STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285237	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BELLE TERRACE	1133 NORTH THIRD ST TECUMSEH, NE 68450

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 0728 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training.** Based on interview and record review, the facility failed to ensure 6 Staff Members (Staff Members G, H, I, J, K, and L) working in the facility as nurse aides were provided training and assessed for competency. This had the potential to affect all residents residing in the facility. The facility had a total census of 46 residents. The findings are: A review of Active Employee Listing provided by the facility revealed Staff Members G, H, I, J, K, and L were identified as temporary nurse aides. A review of facility training documentation did not reveal any training documentation or competency assessments related to nurse aide duties for Staff Members G, H, I, J, K, and L. In interviews on 6/23/20 at 1:17 PM and 1:50 PM the DON (Director of Nursing) reported facility was unable to locate any documentation of training or competency assessments for Staff Members G, H, I, J, K, and L. The DON confirmed Staff Members G, H, I, J, K, and L had been working with residents performing all nurse aide duties.
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** Licensure Reference Numbers 175 NAC 12-006.17A and 12-006.17B Based on observation, interview, and record review; the facility failed to implement staff and resident screening for COVID-19 in accordance with CMS guidelines, failed to ensure that staff did not screen themselves for signs and symptoms of COVID-19, failed to prevent potential cross-contamination related to proper PPE (Personal Protective Equipment) usage in isolation rooms and proper hand hygiene after resident contact and failed to place 1 resident (Resident 9) receiving [MEDICAL TREATMENT] outside of the facility in isolation and on transmission-based precautions. This had the potential to affect all residents residing in the facility. The resident sample was 11. The facility had a total census of 46 residents. The findings are: Implementing Staff/Resident Screening A. A review of CMS Memo QSO-20-14-NH, last revised 3/13/20 revealed the following guidance for nursing homes: 2. Implement active screening of residents and staff for fever and respiratory symptoms. 4. Screen 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 they are ill, have them put on a facemask and self-isolate at home. B. A review of facility documentation of staff screening of signs and symptoms related to COVID-19 did not reveal any documentation prior to 3/31/20. In an interview on 6/23/20 at 12:17 PM, the DON (Director of Nursing) confirmed the facility did not have any documentation of staff screenings prior to 3/31/20. C. A review of documentation provided by the facility of resident screenings for signs and symptoms related to COVID-19 did not reveal any documentation prior to 4/17/20. Documentation was not consistently done from 4/17/20 - 5/21/20 and there was no documentation of screening of COVID-19 symptoms from 5/21/20 - 6/22/20. In an interview on 6/24/20 at 2:40 PM, the DON confirmed resident screenings for signs and symptoms related to COVID-19 were not done consistently prior to 6/23/20. The DON also reported the earliest documentation found for resident screening was on 4/3/20. Staff Self-Screening D. In an interview on 6/23/20 at 12:25 PM, the DON reported the off-going shift was to screen the staff for the on-coming shift for signs and symptoms of COVID-19. In an interview on 6/23/20 at 11:00 AM, Staff Member G reported staff screen themselves in the vestibule and then alert a nurse if they have a fever or respiratory symptoms. Staff Member G stated if staff had a fever when checking their own temperatures in the vestibule they would wait for someone to walk in the door and get a nurse for them, as there is no way to call someone from the vestibule. In an interview on 6/23/20 at 11:08 AM, LPN A reported the on-coming or off-going nurse would screen the staff coming on shift in the front vestibule. Cross-Contamination/PPE Usage in Isolation Rooms E. Observations on 6/23/20 between 10:45 AM and 1:45 PM revealed blue and green dots outside the doors of resident rooms. An observation on 6/23/20 at 11:19 AM of a sign hanging by the front entrance of the building revealed the following: Attention Staff - Please date your masks! Masks are to be thrown away after 1 week, if soiled, or if you have gone into a quarantine/isolation room. Please be diligent on replacing your masks as needed. A review of a COVID Floor Plan provided by the facility revealed the following: -Designated COVID Positive Room was room [ROOM NUMBER] (Red) -COVID Signs and Symptoms Rooms were Rooms 202, 203, 204 (Yellow) -Quarantine Rooms - Individuals Returning from Hospital, Asymptomatic (Blue) -Asymptomatic Residents Residing in Assigned Rooms (Green) An observation on 6/23/20 at 11:40 AM revealed MA (Medication Aide)-M exiting room [ROOM NUMBER] (a blue-dot room) wearing a procedure mask. MA-M then entered room [ROOM NUMBER] (a green-dot room) wearing the same mask, and then entered room [ROOM NUMBER] (a green-dot room) while still wearing the same mask. In an interview on 6/23/20 at 11:45 AM MA-M reported the resident in room [ROOM NUMBER] was in quarantine because of a recent hospital stay. MA-M stated that the proper PPE for quarantine rooms was a facemask and gloves and a gown would be added if resident contact was going to be made. MA-A also confirmed MA-A wore the same mask in room [ROOM NUMBER], 205, and 206 and stated that staff do not change masks in between blue-dot rooms and green-dot rooms. In an interview on 6/23/20 at 11:08 AM, LPN-A reported the only PPE required in blue-dot rooms was a mask and gloves. LPN-A also stated the same procedure mask was worn in blue-dot rooms as was worn by staff throughout the rest of the building and rooms. In an interview on 6/23/20 at 11:00 AM, Staff Member G reported the only PPE required in blue-dot rooms was a mask and gloves. Staff Member G stated the mask would be the same mask staff where everywhere else in the building and other rooms. An observation on 6/23/20 at 11:55 AM revealed Staff Member G entered room [ROOM NUMBER] (a blue-dot room) to answer a call light in a cloth mask and no other PPE. Staff Member G exited room [ROOM NUMBER] and then entered room [ROOM NUMBER] (a green-dot room) wearing the same cloth mask. In an interview on 6/23/20 at 2:25 PM, the DON confirmed there was a potential for cross-contamination with staff going into blue-dot rooms and green-dot rooms wearing the same masks. The DON also confirmed the staff were not wearing the correct PPE in isolation/quarantine (blue-dot) rooms. Hand Hygiene F. An observation on 6/23/20 at 2:50 PM revealed Staff Member I adjusted Resident 10's mask up on (gender) face. Staff Member I then adjusted (gender) own mask and went on to adjust Resident 11's mask up on (gender) face. No hand hygiene was ever performed. G. Screening: Observation on 6/23/20 at 10:30 AM revealed a large sign on the front door which read: To all venders: Please complete COVID-19 self-screening at the entrance table before entering the building. If you have a temperature or respiratory symptoms do not enter. Interview on 6/23/20 at 10:40 AM with the facility Director of Nursing confirmed that the sign should not be there and venders are to be screened by staff. Interview on 6/23/20 at 10:45 AM with the facility Maintenance Supervisor revealed that staff screen themselves when they come in to work. They enter the front door, take their temperature and log it on the log sheet inside the exterior door. They also circle yes or no to a series of questions on the log. They are to perform hand hygiene with antiseptic hand wash and put a mask on at the start of the shift. The MS stated that if they have a temperature, they call the nurses and tell them before coming into the building. Interview on 6/23/20 at 11:00 AM with Housekeeper B revealed that at the start of the shift, the staff come in the front door and take

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) their own temperatures and answer questions on the log. They document the temperature on the log and circle yes or no for the questions on the log. If they have a temperature, they are to call the charge nurse before coming into the building. Observation on 6/23/20 at 1:40 PM revealed NA C entered the exterior door of the facility into the alcove between doors. NA C took a temperature on the forehead and logged those results on the log sheet on a table in the alcove. NA C answered the questions on the sheet, got a mask out of a set of masks on the table, placed the mask over the mouth and nose and performed hand hygiene with antiseptic hand wash. NA C then entered the building. Interview on 6/23/20 at 1:42 PM with NA C confirmed that staff perform their own screening when they come on shift and log their results on the log sheet in the alcove. NA C stated they are to wear the same mask all shift and place it into a paper bag at the end of the shift and hang in the front activity room. Observation on 6/23/20 at 1:45 PM revealed NA D entered the building through the front door into the alcove. NA D took a temperature on the forehead and logged the results and the answered the questions on the log sheet on the table in the alcove. At this point, the owner of the facility entered the alcove and stopped NA D, retook NA D's temperature and visited with the NA. The NA then entered the building, went directly to the administrator's office and closed the door. Interview on 6/23/20 at 2:10 PM with the Dietary Manager revealed that the dietary staff screen themselves at the front door. If they have a fever, they are to notify the Dietary Manager prior to entering the building. H. Cross contamination / PPE Record review of a facility policy entitled Handwashing / Hand Hygiene dated revised August 2015 revealed the following: - 2. All personnel shall follow the hand washing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. - 7. Use an alcohol based hand rub containing at least 62% alcohol or, alternatively, soap and water for the following situations: b. Before and after coming in contact with residents. k. After handling used dressing, contaminated equipment l. after contact with objects in the immediate vicinity of the resident. n. before and after entering isolation precaution settings. - 8. Hand Hygiene is the final step after removing and disposing of personal protective equipment (PPE). Observation on 6/23/20 between 11:50 AM and 11:58 AM revealed Nurse Aide (NA) E came out of room [ROOM NUMBER], a green room. NA E had a surgical mask over the nose and mouth which had been worn since the beginning of the shift. The mask did not fully cover the nostrils. Without changing the mask or performing hand hygiene, NA E stood outside room [ROOM NUMBER], a blue quarantine room. NA E placed an isolation gown over their clothes, untied, and donned gloves. NA E entered room [ROOM NUMBER] with the meal and a garbage bag and delivered the meal tray to the resident. NA E then removed the gown and gloves, rolled them and put them into the bag and exited the room with no hand hygiene performed. NA E took the garbage bag to the hopper room, opened the door (touched the door handle) threw the bag into the room, exited the hopper room. NA E walked into the dining area, touched a dietary tray paper, left the room and walked to room [ROOM NUMBER], a blue quarantine room. NA E entered room [ROOM NUMBER] with no personal protective equipment in place and no hand hygiene performed, stood and talked for 1 minute then turned and walked out of room [ROOM NUMBER]. NA E walked to the break room, opened the door by touching the door handle and went in and performed hand hygiene. Interview on 6/23/20 at 2:20 PM with the DON confirmed that they should change their mask after coming out of a quarentine room, wear a gown, gloves and mask in the blue quarentine rooms and perform hand hygeine before entering and after leaving a blue quarentine room I. Hand hygeine after direct resident contact Observation on 6/23/20 at 1:20 PM revealed that the DON approached Resident 7 in the hallway near the nurses station, adjusted the Resident mask by grasping it on the outside of the mask with hands (no gloves present) and placed it up on the residents face over the nose. The DON then proceeded to walk to the medication room. With no hand hygiene completed, the DON touched the handle of the door and opened the door, got a key out of the medication room, walked to the beauty shop and placed the key into the lock and opened the door to the beauty shop. The DON retrieved a set of supplies from the beauty shop, closed and relocked the beauty shop, handed the supplies to Licensed Practical Nurse (LPN) and returned the key to the medication room after opening the door. The DON then performed hand hygiene while in the medication room. Observation on 6/23/20 at 1:25 PM revealed the DON approached Resident 8 in the hallway near the nurses station, adjusted the resident's mask by grasping it on the outside of the mask with hands (no gloves present) and placed it up on the residents face over the nose. With no hand hygiene performed, the DON grasped the handles of Resident 8's wheelchair and proceeded to push the wheelchair down the hallway. The DON stopped and entered room [ROOM NUMBER], wrapped a electrical cord around a oxygen concentrator and placed it into the hallway. The DON went back into room [ROOM NUMBER], got a wrist blood pressure cuff and took it to the nurses station and wiped it down with a sanitizer cloth. The DON then performed hand hygiene in the medication room. Interview on 6/23/20 at 2:20 PM with the DON confirmed that staff should use antiseptic hand wash or perform hand washing after a residents mask is touched and before anything else is touched. J. [MEDICAL TREATMENT]: Record review of Center for Medicare and Medicaid services Memo QSO-20-28NH revealed that for resident appointments that are considered necessary (i.e. [MEDICAL TREATMENT], a procedure to remove waste products and excess fluids from the body when the kidneys stop working properly.) the facility should monitor the resident upon return for fever and signs and symptoms of respiratory infection for 14 days after the outside appointment (preferably in a space dedicated for observation of asymptomatic residents) (i.e. a blue zone room. Interview on 6/23/20 at 10:50 AM with the Director of Nursing (DON) revealed one resident (Resident 9) was on [MEDICAL TREATMENT] and went out of the facility 3 times per week for treatment. Observation on 6/23/20 at 12:00 PM revealed Resident 9 resided in a room that had a green dot outside the door and was not in an isolation room or under transmission based precautions. Interview on 6/23/20 at 12:17 PM with the DON confirmed that Resident 9 was not in an isolation zone or under transmission based precautions and resided in a green room.