hall 200. He/she then went back into the PUI area with the ice pitchers. During an interview on 08/18/20 at 12:00 PM, CNA-B stated he/she was trained to come out of the PUI area and fill the pitchers and return them to the resident. During an interview on 08/18/20 at 12:06 PM, the Administrator stated the pitchers should not be removed from the PUI area to hall 200. 5. Resident 15 had [DIAGNOSES REDACTED]. The resident's quarterly Minimum Data Set (MDS) dated , 7/22/20, indicated the resident's Brief Interview for Mental Status score was 15, indicating the resident's cognition was intact. The MDS also indicated the resident was dependent on staff for activities of daily living. The quarterly MDS assessment indicated the resident required oxygen therapy, suctioning, [MEDICAL CONDITION] care and was on a ventilatory. The resident's care plan documented that the oxygen tubing should not be on the floor. On 08/18/20 at 11:15 AM, oxygen tubing was observed lying on

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) the floor. On 08/20/20 at 7:37 AM, the Director of Nursing (DON) stated the oxygen tubing should not have been on the floor. The resident could not have gotten in or out of bed without staff assistance. Staff should have checked to make sure the oxygen tubing was off the floor.