STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285081	A. BUILDING _____ B. WING _____	06/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHI HEALTH ST FRANCIS	2116 WEST FAIDLEY AVENUE GRAND ISLAND, NE 68803

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 0880 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to protect all residents in the facility by not following acceptable infection control practice recommendations for COVID-19 from the Centers for Disease Control (CDC) and the Centers for Medicare and Medicaid (CMS) Services. The facility failed to have a screening system in place to ensure all staff and visitors were screened for signs and symptoms of COVID-19 prior to having contact and providing care to the residents. The facility failed to initiate a COVID-19 screening on a federal surveyor, allowing the federal surveyor access to resident care areas, allowed staff to enter the facility and pass multiple resident rooms prior to being screening for signs and symptoms of COVID-19 and obtaining a mask at the nurses station. The facility failed to follow up on employee documented signs and symptoms of COVID-19 and allowed them to work and provide care to the residents. The facility failed to ensure an employee was screened for signs and symptoms of COVI-19 on 4/13 and 4/14/20, and allowed the employee to work and provide care to the residents. This employee exhibited signs and symptoms of COVID-19 on 4/18/20, which included fever and cough, and tested positive for COVID-19 on 4/21/20. This deficient practice placed all 18 residents at risk for contracting COVID-19 and resulted in Immediate Jeopardy. As a result of the identified non-compliance, the Administrator was notified on 6/18/20 at 5:20pm of the Immediate Jeopardy (IJ). Findings include: During an interview on 6/18/20 at 11:40am, the Director of Nursing (DON) stated the facility began screening all staff for signs and symptoms of COVID-19 on 4/6/20. Review of CMS, Center for Clinical Standards and Quality, Safety and Oversight (QSO) Memo 20-14-NH, dated 3/13/20, provided guidance to long term care facilities which included screening all staff at the beginning of their shift for fever and respiratory symptoms. Actively take their temperature and document absence of shortness of breath, new or change in cough and sore throat. If ill, have them self-isolate at home. Review of the CDC's Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings, dated 3/13/20, showed the following: -Screen all healthcare professionals (HCP) at the beginning of their shift for fever and symptoms consistent with COVID-19. If they are ill, have them keep their facemask on and leave the workplace. -Fever is either measured temperature >100.0 degrees Fahrenheit or subjective fever. Respiratory symptoms consistent with COVID-19 are cough, shortness of breath and sore throat. Review of the COVID-19 screening log book provided by the DON on 6/18/20, showed the facility failed to actively screen staff and visitors for signs and symptoms of COVID-19 from March 13 through April 5, 2020. On 6/18/20 at 8:30am, a federal surveyor entered the building on the first floor and approached a person sitting behind a table. The person identified that the skilled nursing facility was located on the third floor. The surveyor was then directed to the elevator. Once off the elevator, a stand up sign was observed, which stated Stop No Visitation. The federal surveyor observed a hallway to the left and to the right. An employee asked if the surveyor had been helped and the surveyor who she was and why she was there. Approximately two minutes later, Practical Nurse (PN)2 approached the surveyor. PN2 proceeded to allow the surveyor to ambulate down the hall past resident rooms but the surveyor stopped and let the PN2 know a screening for signs and symptoms of COVID-19 screened had not been conducted and requested a screening prior to entering any resident care areas. PN2 asked the surveyor if there was anyone at the table downstairs and surveyor stated yes, but no screening was offered. PN2 proceeded to assess the surveyor's temperature and asked about a sore throat and any travel outside of the country. During an interview on 6/18/20 at 9:30am, the DON stated the screening person at the table on the first floor should have called up to the skilled nursing unit on the 3rd floor and let someone know that someone was coming to the unit. She stated someone would have been standing by the elevator to conduct a screening for signs and symptoms of COVID-19. During an interview on 6/18/20 at 9:30 am, DON stated that staff had been instructed to conduct screenings for COVID-19 on themselves at the nurse's station prior to providing care to the residents. She stated staff entered the unit from the front stairs and elevator and the back stairs and elevator. She stated the front elevator and stairs were only used at certain times by staff due to it being used as a public elevator for people from the community going to the fourth floor to see physicians. During a tour of the facility on 6/18/20 at 9:45am, the DON identified the back elevator at the end of a hallway. She stated that once staff exited the back stairwell or elevator onto the third floor, they would continue down the hallway passing by resident rooms 335, 337, 339, 341, 343, 345 and 347 prior to entering the nurse's station to screen themselves for signs and symptoms of COVID-19 and obtain a mask. During an interview on 6/18/20 at 10:24am, housekeeper (HK)1 stated she typically worked in the Intensive Care Unit (ICU) at the hospital but sometimes worked at the skilled nursing facility. She stated when she came to work at the skilled nursing unit she had stopped at the screening table on the first floor but was told they only screened people who were going to the family practice offices located on the fourth floor of the building. She stated she came up the back elevator and went to the nurse's station and took her temperature and completed the screening form. During an interview on 6/18/20 at 10:34am, Physical Therapist (PT)1 stated she comes up the back stairs and goes to the nurse's station and checks her temperature. She stated that she did not complete the screening form to assess for signs and symptoms of COVID-19 but would only take her temperature. Review of the employee screening log dated 6/18/20 showed no documentation of PT1 being screened for signs and symptoms of COVID-19 prior to providing care to the residents. During an interview on 6/18/20 at 10:39am, Nurse Aide (NA)1 stated that she goes to the nurse's station and takes her temperature and completes the COVID-19 screening form when she comes to work. Review of the employee screening log dated 6/18/20 showed no documentation of NA1 being screening for signs and symptoms of COVID-19 prior to providing care to the residents. During an interview on 6/18/20 at 10:44am, NA7 stated she normally worked on the Medical Surgical floor of the hospital but did work in the skilled nursing facility a few times a month. She stated she did care for COVID-19 positive patients at the hospital about a month ago. She stated when she came to work on 6/18/20 she was screened by the screener on the first floor and given a mask to wear. During an interview on 6/18/20 at 2:01pm, the screener on the first floor identified she screens individuals who are going to see physicians on the fourth floor and had not screened any employees working in the skilled nursing unit on this day. During an interview on 6/18/20 at 10:55am, NA2 stated she screens herself at the nurse's station. She stated she checks her temperature and completes the screening form. During an interview on 6/18/20 at 11:03am, NA3 stated when she comes to work she goes to the nurses station and screens herself by taking her temperature and completing the screening form. She stated she also works at the hospital. She stated she had provided care to COVID-19 positive patients on the Medical Surgical floor at the hospital on [DATE]. Review of the employee screening log dated 6/18/20 showed no documentation of NA3 being screened for signs and symptoms of COVID-19 prior to providing care to the residents. During an interview on 6/18/20 at 11:40am, the DON stated some of the employees were part of a resource pool and worked at the hospital and the skilled nursing facility. She stated these employees were not supposed to care for COVID-19 positive patients at the hospital and then care for residents in the skilled nursing facility. She was not aware of any staff who have provided care to COVID-19 positive patients at the hospital and then provided care to residents of the skilled nursing facility. Review of the employee COVID-19 screening form on 6/18/20 showed staff were to write their name, circle yes or no if they had shortness of breath, new onset of cough or change in cough, or sore throat and if they had a temperature greater than 99.9 degrees

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 -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) Fahrenheit. Review of an employee screening form dated 4/11 and 4/13/20, showed LPN1 documented having a sore throat. Review of LPN1's time clock records revealed she worked 13 hours and 30 minutes on 4/11/20 and 12 hours on 4/13/20. Review of an employee screening form dated 4/12 and 4/26/20, showed NA5, and documented having a sore throat. Review of NA5's employee time clock records revealed she worked 6 hours and 45 minutes on 4/12/20 and 7 hours and 45 minutes on 4/26/20. Review of an employee screening form dated 4/14/20, showed RN1, documented having occasional cough. Review of RN1's employee time clock records revealed she worked 12 hours and 15 minutes on 4/14/20. Review of NA3's employee screening form dated 4/6-4/7/20 revealed no documentation of a temperature being assessed. Review of employee screening forms dated 5/24, 5/26, 6/1, 6/2, and 6/3/20, showed Activity Director (AD)1 circled yes on the forms indicating she had shortness of breath, new onset of cough or change in cough, or sore throat. Review of AD1's employee time clock records showed she worked 8 hours and 45 minutes on 5/24, 8 hours on 5/26, 8 hours on 6/1, 8 hours on 6/2 and 8 hours and 15 minutes on 6/3/20. During an interview on 6/18/20 at 11:40am, the DON stated it was the employee's responsibility to conduct screenings on themselves at the nurse's station for signs and symptoms of COVID-19 prior to providing care to the residents. When staff identified symptoms of COVID-19 on their screening form, they had been instructed not to work and to contact the employee health nurse. The employee health nurse would then make a decision on how to proceed. She stated that she and the employee health nurse were responsible to ensure all screenings for signs and symptoms of COVID-19 were completed on all staff prior to providing care to the residents. During an interview on 6/18/20 at 1:18pm, the Employee Health Nurse stated employees were supposed to call her if they documented any signs or symptoms of COVID-19 on the employee screening form. She said occasionally she would find out through a manager that an employee was ill so she would get their number and call them. She stated employees were told not to work if they documented any signs or symptoms of COVID-19 on the screening form. During an interview on 6/18/20 at 1:18pm, the Employee Health Nurse provided a tracking document that she utilized when she was notified of employees with signs and symptoms of COVID-19. The document identified the date the illness started, symptoms, tested for COVID-19, results of test, self-monitoring, self-isolating and a return to work date for employee's who reported signs and symptoms of COVID-19 when completing their screening form. Review of the tracking document provided by the Employee Health Nurse showed no documentation of LPN1, NA5, RN1, NA3, and AD1 signs and symptoms of COVID-19 being reported to the employee Health Nurse. Review of the tracking document provided by the employee health nurse showed NA6 reported symptoms of cough and fever on 4/18/20, and tested positive for COVID-19 on 4/21/20. Review of NA6 time clock records showed she worked in the skilled nursing facility for 12 hours on 4/13/20 and 12 hours on 4/14/20 and provided care to the residents. Review of the employee screening form dated 4/13 and 4/14/20 showed no documentation of NA6 being screened for signs and symptoms of COVID-19 prior to providing care to the residents. During an interview on 6/18/20 at 1:48pm, the DON stated she was not aware that NA6 had reported signs and symptoms of COVID-19 on 4/18/20 and tested positive for COVID-19 on 4/21/20. During an interview on 6/18/20 at 12:47pm, the Infection Control Nurse stated staff were supposed to be monitoring themselves for signs and symptoms of COVID-19 prior to coming to work and she felt that they were [MEDICATION NAME] social distancing when ambulating to the nurses station and passing multiple resident rooms prior to screening themselves for signs and symptoms of COVID-19. She stated it would not be appropriate for staff who were exhibiting signs and symptoms of COVID-19 to be in close contact of resident rooms. She stated if any staff had any signs or symptoms of COVID-19, they should not be coming to work. The facility submitted an acceptable plan and the IJ was removed and deficient practice corrected on 6/19/20 after verification of implementation of the removal plan.