STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285191	A. BUILDING _____ B. WING _____	**07/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ELMS HEALTH CARE CENTER	**P O BOX 628, 410 BALL PARK ROAD PONCA, NE 68770**

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**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 Based on observations, interviews and record review; the facility failed to ensure a safe environment, free of accident hazards as: 1) elopement (leaving the facility unattended and without staff knowledge) interventions were not implemented in an attempt to prevent further elopement for Resident 10; 2) interventions were not in place to prevent potential elopements for 7 (Residents 1, 4, 8, 9, 15, 16 and 17) facility residents who were at risk for wandering and potential elopement; and 3) causal factors were not identified and fall interventions were not revised and/or additional interventions developed for the prevention of falls for 2 (Residents 1 and 8) of 3 sampled residents. The total sample size was 18 and the facility census was 37. Findings are: A. Interview with Licensed Practical Nurse (LPN)-K on 7/22/20 at 7:45 AM revealed that the nursing staff was not in charge of monitoring the physical door alarm function, was not aware of who was responsible, and did not know when or if door alarm function was being monitored. B. During an initial tour of the facility on 7/22/20 from 8:10 AM to 8:35 AM, the following concerns were identified: -the exit door on the West corridor had a non-functioning alarm. The door had been equipped with an alternate alarm which was affixed to the upper door frame of the door; -the exit door to the East corridor alarmed with an attempt to open, but did not open even after holding steady pressure for 1 full minute; -the exit door to the North corridor alarmed when an attempt was made to open it, and the door opened after applying continuous pressure for 15 seconds. The alarm continued to sound after the door was closed. A Medication Aide (MA)-I was standing at a medication cart located in the corridor. MA-I ignored the alarm until prompted by the Business Office Manager to respond. MA-I was unaware of what code was required to de-activate the alarm and made no attempt to determine the reason the alarm was sounding; and -a portion of the Wander Guard (a bracelet/signaling device is worn by the resident and sounds an alarm if the resident comes within a certain distance of the door) alarm system located at the entry to the Assisted Living was surrounded with medical tape and had a rubber band which was then wrapped loosely around the tape. A red light was visible on the system. C. Observations and interview with the Director of Nursing (DON) on 7/22/20 from 8:40 AM to 8:57 AM revealed the following: -the exit door to the West corridor was to have an alarm which was to sound continuously until it was de-activated by a staff member. The DON was aware the door alarm no longer functioned and indicated a secondary alarm had been placed at the top of the door. This alarm only sounded when the door was first opened but shut off as soon as the door closed; -the exit door to the East corridor alarmed when the DON applied steady pressure to the door handle for 15 seconds. The door alarm sounded but the door did not release and open for exit. The DON then reached to the top of the door and activated a reset switch and then the door released and opened. The door continued to alarm despite entering a deactivation code into the code panel located on the south side of the door. The DON summoned for assistance from LPN-K to silence the alarm; -the Wander Guard system located between the Nursing Home and the Assisted Living entrance did not sound when the DON attempted to activate the system with a tester; -an exit door in the Assisted Living dining room had a Wander Guard alarm which the DON could not activate with the tester. A small alarm had been placed at the top of the door which alarmed for approximately 3 seconds when the door opened but then silenced before the door was even completely closed; and -the DON verified the facility was aware of the concerns with the alarms for the West corridor exit, the Assisted Living corridor Wander Guard alarm, and the Assisted Living dining room exit, and indicated repairs were required but had not been implemented. D. Interview with Nursing Assistant (NA)-J on 7/22/20 at 9:08 AM revealed that staff working in resident rooms could not hear door alarms in the hallways other than the hallways they were working in. E. Review of the policy Missing Resident Policy and Procedure (revised 2/17) revealed if a resident was found missing during scheduled checks, the following was to occur: -notification of the Charge Nurse; and -all available staff to begin a systematic search of the entire premise, both inside and out. Upon return of the resident to the facility, the resident would be examined for injuries and an incident report would be completed. The following information was to be included; the time, any individuals were contacted regarding the elopement, condition of the resident upon return to the facility, physician notification and any new physician orders, any treatment indicated, pertinent information and the time of family notification. The policy indicated the maintenance person was to be responsible for ensuring the door alarms were operational and were routinely checked. In the event of an alarm malfunction, maintenance personnel was to be contacted immediately. F. During an interview on 7/22/20 at 7:45 AM, Medication Aide (MA)-I was unable to identify which of the current facility residents were at risk for wandering and was uncertain as to which of the residents had a Wander Guard. MA-I indicated Nursing Staff were to check placement and function of the Wander Guards each shift and then document the check in each individual resident's Treatment Administration Record (TAR). G. Review of Resident 10's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 6/8/20 revealed the resident was having hallucinations and delusions, with no evidence of any further behaviors. The resident was independent with transfers and with walking on/off the unit. In addition, the resident had [DIAGNOSES REDACTED]. Review of an Elopement Risk assessment dated [DATE] at 10:17 PM for Resident 10 revealed the resident was not at risk for wandering and no interventions had been developed. Review of a facility investigation of potential abuse and/or neglect dated 6/24/20 revealed at 7:00 AM the staff found Resident 10 outside of the facility. The resident had exited the building without staff knowledge and/or supervision. The resident had gone for a walk and was seated outside the building when staff reported for the day shift. A new intervention was developed for a Wander Guard to be placed on the resident. Review of Resident 10's Nursing Progress Notes dated 7/14/20 revealed the following: -8:45 PM staff were unable to find the resident in the facility. No one had seen the resident since the evening snack had been passed; -9:05 PM staff initiated a search of the town; -10:05 PM the Administrator notified the police department the resident was missing and the Director of Nursing (DON) arrived at the facility. The facility was checked again and additional staff were called to continue searching. Resident 10's family were notified the resident was missing; -10:25 PM the resident was seen headed on the bike path along the highway to the State Park; and -10:55 PM the resident returned to the facility with the DON. Review of Resident 10's electronic medical record revealed no evidence the staff were checking Resident 10's Wander Guard bracelet for placement or for function each shift. Interview with the Director of Nursing (DON) on 7/22/20 at 1:30 PM revealed on 6/18/20 the facility had an assessment completed by the company which provided the facility's current Wander Guard system. The facility had called the company due to identified concerns related to exit door alarms, with the Wander Guard system between the Nursing Home and the entrance to the Assisted Living and an exit door in the Assisted Living dining room. The facility failed to follow through with the required repairs and no further attempts were made to assure the repairs were completed to correct these concerns. Further interview with the DON confirmed the following regarding Resident 10: -an elopement risk

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 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) assessment was completed on 6/7/20 and the resident was not at risk for elopement at the time. No interventions were developed based on this assessment; -the resident had an elopement on 6/24/20. When the day shift staff reported to work at 7:00 AM, the resident was found outside. The night shift staff were unaware the resident was outside and unsupervised. The resident had exited the facility through the corridor which connected the Nursing Home and the Assisted Living and then went out the dining room door in the Assisted Living. A Wander Guard bracelet was to have been placed on the resident in an attempt to prevent further elopements; -the resident had a second elopement on 7/14/20. The staff were unable to find the resident at 8:45 PM and no one had observed the resident since the evening snack pass. The facility and the grounds were searched and when the staff were unable to find the resident, the police and additional staff were called to search the town. At 10:55 PM the resident was returned to the facility. The resident identified exiting the facility through the same route as the previous elopement; -the resident should have had an elopement risk assessment completed after each elopement to assure interventions were developed for prevention of elopement but no further assessments were completed; -a Wander Guard bracelet was to have been placed on the resident after the elopement on 6/24/20 however, staff did not place the Wander Guard until after the resident's elopement on 7/14/20. Staff are to monitor residents with Wander Guards each shift to assure placement and function and to document in the TAR. There was no documentation to indicate staff had completed this monitoring; -after the resident's elopement on 7/14/20, staff were to provide 15 minute checks on the resident for 24 hours. There was no documentation to indicate the checks were completed; and -the following residents were also at risk for wandering and elopement, Residents 1, 4, 8, 9, 15, 16 and 17. All of these residents currently have Wander Guard bracelets. H. During an interview on 7/22/20 at 1:40 PM, the Business Office Manager confirmed there was no current Maintenance Supervisor employed at the facility. The Maintenance Supervisor was responsible for checking the exit doors and for testing the Wander Guard systems on a weekly basis to assure they were functioning correctly. There was no evidence the facility exit doors and the Wander Guard system had been checked/tested since 11/29/19. The immediate jeopardy identified on 7/22/20 was abated to an E level on 7/22/20 at 2:30 PM when: -the facility placed a staff member at each of the exit doors which had been identified with concerns related to alarms and non-functioning Wander Guard systems to assure no further elopements; -the facility contacted the company which had assessed the facility doors and Wander Guard system on 6/18/20 to initiate the required repairs; -a schedule of staff who were to be placed at exit doors was completed for the next few days pending the arrival of the company and the completion of required repairs for the exit doors and Wander Guard systems; and -a staff member was assigned to perform weekly, monthly and quarterly equipment inspection and testing with assignments to be overseen by the Business Office Manager to assure completion. I. Review of Resident 1's MDS dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 4 (with a score between 0 and 7 indicating severe cognitive impairment). Review of Resident 1's Care Plan revealed the resident was at risk for falls related to the loss of balance at times. The resident has a history of impulsiveness and poor safety awareness. The resident has had some falls related to not using the resident's walker. Interventions include: -Occupy the resident with meaningful distractions, -check on the resident frequently, -utilize the 4 wheeled walker again instead of the 2 wheeled walker (which the resident didn't like), -give verbal reminders to not ambulate without a walker, -keep the call light within reach, -keep the resident's room free of clutter, -keep personal items within reach, and -provide a quiet, non-hurried environment. Review of an Event Report dated 6/26/20 revealed Resident 1 fell in the resident's room. The fall was witnessed and the resident was standing prior to the fall. Further review revealed no possible contributing factors were identified and no interventions were identified. Continued review revealed the resident's pajamas were falling down and the resident tried to pull them up and fell backwards. There was no evidence to indicate the resident's clothing was looked at to ensure a proper fit. Review of an Event Report dated 7/1/20 revealed Resident 1 fell in the hallway and was identified as wandering hallway prior to the fall. Further review revealed no possible contributing factors were identified and no interventions were identified. Continued review revealed the resident had come to the nurse's station and was yelling at staff. The resident was asked to return to the resident's room and the resident continued to yell and as staff was walking with resident to room resident tripped over feet and fell on the residents buttocks. No evidence to indicate the cause of the resident's behavior at the time of the fall was addressed and no evidence additional interventions were identified to prevent recurrence. Review of an Event Report dated 7/13/20 revealed Resident 1 fell in the hallway. The resident was up against the kitchen when the door hit the resident causing the resident to fall. An immediate intervention of rest was identified. Further review revealed the resident was observed turning around after trying to enter the kitchen, as the resident walked away the kitchen door swung shut and knocked the resident off balance but that the kitchen staff had opened the kitchen door. No evidence to indicate the resident's reason for entering the kitchen or the kitchen door was reviewed for potential contributing factors. J. Review of Resident 8's MDS dated [DATE] revealed the resident had a BIMS score of 8 (with a score between 8 and 12 indicating moderately impaired cognition). Review of Resident 8's Care Plan revealed the resident was at risk for falls related to medications that caused unsteadiness especially with rising too quickly. The resident had a walker and did well with the walker but at times would forget the walker. The resident also had dementia with behavioral disturbances. Review of an Event Report dated 6/20/20 revealed Resident 8 fell in the hallway. Further review revealed no possible contributing factors were identified and first aid was identified as the intervention. Interview with the DON on 7/21/20 from 8:50 AM to 9:05 AM revealed the facility had implemented a post fall huddle form and a review form which should look at the cause and identify additional interventions, but this was still a work in progress as the nurses would ideally complete the form but some of the nurses didn't feel comfortable doing that so then it would be completed when the DON returned to work. The DON typically worked 4 days per week. The DON was unaware of any training that had been completed in the past year with the staff in relation to residents with dementia, mental illness, or behaviors.
F 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** Licensure Reference Number 175 NAC 12-006.02 Based on observations, record review and interview, the Administration failed to ensure effective management of facility resources related to: 1) the safety of 8 residents who were identified at risk for elopement (when a resident leaves the premises or a safe area without authorization and/or supervision) and utilized Wander Guards (a bracelet/signaling device is worn by the resident and sounds an alarm if the resident comes within a certain distance of the door); 2) maintenance of resident care equipment in a manner to ensure a safe environment for facility residents; 3) ongoing concerns related to infection control; 4) continued concerns related to falls; 5) failure to complete audits identified in the facility plan of correction; and 6) concerns related to the facility Quality Assessment and Assurance committee. These failures had the ability to affect all residents. The total sample size was 18 and the census was 37. Findings are: A. Observations conducted on 7/22/20 from 8:10 AM to 8:57 AM revealed concerns related to an alarm on the exit door of the West corridor, the locks on the exit door on the East corridor and the functioning of the Wander Guard system at the entrance to the Assisted Living and the exit door in the Assisted Living dining room door. B. Interview with the Director of Nursing (DON) on 7/22/20 at 1:30 PM revealed on 6/18/20 the facility had an assessment completed by the company which provided the current Wander Guard system. The facility had called the company due to identified concerns related to exit door alarms and with the Wander Guard system between the Nursing Home and the entrance to the Assisted Living and an exit door in the Assisted Living dining room. The facility failed to follow through with the required repairs and no further attempts were made to assure the repairs were completed to correct these concerns. Further interview with the DON confirmed Resident 10 had elopements on 6/24/20 and on 7/14/20 and the resident had exited the building through the Assisted Living dining room door with both of these elopements. In addition, the DON identified the following residents were also at risk for wandering and elopement, Residents 1, 4, 8, 9, 15, 16 and 17. All of these residents currently have Wander Guard bracelets C. During an interview on 7/22/20 at 1:40 PM, the Business Office Manager confirmed there was no current Maintenance Supervisor employed at the facility. The Maintenance Supervisor was responsible for checking the exit doors and for testing the Wander Guard systems on a weekly basis to assure they were functioning correctly. There was no evidence the facility exit doors and the Wander Guard system had been checked/tested since 11/29/19. The immediate jeopardy identified on 7/22/20 was abated to an E level on 7/22/20 at 2:30 PM when: -the facility

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F 0835 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 2) placed a staff member at each of the exit doors which had been identified with concerns related to alarms and non-functioning Wander Guard systems to assure no further elopements; -the facility contacted the company which had assessed the facility doors and Wander Guard system on 6/18/20 to initiate the required repairs; -a schedule of staff who were to be placed at exit doors was completed for the next few days pending the arrival of the company and the completion of required repairs for the exit doors and Wander Guard systems; and -a staff member was assigned to perform weekly, monthly and quarterly resident care equipment inspections and testing. These assignments were to be overseen by the Business Office Manager to assure completion. D. A revisit survey was conducted and deficiencies cited at F580, F689, and F880 (on 4/14/20) were reviewed. The deficiencies were reviewed to see if the noncompliance had been removed and to ensure that training/supervision/monitoring were in place to maintain compliance. Continued compliance concerns were identified with deficiencies re-cited at the following tags: -F689 was cited related to the facility failing to evaluate causal factors and revise/develop interventions to prevent ongoing falls for Residents 1 and 8. -F880 was cited related to the facility failing to implement infection control practices to prevent potential cross-contamination including COVID-19. This included concerns with visitor screening, resident screening, transmission based precautions, and mask usage. E. A new concern was identified with QAA. F. Interview with the DON on 7/21/20 from 8:50 AM to 9:05 AM confirmed: -The facility had implemented a post fall huddle form and process, however, that process remains a work in progress as some of the nurses aren't comfortable completing the investigation form and interventions, which means it is not reviewed until the next time the DON worked. -The facility has not completed audits (as identified in the plan of correction) for residents with a change in condition. - The facility QAA meeting is held every 3 months. A physician does not attend the meeting in person nor does the physician attend by conference call. The DON stated the facility Medical Director was usually updated the next time they were in the facility doing rounds. - The DON was not aware of any training the facility had completed with staff in the past year with the staff in relation to residents with dementia, mental illness, or behaviors.
F 0838 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.** Based on record review and interview, the facility failed to ensure there was a documented Facility Assessment. This had the potential to affect all residents. The total sample size was 18 and the facility census was 37. Findings are: Review of facility records on 7/27/20 (after requesting a copy of the Facility Assessment) revealed no Facility Assessment. Interview with the Director of Nursing on 7/27/20 at 1:45 PM confirmed the facility did not have a completed Facility Assessment.
F 0868 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have the Quality Assessment and Assurance group have the required members and meet at least quarterly** Licensure Reference Number 175 NAC 12-006.07A Based on interview and record review, the facility failed to ensure the Quality Assessment and Assurance (QAA) committee included all of the required members. This had the ability to affect all of the residents. The total sample size was 18 and the facility census was 37. Findings are: Review of the facility QAA meeting sign in sheets dated 7/15/19, 10/28/19, 1/6/20, 3/3/20, and 6/6/20 revealed no evidence to indicate the facility medical director or a physician designated by the facility was present at the meetings. Interview with the Director of Nursing on 7/21/20 from 8:50 AM to 9:05 AM confirmed the physician was not present for QAA meetings in person or by telephone conference. The DON confirmed this was not a new process related to COVID-19, but rather the physician had not previously attended either.
F 0880 **Level of harm** - 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 12-006.17B Based on observations, interviews, 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 failure to: 1) ensure all visitors were screened for signs/symptoms of COVID-19; 2) complete routine screening of facility residents; 3) ensure transmission based precautions were implemented for 6 (Residents 4, 8, 11, 12, 13 and 14) of 8 sampled residents; and 4) ensure staff wore masks in a manner to prevent potential cross contamination. This had the potential to affect all of the facility residents. The total sample size was 18 and the census was 37 with 3 residents in the hospital. Findings are: A. Review of the facility policy Personal Protective Equipment (PPE)-Face Masks with revision date 9/10 revealed facility personnel were to wear face masks to prevent transmission of infectious agents through the air. The policy further indicated masks were to be worn only once and then discarded, face masks were to cover the mouth and the nose and staff were to never touch the mask while it was in use. B. Review of the policy Infection Prevention and Control for COVID-19 dated 4/6/20 revealed visitors were to be restricted except for certain [MEDICATION NAME] care situations (end of life). Decisions about visitors should be made on a case to case basis and should include careful screening for fever or respiratory symptoms. Those visitors permitted were to wear a face mask while in the building and to restrict their visit to the resident's room. C. Review of the CMS Center for Clinical Standards and Quality, Safety and Oversight Group dated 3/13/20 revealed the following guidance for nursing homes regarding infection control and prevention of Coronavirus Disease 2019 (COVID-19): -restriction of all visitors and non-essential healthcare personnel except for certain end of life situations: -implement active screening of residents for fever and respiratory symptoms; -for individuals that enter in [MEDICATION NAME] care situation (such as end-of-life) the facility should require visitors to perform hand hygiene and use personal protective equipment such as facemasks; -screen all staff at the beginning of their shift for fever and respiratory symptoms. Actively take their temperatures and document the absence of shortness of breath, new or change in cough and sore throat; and -dedicate a unit/wing exclusively for any residents coming or returning from the hospital where they would remain for 14 days with no symptoms. D. Observations on 7/17/20 revealed the following: -7:45 AM, Licensed Practical Nurse (LPN)-A greeted the survey team at the front entrance of the facility. LPN-A took the temperature of both surveyors but then failed to document the temperatures. In addition, LPN-A failed to ask any screening questions regarding potential signs and symptoms of COVID-19 before allowing entrance to the facility; -7:50 AM, LPN-A wore a cloth mask which was positioned below the LPN's nose. LPN-A was passing medications and was going into and out of resident's rooms while wearing face mask in this position; -7:58 AM, House Keeper (HK)-C was in Resident 1's room and was sweeping the floor. HK-C was wearing a face mask, but the mask was positioned underneath of HK-C's chin; -8:00 AM, HK-D was walking in the corridor and face mask was worn below staff's nose; -8:32 AM, Medication Aide (MA)-F was in the corridor and was wearing a cloth face mask as MA-F was going from room to room passing medications; -8:45 AM, Nurse Aide (NA)-G was in the Sunset Corridor and was delivering room trays for the breakfast meal. NA-G was going into and out of the resident's room and had a face mask which was positioned below NA-G's nose; and -from 9:27 AM to 11:00 AM Registered Nurse (RN)-H was wearing a surgical mask which was observed below the staff's nose, RN-H was in the dining room and the facility corridors with mask in this position and made no attempts to reposition. E. Review of Resident 4's Progress Notes dated 7/8/20 at 4:00 PM revealed the resident was admitted after an in-patient hospitalization related to aggressive and threatening behaviors. Observation of Resident 4's room on 7/17/20 at 8:08 AM revealed no signage on or around the resident's door/doorway and no isolation equipment in or around the resident's doorway to indicate the need for transmission-based precautions. During an interview on 7/17/20 at 9:30 AM, the Director of Nursing (DON) confirmed Resident 4 had not been placed on transmission-based precautions even though the resident was a new admission, had a recent hospitalization and had been a resident in a different facility prior to hospitalization . Review of Resident Screening Logs revealed no evidence that Resident 4 had been screened for signs/symptoms of COVID-19 on 7/8/20 prior to entry into the facility. F. Observation on 7/17/20 at 8:40 AM revealed Resident 5 was seated at a table in the main dining room. Resident 5's spouse was seated next to the resident and was providing assistance with the breakfast meal. Resident 5's spouse was not wearing a face mask. During an interview on 7/17/20 at 8:45 AM, Resident 5's spouse indicated the facility allowed visitation on a daily basis. Observation on 7/17/20 at 9:20 AM revealed Resident 5's spouse was propelling the resident's wheelchair from the dining room through the corridor and to the resident's room. Resident 5's family member was

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F 0880 **Level of harm** - Actual harm **Residents Affected** - Many	(continued... from page 3) not wearing a face mask. During interview on 7/17/20 at 9:40 AM, the DON confirmed Resident 5's spouse was allowed to visit the resident on a daily basis. Review of the facility Visitor Screening Logs revealed no evidence Resident 5's spouse was screened for signs and symptoms of COVID-19 from 6/1/20 to 6/14/20, 6/16/20 to 6/18/20, 6/23/20, 6/27/20 to 6/30/20, 7/1/20 to 7/12/20, 7/14/20 and 7/15/20 (36 out of 45 days the visitor should have been screened). Review of the Screening Log for Resident 5 revealed staff failed to assess the resident's pulse and respirations on 6/16/20, 6/17/20, 6/20/20, 6/30/20, 7/1/20, 7/4/20, 7/5/20, 7/9/20, 7/10/20, 7/14/20, 7/15/20 and on 7/16/20. In addition, staff failed to assess the residents for sore throat, cough and shortness of breath on 7/13/20. G. Review of Resident 11's Progress Notes dated 7/21/20 at 2:58 PM revealed the resident was readmitted to the facility after an in-patient hospitalization related to aggressive and threatening behaviors. The resident had been hospitalized from [DATE] through 7/21/20. Observation of Resident 11's room on 7/22/20 at 8:45 AM revealed no signage on or around the resident's door/doorway and no isolation equipment in or around the resident's doorway to indicate the need for transmission-based precautions. During an interview on 7/22/20 at 1:30 PM, the DON confirmed Resident 11 had not been placed on transmission-based precautions even though the resident was hospitalized from [DATE] to 7/21/20. In addition, the resident was readmitted to previous room with the resident's previous roommate (Resident 14). H. Review of Resident 12's Nursing Progress Notes dated 7/20/20 at 1:40 PM revealed the resident was readmitted from a hospitalization . The resident was pacing thru the halls and refused to eat lunch. Observation of Resident 12's room on 7/22/20 at 8:28 AM revealed no signs on or around the door to indicate any type of precautions. In addition, the resident's roommate (Resident 13) was observed in the room with Resident 12. Review of a Nursing Progress Note dated 7/22/20 at 12:43 PM revealed the resident goes outside to smoke with smokers. During an interview on 7/22/20 at 1:30 PM, the DON confirmed Resident 12 had not been placed on transmission-based precautions even though the resident was a re-admission from the hospital. In addition, Resident 12 returned to previous room with roommate. In addition, the DON indicated Resident 12 had been restless and often walked in the corridors and had been going to smoke outside with the other smokers since return from the hospital. I. Observation of Resident 8's room on 7/22/20 at 8:45 AM revealed there were no signs on or around the resident's room door and there was no isolation equipment outside of the resident's room to indicate the resident was on transmission based precautions. During an interview on 7/22/20 at 1:40 PM the DON verified the resident was admitted to the hospital on [DATE] at 8:10 AM and returned to the facility on [DATE] at 8:17 PM. The resident had not been placed on transmission based precautions with readmission to the facility. J. Continued survey on 7/27/20 revealed continued compliance concerns. Tour of the facility on 7/27/20 at 9:45 AM revealed that Residents 8, 11 and 12 had signage on the doors of their rooms indicating that transmission based (droplet) precautions were indicated. There was no evidence that Personal Protective Equipment (PPE) was available for staff use in caring for Residents 8, 11 or 12. Observation of Resident 13's room on 7/27/20 at 9:45 AM revealed no signage or indication that the resident was on transmission based precautions, even though Resident 13 had shared a room with Resident 12 upon re-admission to the facility. Observation of Resident 14's room on 7/27/20 at 9:45 AM revealed no signage or indication that the resident was on transmission based precautions, even though Resident 14 had shared a room with Resident 11 upon re-admission to the facility. Interview with MA-F on 7/27/20 at 10:00 revealed; -Residents 8, 11 and 12 were on transmission based precautions, -staff were not wearing addition PPE (gowns, N95 masks, or face shield) in resident rooms on transmission based precautions, -Residents 13 and 14 were not on transmission based precautions, and -staff were unsure if N95 masks were available for staff use.
F 0908 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Keep all essential equipment working safely.** LICENSURE REFERENCE NUMBER 175 NAC 12-006.18B3 Based on observations, record review and interview, the facility failed to ensure exit door alarms/locks and the Wander Guard system in the facility were maintained and were operating in a safe condition. This had the potential to effect all residents in the building. The total sample size was 18 and the facility staff identified a census of 37. Findings are: A. Interview with Licensed Practical Nurse (LPN)-K on 7/22/20 at 7:45 AM revealed that the nursing staff was not in charge of monitoring the physical door alarm function, was not aware of who was responsible, and did not know when or if door alarm function was being monitored. B. During an initial tour of the facility on 7/22/20 from 8:10 AM to 8:35 AM, the following concerns were identified: -the exit door on the West corridor had a non-functioning alarm. The door had been equipped with an alternate alarm which was affixed to the upper door frame of the door; -the exit door to the East corridor alarmed with an attempt to open, but did not open even after holding steady pressure for 1 full minute; -the exit door to the North corridor alarmed when an attempt was made to open it, and the door opened after applying continuous pressure for 15 seconds. The alarm continued to sound after the door was closed. A Medication Aide (MA)-I was standing at a medication cart located in the corridor. MA-I ignored the alarm until prompted by the Business Office Manager to respond. MA-I was unaware of what code was required to de-activate the alarm and made no attempt to determine the reason the alarm was sounding; and -a portion of the Wander Guard alarm system located at the entry to the Assisted Living was surrounded with medical tape and had a rubber band which was then wrapped loosely around the tape. A red light was visible on the system. C. Observations and interview with the Director of Nursing (DON) on 7/22/20 from 8:40 AM to 8:57 AM revealed the following: -the exit door to the West corridor was to have an alarm which was to sound continuously until it was de-activated by a staff member. The DON was aware the door alarm no longer functioned and indicated a secondary alarm had been placed at the top of the door. This alarm only sounded when the door was first opened but shut off as soon as the door closed; -the exit door to the East corridor alarmed when the DON apply steady pressure to the door handle for 15 seconds. The door alarm sounded but the door did not release and open for exit. The DON then reached to the top of the door and activated a reset switch and then the door released and opened. The door continued to alarm despite entering a deactivation code into the code panel located on the south side of the door. The DON summoned for assistance from LPN-K to silence the alarm; -the Wander Guard system located between the Nursing Home and the Assisted Living entrance did not sound when the DON attempted to activate the system with a tester; -an exit door in the Assisted Living dining room had a Wander Guard alarm which the DON could not activate with the tester. A small alarm had been placed at the top of the door which alarmed for approximately 3 seconds when the door opened but then silenced before the door was even completely closed; and -the DON verified the facility was aware of the concerns with the alarms for the West corridor exit, the Assisted Living corridor Wander Guard alarm, and the Assisted Living dining room exit, and indicated repairs were required but had not been implemented. D. Interview with Nursing Assistant (NA)-J on 7/22/20 at 9:08 AM revealed that staff working in resident rooms could not hear door alarms in the hallways other than the hallways they were working in. E. Interview with the DON on 7/22/20 at 1:30 PM revealed on 6/18/20 the facility had an assessment completed by the company which provided the current Wander Guard system. The facility had called the company due to identified concerns related to exit door alarms and with the Wander Guard system between the Nursing Home and the entrance to the Assisted Living and an exit door in the Assisted Living dining room. The facility failed to follow through with the required repairs and no further attempts were made to assure the repairs were completed to correct these concerns. Further interview with the DON confirmed Resident 10 had elopements on 6/24/20 and on 7/14/20 and the resident had exited the building through the Assisted Living dining room door with both of these elopements. F. During an interview on 7/22/20 at 1:40 PM, the Business Office Manager confirmed there was no current Maintenance Supervisor employed at the facility. The Maintenance Supervisor was responsible for checking the exit doors and for testing the Wander Guard systems on a weekly basis to assure they were functioning correctly. There was no evidence the facility exit doors and the Wander Guard system had been checked/tested since 11/29/19. The immediate jeopardy identified on 7/22/20 was abated to an F level on 7/22/20 at 2:30 PM when: -the facility placed a staff member at each of the exit doors which had been identified with concerns related to alarms and non-functioning Wander Guard systems to assure no further elopements; -the facility contacted the company which had assessed the facility doors and Wander Guard system on 6/18/20 to initiate the required repairs; -a schedule of staff who were to be placed at exit doors was completed for the next few days pending the arrival of the company and the completion of required repairs for the exit doors and Wander Guard systems; and -a staff member was assigned to perform weekly, monthly and quarterly equipment inspection and testing with assignments to be overseen by the Business Office Manager to assure completion.
F 0943 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.** **Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285191	A. BUILDING _____ B. WING _____	**07/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ELMS HEALTH CARE CENTER	**P O BOX 628, 410 BALL PARK ROAD PONCA, NE 68770**

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