STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285273	A. BUILDING _____ B. WING _____	08/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PLAINVIEW MANOR	P O BOX 219, 101 HARPER STREET PLAINVIEW, NE 68769

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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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 Number 175 NAC 12-006.17C Based on observations, record reviews, and interviews; the facility failed to implement infection control practices to prevent potential cross contamination including the spread of COVID-19. The facility failed to 1)screen resident's for signs and symptoms of COVID-19, 2) place and maintain residents in transmission based precautions, 3) implement standard precautions, 4) protect resident's from staff members displaying symptoms of COVID-19, and 5) ensure reusable items were cleaned in an approved manner. This had the ability to affect all residents. The sample size was 20 and the facility census was 29. Findings are: A. The facility policy for Isolation-Categories of Transmission Based Precautions dated October 2018 stated: -Standard precautions were used when caring for residents at all times regardless of their suspected or confirmed infection status. -Transmission based precautions were additional measures that protect staff, visitors and other residents from becoming infected. These measures were determined by the specific pathogen and how it spreads from person to person. -The Center for Disease Control and Prevention (CDC) maintained a list of diseases, modes of transmission, and recommended precautions. -Contact Precautions may be implemented for residents known or suspected to be infected with microorganisms that could be transmitted by direct contact with the resident or indirect contact with environmental surfaces. B. The Center for Medicare and Medicaid Services (CMS) Memorandum QSO-14-28-NH dated 3/9/20 revealed: -CMS was responsible for ensuring the health and safety of nursing home residents by enforcing the standards required to help each resident attain or maintain their highest level of well-being. In light of the recent spread of COVID-19 CMS took several steps to help prevent the spread of [MEDICAL CONDITION]. -Prompt detection, triage, and isolation of potentially infectious residents was essential to prevent unnecessary exposures among residents, healthcare personnel, and visitors at the facility. -Facilities should be vigilant in identifying any possible infected individuals and preform frequent monitoring for symptoms of respiratory infections throughout the day. C. The Department of Health and Human Services Long Term Care COVID-19 Phasing Guidance dated 6/15/20 revealed the following guidance for resident screening: -screening must be completed for residents at least daily, -screening must include body temperature and questions/observations for other signs and symptoms of COVID-19. D. Review of the Resident Screening Logs for all facility residents dated July 2020 and August 2020 revealed the facility was monitoring residents' body temperatures daily until 8/6/20 and then starting on 8/6/20 the facility began to check the residents' body temperatures 2 times daily and resident oxygen saturations daily. There was no evidence that the facility was questioning/observing the residents for other signs and symptoms of COVID-19. E. Review of Resident 15's MDS (minimum data set- a federally required comprehensive assessment of the resident's condition) dated 5/26/20 revealed; -a [DIAGNOSES REDACTED]. Observation of Resident 15 on 8/12/20 revealed; -at 8:30 AM the resident was in a wheelchair near the nurses station wheeling about with no mask, staff did not attempt to apply a mask, or redirect or assist the resident to their room. -at 11:00 AM the resident was wheeling about the nurse station area with a surgical mask in place. -at 1:15 PM the resident was sitting in a wheelchair by the nurse station with a surgical mask not covering the nose or mouth. Review of Resident 15's Progress Notes revealed; -A late entry on 8/13/20 at 9:54 AM which revealed the facility received notification on 8/12/20 that the resident was COVID-19 positive. -on 8/13/20 at 2:54 AM the resident was frequently trying to leave the resident room and hallway. Interview with the facility Administrator on 8/12/20 at 10:00 AM confirmed Resident 15 was not wearing a mask, did not routinely wear a mask, and was not being kept in the resident's room. F. Review of Resident 14's MDS dated [DATE] revealed; -a prognosis that could result in a life expectancy of less than 6 months, -the resident required moderate assistance with bed mobility, transfers, dressing and toileting, and was able to eat independently, and -special treatments and procedures included hospice care and oxygen. Review of Resident 14's Progress Notes revealed: -A late entry on 7/24/20 at 3:11 PM which revealed on 7/8/20 the resident, the resident's son, and the son's wife were out of the facility for an eye appointment. -On 7/23/20 at 11:47 AM the residents oxygen saturation level was 86 percent (%) (normal is 90% or above). The resident reported feeling tired and diminished lung sounds were noted by the hospice nurse whom administered a nebulizer treatment for [REDACTED]. There was no indication that the facility implemented transmission based precautions for a potential respiratory illness. -On 7/24/20 at 9:21 AM the Respiratory Therapist reported the resident was short of breath when riding the stationary bike and the resident's oxygen saturation level was 86%. The resident's oxygen saturation after a nebulizer treatment improved to 88-89% and then to 92% after oxygen was administered. -On 7/24/20 at 11:34 AM the resident was out to church. -On 8/4/20 at 10:13 PM the resident had crackles in the base of the left lung and complained of chest feeling kinda tight. -On 8/7/20 at 11:26 AM the resident was tested for COVID-19. -On 8/8/20 at 10:35 AM the resident complained of right inner calf soreness. -On 8/11/20 at 6:30 PM the resident complained of not feeling well, arthritis pain, chest pain, stomach distress, and anxiety. -On 8/12/20 at 1:18 AM the resident continued to complain of not feeling well, being weak and tired, and was reported to be weak and unsteady requiring the use a mechanical lift for toileting. Review of Resident 14's Physician order [REDACTED]. G. Interviews with the facility Administrator on 8/12/20 between 1:00 PM and 3:00 PM confirmed Resident 14 and Resident 15 were now COVID-19 positive. Interview with Licensed Practical Nurse (LPN)-C on 8/12/20 at 10:10 AM revealed all residents were having their temperature and oxygen saturation taken twice a day, and that lung sounds and additional assessments were only completed on residents whom were identified as ill. Interview with LPN-B on 8/12/20 at 10:00 AM revealed this nurse normally went throughout the facility taking temperature and oxygen saturations at the beginning of the shift or with the morning medication pass if unable to complete them prior to the medication pass. Residents who had identified illness received additional assessments. No routine screening assessments were completed on all the residents. H. Observations of Resident 19 on 8/9/20 at 9:25 AM, at 10:00 AM, and at 10:55 AM revealed the resident was seated in a wheelchair moving through the hallways without a face mask on. There were 2 other residents (Resident 15 and Resident 20) roaming through the hallways without face masks on. Staff members had not approached Resident 19 to encourage the use of a face mask and did not redirect the resident to a separate area away from others. This had the potential to expose Resident 19 and others to COVID-19. I. Review of the CDC COVID-19; Strategies for Optimizing the Supply of Eye Protection (updated 7/15/20) revealed the following: -while wearing gloves, wipe the inside, followed by the outside of the face shield using a clean cloth saturated with neutral detergent solution or cleaner wipe; -wipe the outside of the face shield using a wipe or clean cloth saturated with an EPA-registered hospital disinfectant solution; -fully dry (air dry or use clean absorbent towels); and -remove gloves and perform hand hygiene. J. Review of the undated facility policy Cleaning and Disinfecting of Equipment and Supplies revealed all equipment would be sanitized after each use and sanitizer would be located at the nurse's station, dirty hopper room, and on mechanical lifts. K. During observations on 8/9/20 at 10:00 AM the following was revealed: -Nursing Assistant (NA)-G and NA-L exited room [ROOM NUMBER] (in which the resident was on transmission based precautions) after cares were provided and removed the isolation gowns and gloves outside of the room as opposed to removing them inside the room; -NA-G and NA-L then rolled the gowns into a ball and carried them (without putting them in a

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) bag), down the hall to the laundry cart located outside another room potentially exposing others to cross contamination from the gowns; and -NA-G and NA-L used an alcohol wipe to clean (approximately 1 inch square) the inside and outside of the face shields while wearing them. An observation of Medication Aide (MA)-F, on 8/9/20 at 10:20 AM revealed the following: -MA-F exited room [ROOM NUMBER] (in which the resident was on transmission based precautions) after cares were provided and removed the isolation gown outside of the room as opposed to inside the room; -MA-F then rolled up the gown in a ball and carried it (without a bag) to the opposite end of the hall and placed the gown inside the laundry cart, potentially exposing others to cross contamination from the gown. During observations of LPN-B on 8/9/20 at 11:25 AM, the following was revealed: -LPN-B provided cares to a resident in room [ROOM NUMBER], who was on transmission based precautions; -LPN-B exited the room and removed the isolation gown outside of the room as opposed to inside the room; -LPN-B then rolled up the isolation gown in a ball and carried the gown (without a bag) to the end of the hallway and placed it inside the laundry cart, which potentially exposed others to cross contamination from the gown; and -LPN-B used an alcohol wipe (approximately 1 inch square) to clean the inside and outside of the face shield while wearing it. During observations of a Dietary Member (DM)-M on 8/9/20 from 11:30 AM to 11:40 AM the following was revealed: -DM-M was wearing an N95 mask, face shield, cloth isolation gown and gloves; -DM-M carried a meal tray into room [ROOM NUMBER] and touched the resident's items on the bedside table moving them to the side; -DM-M disinfected the resident's hands with a spray bottle of hand sanitizer, then placed the resident's meal on the bedside table and exited the room; -DM-M had not removed gloves or sanitized hands before exiting the room; -DM-M then picked up a different tray off the meal cart and delivered it to the resident in room [ROOM NUMBER]; -DM-M had not removed gloves or sanitized hands after leaving room [ROOM NUMBER]; -DM-M then assisted LPN-B with putting on and securing the ties on LPN-B's isolation gown; and -DM-M had not removed gloves or sanitized hands before resuming the delivery of meal trays to other residents, which potentially exposed residents to cross contamination. L. An interview with LPN-B on 8/9/20 at 11:25 AM verified staff used alcohol wipes (approximately 1 inch square) to disinfect the face shields. M. Review of an Advanced Screening Tool dated 8/11/20 revealed Nursing Assistant (NA)-A was nauseous and had had a headache, the NA requested to go home after rounds (process of checking on all residents and providing toileting and any other cares needed). The request was made at 4:11 AM and the staff member left the facility at 5:21 AM. Interviews with the Director of Nursing (DON) on 8/12/20 from 9:00 AM to 4:30 PM confirmed NA-A felt ill and wanted to go home but not until after rounds were completed. The DON confirmed NA-A was allowed to stay and complete rounds prior to going home ill. N. Review of an Advanced Screening Tool dated 8/3/20 revealed LPN- I had multiple symptoms of illness (with potential other causes) including cough, shortness of breath, fatigue, muscle or body aches, and a headache. LPN-I also indicated running a temperature after mid-night with a temperature of 101.2 degrees at 1:00 AM. Further review revealed the nurse continued to work the remainder of the shift and provided cares to residents that needed morning medications and one other resident. O. Review of the facility COVID-19 Return-To-Work Procedures updated 7/15/20 revealed a process to be implemented for staff members due to signs or symptoms of COVID-19 (fever, cough, shortness of breath) and/or a positive COVID-19 test. The following criteria was identified: -exclude from work until at least 2 consecutive negative COVID tests done over 24 hours apart, or -exclude from work until 10 days since symptoms first appears with improvement in respiratory symptoms with at least 3 days with a temperature less than 99 degrees without fever reducing medications. Review of Advanced Screening Tools and the facility Nursing Schedule dated 7/2020 and 8/2020 revealed: - NA-K's Advanced Screening Tool dated 7/20/20 revealed NA-K had a headache with either nausea, vomiting, and/or diarrhea. NA-K was sent home on 7/20/20. - NA-J's Advanced Screening Tool dated 8/6/20 revealed NA-J had been having an increase in coughing with chills, fatigue, muscle aches, headache, and nausea. NA-J was sent home. NA-J also stated a family member and child may have COVID-19. Interview with the Infection Preventionist on 8/12/20 at 1:05 PM revealed NA-K returned to work on 7/23/20 and NA-J returned to work on 8/8/20 (less than 10 days since the start of symptoms and there was also no indication that 2 negative COVID tests had been completed). P. Review of the Long-Term Care COVID-19 Phasing Guidance dated 6/15/20 revealed if a facility had any residents in red zone or yellow zone isolation they had to be in Phase 1. In Phase 1 communal dining must be limited to only COVID-19 negative or asymptomatic residents and the facility was to restrict group activities. Review of a Progress Note dated 8/5/20 at 11:01 AM revealed Resident 6 was hard to arouse and was having increased confusion. Review of a Progress Note dated 8/5/20 at 5:35 PM revealed the resident had gone out to the dining room for dinner as well as for afternoon snack and activity. Interview with the Administrator on 8/12/20 at 3:30 PM confirmed Resident 6 (among others) had now tested positive for COVID-19. The deficient practices placed all 29 residents at risk for contracting COVID-19 and resulted in Immediate Jeopardy (IJ). As a result of the identified non-compliance the Administrator was notified on 8/12/20 at 2:40 PM of the IJ. The facility submitted an acceptable plan and the IJ was abated on 8/12/20 at 4:40 PM.