STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285065	A. BUILDING _____ B. WING _____	08/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLD CREST RETIREMENT CENTER	200 LEVI LANE ADAMS, NE 68301

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 0582 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide 1 (Resident 34) of 3 residents sampled with a NOMNC (Notice of Medicare Non-Coverage - a form facilities must issue when there is a termination of all Medicare Part A services for coverage reasons to inform the beneficiary of their right to an expedited review of a services termination) and SNF ABN (Skilled Nursing Facility Advanced Beneficiary Notice - a form facilities must issue to residents/beneficiaries prior to providing services Medicare usually covers) upon facility-initiated discharge from Medicare Part A Services. The facility had a total census of 39 residents. The findings are: A review of Resident 34's electronic medical record revealed Resident 34 was admitted to the facility on [DATE] under Medicare Part A services. Resident 34 was discharged from Medicare Part A services on 4/11/20, but remained in the facility as a private-pay resident. Resident 34 discharged home from the facility on 5/15/20. A review of a facility-completed SNF Beneficiary Protection Notification Review form indicated the facility initiated Resident 34's discharge from Medicare Part A Services when benefit days were not exhausted. The form also indicated NOMNC and SNF ABN forms were not provided to Resident 34. In an interview on 8/17/20 at 2:35 PM, the DON (Director of Nursing) reported Resident 34 was discharged from Medicare Part A Services due to meeting all therapy goals, but had not exhausted all benefit days. The DON stated Resident 34 was supposed to discharge home, but was unable to due to a COVID-19 outbreak in the facility. The DON confirmed no NOMNC or SNF ABN forms were provided to Resident 34.- In an interview on 8/18/20 at 2:35 PM, the DON confirmed Resident 34 should have been provided with both NOMNC and SNF ABN forms and wasn't.
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to provide written notification of transfer to the Resident and Resident's representative, for one resident (Resident 12), of one sampled resident. The facility census was 39. Findings are: Record review of Resident 12's Progress Notes dated 4/30/20 at 8:46 PM revealed a call was placed to the DON (Director of Nursing) and Resident 12's POA (Power of Attorney) with updates on Resident 12's fall. Record review of Resident 12's Progress Notes dated 4/30/20 at 9:35 PM revealed the facility received a telephone order from Resident 12's health care provider to transfer Resident 12 to the emergency room for an evaluation. Record review of Resident 12's health record on 4/30/20 revealed, an absence of documentation related to written notice of transfer for Resident 12 or Resident 12's Representative. Record review of Resident 12's Progress Notes dated 05/14/20 revealed Resident 12 returned to the facility on [DATE] with a [DIAGNOSES REDACTED]. Interview on 08/18/20 at 11:30 A. M with MDS Coordinator (Minimum Data Set-a federally mandated process for clinical assessment of residents in nursing homes) confirmed the facility did not send a written notice of transfer to resident representatives when a resident is transferred out of the facility. Interview on 08/18/20 at 12:56 P.M. with the DON confirmed the facility did not provide a written notice of transfer to the resident or resident representative when a resident is transferred out of the facility, but facility staff would notify the resident representative via telephone call.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **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 12-006.09D Based on observations, record reviews and interviews the facility failed to protect residents for possible elopement by ensuring the Memory Care Unit was secured, this had the potential to affect all the resident on the memory care unit. The facility census was 39. Findings are: An observation on 08/12/20 09:27 AM of the Memory Care Unit door to the outdoor enclosed patio was propped open with a cement block. Resident 14 and 28 were outside in the enclosed patio area. The gates to the enclosed patio area were not locked and could be opened. The latch to lock the door lock was located on the outside of the door. The MA (Medication Aide) was sitting on the double recliner and was looking forward toward the hallway at times. There were 2 residents located on the patio, the other residents were indoors and in multiple locations in the dining area/living area. An interview on 8/12/20 at 9:27 AM with MA E confirmed the gate was unlocked to the patio accessible by memory care residents. The MA reported they had been the only person on the memory unit prior to another staff member arriving for outdoor visits. The MA confirmed the door was blocked open with a cement stone. The MA reported if they were on the unit alone and something were to happen they would call for some assistance. An interview on 08/12/20 at 9:45 AM with Activities Assistant confirmed if a resident was sitting on the patio, and the gate was not locked and it would be an unsecured area. An observation on 8/12/20 at 09:45 AM the activities assistant demonstrated how to get out by lifting the latch and pushing the door open. An interview on 08/12/20 at 10:49 AM with Resident 14 revealed Resident 14 reported (gender) wanted to go home with their child and (genders) spouse, who lived in a neighboring town. An interview on 8/12/20 at 3:22 PM with the DON (Director of Nurses) revealed Elopement Assessments- the facility does not do elopement assessments. The DON reported the facility had no elopements for a very long time. The DON reported the facility had a secured memory unit. The DON confirmed the memory unit had one assigned staff member except on bath days there was a second staff to assist with bathing. The DON confirmed if the staff was unable to see the door from where they were; the area would be unsecured if the door was blocked open. An interview on 8/12/20 at 3:40 PM with the Administrator confirmed the double fire doors leading into the facility from the Memory Care unit were locked to secure the unit. The administrator reported the patio doors were not locked due to the regulations and the Fire Marshall concerns. The Administrator reported the area would be secure if a staff member was present on the unit. An observation on 08/13/20 at 02:22 PM of the patio gate to the memory care unit remained unsecured Record review of Gold Crest Retirement Center Memory Care Admission Agreement no dated revealed Admission Criteria for the Memory Unit was: 1. Will have an established [DIAGNOSES REDACTED]. 2. Must not have behavior difficulties that present a danger to themselves or other resident of the home, or disrupt the overall operations of the facility. 3. Must be self-mobile, can use an assistive device as long as they remain independent or a one assist transfer as needed. 4. May need basic assistance with activities of daily living (dressing, grooming, personal hygiene, meals, activities etc.). 5. Will have a written order from their physician stating they are appropriate for nursing home care. 6. Will not be discriminated against due to race, religion, color, creed, age,

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

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) sex, or disability.
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 NAC 12-006. Based on observations, interviews and record reviews; the facility failed to ensure hand hygiene was performed to prevent the potential for food contamination and the hood vents above the cooking surface were free of grey fuzzy matter. This had the potential to affect all residents in the facility. The facility census was 39. Findings are: Based on observation, interview and record review the facility failed to ensure hand hygiene was completed to prevent the potential for cross contamination during food preparation, the facility also failed to ensure the hood/vents were cleaned and free from dark fuzzy matter, this had the potential to affect all residents in the facility. An observation of Food Preparation on 8/13/20 at 09:00AM with Cook F revealed; Celery was chopped on the vegetable food area on a cutting board, 4 cups, carrots were retrieved from the freezer and 4 cups were added, onions were retrieved from the walk-in cooler and 1 cup was added to a pot with unmeasured butter to saut vegetables. An observation on 8/13/20 at 09:20 AM of Cook F who had retrieved a Large Mayo container from the walk-in cooler the product was transferred in to a stainless steel pan, the mayo container was too big for the swinging trash container, the cook lifted that trash lid and tossed the container in the trash. No Hand hygiene had been completed. Hand Hygiene was performed the faucet was turned on, hands were wet and soap was applied scrubbing motion from 9:27:31-9:27:49 (18 seconds), hands were rinsed and dried with paper towel, the faucet was turned off with a paper towel. The Cook F touched their neck and then stirred the soup with the spoon Hand Hygiene was performed the faucet was turned on, hands were wet and soap was applied scrubbing motion from 9:29:10-9:27:17 (7 seconds), hands were rinsed and dried with paper towel, the faucet was turned off with a paper towel. An interview on 8/13/20 at 9:30 AM with the Cook confirmed; the hand hygiene was short of 20 seconds. The Cook reported was about 10 seconds. The soup was stirred. Hand Hygiene was performed the faucet was turned on, hands were wet and soap was applied scrubbing motion from 9:34:41-9:34:51 (10 seconds), hands were rinsed and dried with paper towel, the faucet was turned off with a paper towel. Gloves donned at 9:40 cheese was pulled from zip lock bag. Ham and cheese croissants were made and cut in half. Placed in a container gloves doffed and the container was moved to the walk-in cooler. Hand Hygiene was performed the faucet was turned on, hands were wet and soap was applied scrubbing motion from 9:44:23-9:44:35 (12 seconds), hands were rinsed and dried with paper towel, the faucet was turned off with a paper towel. At 09:45 AM cream soup base was added to one gallon of water and mixed. 1 cup of chicken broth was mixed and added to the pot with the vegetables. 1 Can of classic potatoes sliced were added to the pot followed by the creamed soup base mixture. Hand Hygiene was performed Faucet was turned on, hands were wet and soap was applied scrubbing motion from 9:53:04-9:53:16 (12 seconds), hands were rinsed and dried with paper towel, the faucet was turned off with a paper towel. At 09:55 the counter was cleansed with a wash cloth retrieved from a bucket. An interview with on 8/13/20 at 10:05 AM with the Cook revealed that they did not test the water in the buckets, they got the water from the sink that had a sanitizing dispenser. Hand Hygiene was performed Faucet was turned on, hands were wet and soap was applied scrubbing motion from 9:57:24-9:57:36 (12 seconds), hands were rinsed and dried with paper towel, the faucet was turned off with a paper towel. A scale was placed on the food prep counter and a bag of cheese from the cooler was placed on the counter. Gloves donned -1 pound of cheese was measured and placed in the pan with the soup, the soup was mixed and transferred to stainless steel pan and placed in the warmer. At 10:06 AM 2 cans of green beans were placed in a stainless steel pan and placed on the burner. A bag of corn was brought from the freezer and water was filled to the top of the corn and was placed on the burner. At 10:11 AM the Cook F reported they had run out of croissants to feed the residents the rest of the sandwiches would be made out of bread. Drawer to get a knife Hand Hygiene was performed Faucet was turned on, hands were wet and soap was applied scrubbing motion from 10:12:56-10:13:04 (8 seconds), hands were rinsed and dried with paper towel, the faucet was turned off with a paper towel. How to Wash Hands: 1. Turn on the faucet. 2. Wet hands and forearms with warm water and apply soap. 3. Scrub well with soap and additional water as needed/ scrubbing all areas thoroughly. Wash with friction at least 1 inch above wrists. Pay close attention to the fingernails using a brush as needed. Scrub for a minimum of 20 seconds. Apply vigorous friction between the fingers and fingertips. Rinse with clean, running warm water in a way that allows the water to flow from the wrist to the finger tips. 4. Dry hands with paper towel. Turn the faucet off with a clean paper towel. 5. Use the towel to open the door if needed/ and then discard the towel. Staff is educated on the importance of hand washing and retrained and reminded as necessary on the above guidelines. B. An observation on 8/13/20 at 09:15 AM of a dark fuzzy, black and wet matter located on the vents above the cooking stove. An observation on 8/13/20 at 10:22 AM with the DM (Dietary Manager) of the vents about the stove. An interview on 8/13/20 at 1:22 AM with the DM reported that the dark grey fuzzy matter was dust and grease. The DM confirmed; the cleaning had not been completed in July. An interview on 8/13/20 with the Dietary Manager confirmed; the vent hood above the cook stove had not been cleaned since May 25, 2020. The DM reported that the stove needed to be cleaned Monthly and the 6 month professional clean had been missed related to lock down and COVID. Record review of Daily cleaning List for May 25 revealed the Hood and filters had been washed inside and outside. Record review of Daily cleaning List for June and July revealed the Hood and Filters had not bee cleaned. Record review of Triple A Grease Away dated 6/9/2019 was the last date of service. How to Wash Hands: 1. Turn on the faucet. 2> Wet hands and forearms with warm water and apply soap. 3. Scrub well with soap and additional water as needed/ scrubbing all areas thoroughly. Wash with friction at least 1 inch above wrists. Pay close attention to the fingernails using a brush as needed. Scrub for a minimum of 20 seconds. Apply vigorous friction between the fingers and fingertips. Rinse with clean, running warm water in a way that allows the water to flow from the wrist to the finger tips. 4. Dry hands with paper towel. Turn the faucet off with a clean paper towel. 5, Use the towe! to open the door if needed/ and then discard the towel.
F 0880 **Level of harm -** Minimal harm or potential for 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 Numbers 175 NAC 12-006.17A and 12-006.17B Based on record reviews, observations and interviews the facility failed to properly prevent and/or contain COVID-19 as evidenced by the facility failed to prevent the potential for cross contamination from room to room related to cleaning, which had the potential to affect all residents in the facility. The facility failed to ensure staff were masked when providing dining for 1 Resident (Resident 134) of 12 reviewed. The facility census was 39. Findings are: A) Observation on 8/13/20 at 8:10 A.M. revealed Housekeeper C took a sponge out of the mop bucket water on the housekeeping cart and walked into a resident room with sponge. Observation on 8/13/20 at 8:13 A.M. revealed Housekeeper C, with gloved hands took Swiffer (wet mopping pad) and dipped it in mop bucket that the sponge was in, wrung out Swiffer and mopped resident's floor. Observation on 8/13/20 at 12:10 P.M. revealed Housekeeper C: 1) Sprayed alkaline bathroom cleaner and disinfectant on resident's sink. 2) Left room to get the sponge out of the mop bucket on the housekeeping cart. 3) Entered room with sponge, wiped the sink, then toilet seat. Housekeeper C lifted the toilet lid with visible stool observed on underside of lid and wiped off the toilet with the sponge. 4) Housekeeper C left room and put the used sponge back in mop bucket on the housekeeping cart. 5) Housekeeper C dipped Swiffer in the mop bucket on the housekeeping cart. 6) Wrung out Swiffer in mop bucket and mopped resident's floor. Interview on 8/13/20 at 8:18 A.M. with Housekeeper C revealed disinfectant was in the mop bucket water on the housekeeping cart. Housekeeper C confirmed resident's sink and toilet were cleaned with the same water and sponge that is used for mopping the residents' floors in their rooms. Interview on 8/13/20 at 12:20 P.M. with Housekeeper C confirmed the mop water in the bucket on the housekeeping cart does not get changed from room to room. Housekeeper C revealed the sanitizer in the water maintained cleanliness of the sponge. Interview on 8/13/20 at 12:25 P.M. with Housekeeper D revealed water in the mop bucket does not get changed from room to room. Housekeeper D stated revealed the water would be changed if visibly dirty. Interview on 8/13/20 at 2:08 P.M. with Administrator revealed, sanitizer is supplied by Eco lab and they set us up with the disinfectant and sanitizer in a pump system for automatic mixing. Administrator revealed the practice of reusing the sponge from room to room would need to be reviewed. Interview on 8/17/20 at 1:41 P.M. with Administrator revealed Eco Lab came out to the facility on [DATE]th, 2020 and checked the pump system that the disinfectant and sanitizer are mixed in. Administrator revealed on August 14th, 2020 Housekeeping staff were educated on using a different cleaning process for rooms. Housekeepers were educated on using a rag for the sink and a different rag for the toilet, then discarding in bags on the housekeeping carts. Administrator was unable to clarify why the practice of using a sponge started. Interview on 8/18/20 at 1:30 P.M. with Administrator confirmed the process for cleaning was not done correctly prior to staff

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) reeducation. B. An observation on 8/17/20 at 12:03 PM revealed MA (Medication Aide)-A had a surgical mask under (gender) chin and MA-A's nose and mouth were both uncovered. MA-A was standing at the island counter in the memory care area with a sandwich on a plate and an open canned beverage in front of (gender). MA-A then bent down to assist Resident 134 (who was seated at a table pushed up to the back of the island) to eat. MA-A was approximately 1 foot away from Resident 134's unmasked face with MA-A's mask still under (gender) chin and both MA-A's nose and mouth were uncovered. MA-A then went to the sink, washed (gender) hands, and got a knife from a drawer in the kitchen. MA-A then went back to cut up Resident 134's food and was, again, approximately 1 foot away from Resident 134's face. MA-A then pulled (gender) mask over (gender) mouth and nose and continued to assist Resident 134 with eating. No hand hygiene was performed after MA-A touched MA-A's face mask. In an interview on 8/17/20 at 12:10 PM, MA-B stated sometimes staff eat with the residents if there are 2 people in memory care working. In an interview on 8/17/20 at 1:27 PM, the DON (Director of Nursing) reported staff eat in dining areas or the break room and in memory care they eat at the resident dining tables after the residents eat. The DON reported staff have to maintain at least 6 foot distance from residents when not wearing a mask. The DON confirmed staff should not be assisting residents without being masked. A review of the facility's undated Universal Masking of Residents, Staff and Visitors During COVID-19 Policy revealed the following: Healthcare Personnel -When providing direct patient care to any resident, staff should don a medical grade (official PPE) facemask or respirator depending on the care provided (i.e. N95 with aerosol generating procedures). The CDC says, Cloth face coverings are not considered PPE because their capability to protect healthcare personnel is unknown. -Healthcare personnel who provide support services but do not provide direct patient care should also wear a facemask. Surgical masks are preferred however, should the facility be in a situation that warrants the conservation of supplies, cloth face coverings may be utilized by staff not providing direct resident care. -Masks may be removed when social distancing of at least 6 feet is possible (e.g., after entering a private office). In order to ensure staff can take off their masks for meals and breaks, scheduling and location for meals and breaks should ensure at least a 6 foot distance can be maintained between staff when staff needs to remove their mask. It is important for healthcare facilities to emphasize that hand hygiene is essential to maintaining employee safety, even if staff are wearing masks. If the facemask is touched, adjusted or removed, hand hygiene should be performed.
F 0881 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Implement a program that monitors antibiotic use.** Based on interview and record review the facility failed to establish an Antibiotic Stewardship program. This had the potential to affect all residents in the facility. The facility had a total census of 39 residents. The findings are: A review of the facility's Infection Control Policy and Procedure Manual revealed no information related to an Antibiotic Stewardship Program. In interviews on 8/18/20 at 2:00 PM and 2:35 PM, the DON (Director of Nursing) and IP (Infection Preventionist) confirmed the facility does not currently have an Antibiotic Stewardship Program. The DON reported the facility is working on making protocol with the facility medical director.