STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285239	A. Building B. Wing	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Nursing & Rehab Legacy Pointe LLC	3110 Scott Circle Omaha, NE 68112

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 21492 LICENSURE REFERENCE NUMBER 175 NAC 12-006.09C1a Based on record review and interview; the facility staff failed to develop a base line care plan for 1 (Resident 8) of 1 resident. The facility staff identified a census of 60. Finds are: Record review of Resident 8's Progress Notes revealed Resident 8 was admitted to the facility 6-20-22. Record review of Resident 8's medical record that included the progress notes and care plan section of Resident 8's medical record revealed there was no base line care plan as of 6-29-2022. On 6-29-2022 at 11:25 AM an interview was conducted with the Regional Nurse Consultant (RNC). During the interview the RNC reported Resident 8 did not have a baseline care plan completed.

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21492 LICENSURE REFERENCE NUMBER 175 NAC ,d+[DATE].09 Based on record review and interview; the facility staff failed to perform Cardiopulmonary Resuscitation (CPR) for 1 (Resident 3) of 1 resident, failed to identify a residents' Advance Directive (AD) upon admission for 2 residents (Resident 3 and 8), failed to ensure residents' medical records matched residents' AD for 3 residents (Resident 3, 6, 8 and 9), failed to ensure the facility transportation driver was CPR certified, and failed to have a facility process that identified each residents' AD and where the location of the information was located. The facility failure had the potential to affect all residents in the building. The facility staff identified a census of 60. Findings are: A. Review of Resident 3's electronic record revealed Resident 3 admitted to the facility on [DATE]. Further review of Resident 3's electronic record revealed Resident 3's dashboard (first screen that opens when selecting the resident) revealed Resident 3's AD status was not identified. Record review of Resident 3's AD signed [DATE] revealed Resident 3 was a 'Full Code. According to Resident 3's AD signed on [DATE] a full code was described as I understand that if my heart stops beating, or is inadequate, or that if I stop breathing or my breathing is inadequate, all resuscitation procedures will be provided initiated. The process can include chest compression,intubation, and defibrillation and is referred to as CPR. Record review of Resident 3's Progress Note (PN) dated [DATE] with a time of 8:40 AM revealed Resident 3 was found laying face down on the floor and did not respond when Resident 3's name was called. According to Resident 3's PN dated [DATE] and timed at 8:40 AM, Resident 3 was warm to touch but has no palp (palpatiable) pulse or resp (respirations). Is a DNR (Do Not Resuscitate). On [DATE] at 7:57 AM an interview was completed with Registered Nurse (RN) A. During the interview RN A reported being the nurse on duty and being notified Resident 3 was on the floor. RN A confirmed Resident 3 was found without a pulse and was not breathing. RN A confirmed CPR was not initiated for Resident 3. RN A reported during the interview, there was not information in Resident 3's electronic record that identified Resident 3's AD. RN A further reported the facility did not have a process in place to determine a resident's AD upon admission. On [DATE] at 2:05 PM an interview was conducted with the Assistant Director of Nursing (ADON). During the interview the ADON reported would look at the resident's Dash Board for their code status. On [DATE] at 2:05 PM an interview was conducted with the Director of Nursing (DON). During the interview the DON reported would look at the resident's AD for their code status. On [DATE] at 11:00 AM an interview was conducted with the facility DON. During the interview the DON confirmed Resident 3's AD was not identified in the resident's record and further confirmed Resident 3 should have had CPR initiated. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	B. Record review of Resident 9's electronic Dash Board revealed Resident 9 identified code status was a full code. Record review of Resident 9's medical record revealed a consent form dated [DATE] which showed Resident 9 was a Do Not Resuscitate (DNR). Record review of Resident 9's Comprehensive Care Plan (CCP) dated [DATE] revealed Resident 9 was identified as being a Full Code. On [DATE] at 6:59 AM an interview was conducted with the DON. During the interview the DON confirmed Resident 9 was a DNR and Resident 9's dash board and CCP was not correct. C. Record review of a undated Nursing Report (NR) sheet revealed Resident 6 was a DNR. Record review of Resident 6's electronic Dash Board and Resident 6's AD dated [DATE] identified Resident 6 as wanting CPR. On [DATE] at 5:52 AM an interview was conducted with RN B. During the interview RN B reported would look at the NR sheet for code status, if not there would look at a dash board. RN B confirmed the NR sheet identified Resident 6 as a DNR. RN B reported not being sure of what the process was for identifying a resident AD . D. Record review of Resident 8's electronic record revealed Resident 8's Dash Board identified Resident 8 as a full Code and admitted on [DATE]. Further review of Resident 8's electronic medical record revealed there was not an AD to identify Resident 8's directions for CPR. On [DATE] at 7:52 AM an interview was conducted with the DON. During the interview the DON reported there was not an AD for Resident 8 and reported staff would not know what to do for Resident 8. The DON reported the facility does not have a process to identify what the residents AD are. Record review of a AD completed on [DATE] revealed Resident 8 was a DNR. E. On [DATE] at 4:14 PM an interview was conducted with the facility Van Driver (VD) C. During the interview VD C reported transporting residents to appointments such as doctors offices and other facility staff did not always go along. VD C stated no when asked if VD C was CPR certified. F. Record review of the facility Policy for Advance Directive revised ,d+[DATE] revealed the following information: -Policy Statement: -Advance Directives will be respected in accordance with state law and facility policy. -Policy Interpretation and Implementation: -1. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he/she chooses to do so. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-3. If the resident is incapacitated and unable to receive information about his/her right to formulate an advanced directive, the information may be provided to the residents legal representative. -6. Prior to or upon admission of a resident, the Social services Director or designee will inquire of the resident his/her family members and/or his/her legal representative, about the existence of any written advance directive. -7. Information about weather or not the resident has executed an advance directive shall be prominently in the medical record. G. On [DATE] to abate the immediacy of the situation the facility provided the following plan: - Process/Steps to identify others having the potential to be impacted by the same deficient practice: -All staff including agency are educated on the CPR policy with the focus on checking chart-electronic medical record for code status (Dashboard). Assure that no one works until educated on this policy. Competency test will follow. -Sweep of all residents charts to see that advance directives/code status match what is in PCC (Point Click Care, electronic charting system) and Care Planned all area of chart match. -Audit to assure all nurses and necessary ancillary staff (van driver) are CPR certified and current. -Measures put in to place/systemic changes to ensure the deficient practice does not recur: -Admission Coordinator educated on obtaining advance directives on admission with immediate upload to PCC. -Medical Records will upload final signed copy into miscellaneous. -Assistant Director of Nursing (ADON) or Designee (Director of Nursing) will be notified of advance directives upon admission to place an order in PCC on the dashboard. -Clinical Stand-up will be initiated to include code status follow up and verification. -Resuscitation Policy reviewed and revised for updated procedure. -Quarterly Education to all staff on resuscitation policy. -CPR certified staff member to accompany van driver on all resident transport initiated immediately. -Papio transport will be arranged for all appointments until greater plan is secured to assure van driver or an accompany is CPR certified. -Plan to monitor performance to ensure solutions are sustained: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-Random audits of 6 CPR certified staff questioning procedure when finding a resident without a pulse and respirations. Weekly audit X's 4 weeks for 1 month, then monthly X's 3. -Daily audit in clinical start up to assure code status is accurate in PCC, care plan, dashboard, etc on-going. -On going mock code drills. -The plan of correction will be reviewed monthly by QAPI committee for the next 3 months and longer if needed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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** 21492 LICENSURE REFERENCE NUMBER 175 NAC 12-006.18 Based on observation, record review and interview; the facility staff failed to identify and implement interventions to prevent falls for 5 (Resident 2, 4, 5, 6, and 7) of 5 residents. The facility staff identified a census of 60. Findings are: A. Record review of Resident 4's Comprehensive Care Plan (CCP) dated 5-13-21 revealed Resident 4 was at risk for falls due to a history of fall with a fracture, had cognitive impairment and did not always understand safety issue. Further review of Resident 4's CCP revealed a dated entry of 2-22-2022 that identified Resident 4 as a fall risk related to Dementia and impulsivity, in addition as to not have safety awareness. The goal identified for Resident 4 was not to have a major injury from a fall dated 2-25-2022. Interventions identified on Resident 4's CCP to archive this goal included Resident 4's bed to remain in the lowest position at all times except during checking and changing Resident 4, provide a matt on the floor and to user a scoop mattress on the bed with a initiated date of 8-16-2021 and revised on 3-04-2022. Record review of a facility investigation dated 5-06-2022 revealed Resident 4 was found on the floor with a baseball sized pool of blood on the floor next to Resident 4's right side of the head. Further review of the investigation dated 5-06-2022 revealed Resident 4 had a laceration on the right forehead resulting in Resident 4 being sent to the emergency room resulting in Resident 4 receiving 5 stitches to the right eye brow. Further review of the investigation dated 5-06-2022 revealed a scoop mattress was placed onto resident 4's bed. Observation on 6-27-2022 at 1:10 PM revealed Resident 4's bed was at waist height and not in the lowest position and no mat was on the floor. Observation on 6-28-2022 at 10:15 AM revealed Resident 4 was in bed and the bed positioned at waist height. On 6-28-2022 at 10:15 AM an interview was conducted with Nursing Assistant (NA) D. During the interview NA D confirmed Resident 4's bed was not in the lowest position and lowered the bed to the lowest setting. On 6-28-2022 at 3:45 PM an interview was conducted with the Director of Nursing (DON). During the interview the DON reported Resident 4's bed did not have a scoop mattress on the bed when Resident 4 was found on the floor 5-06-2022. Review of Resident 4's CCP was conducted with the DON. The DON confirmed Resident 4 should have had the scoop mattress on the bed prior to the fall on 5-06-2022. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	B. Record review of a facility investigation dated 4-06-2022 revealed Resident 2 was found laying on the floor with blood on the floor. According to the investigation dated 4-06-2022 it .appeared resident rolled out of be [NAME] in a high position. According to the investigation, Resident 2 sustained a laceration above the right eye that measured 2 centimeter (cm's). On 6-28-2022 at 3:54 PM an interview was conducted with the DON. During the interview the DON reported Resident 2 had been on hospice and has since discharged from the facility. The DON reported during the investigation, Resident 2 had fallen from the bed in a high position and should have been in the lowest position. C. Record review of Resident 5's medical record revealed Resident 5 had discharged from the facility on 6-15-2022. Record review of Resident 5's CCP dated 12-15-2020 and revised on 3-24-2022 revealed Resident 5 was at risk for falls related to weakness and a unsteady gait. The goal identified for Resident 5 was to have no falls through the next review. Interventions identified on Resident 5's CCP included a scoop mattress, work with therapy and 1 person assist with transfers. Record review of an incident report dated 5-15-2022 revealed Resident 5 was found in another residents room on the floor. According to the incident report dated 5-15-2022 a new intervention to prevent falls was to increase frequency of eye on Resident 5 every 30 minutes. Record review of an incident report dated 5-23-2022 revealed Resident 5 was lying on the floor in the hallway and socks were wet with urine. The intervention identified on the incident report dated 5-23-2022 was that a toileting schedule was implemented. Record review of an incident report dated 6-05-2022 revealed Resident 5 was on the floor. Further review of the incident report revealed there were no additional interventions implemented to prevent further falls. Review of Resident 5's medical record revealed there was no information identified that the 30 minutes checks had been completed or that Resident 5 was placed onto a toileting program. On 6-27-2022 at 1:20 PM an interview was conducted with the DON. During the interview the DON reported the inability to locate the 30 minute checks. On 6-28-2022 at 4:04 PM a follow up interview was conducted with the DON. During the interview the DON reported a toileting program for Resident 5 had not been completed and no additional interventions were implemented for the fall on 6-05-2022. D. Record review of Resident 6's CCP dated 4-19-2021 and revised on 5-23-2022 revealed Resident 5 was at risk for falls. The goal identified for Resident 6 was not to have any falls resulting in injury. The intervention to meet this goal included a scoop mattress, bed locked in the lowest position and fall mats to be placed. Observation on 6-27-2022 at 1:00 PM revealed Resident 6's bed did not have a scoop mattress in place. Observation on 6-28-2022 at 10:50 AM revealed Resident 6 was in bed. Resident 6 did not have a scoop mattress and did not have the fall mats in place for Resident 6. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	On 6-28-2022 at 11:00 AM an interview was conducted with the DON. During the interview, observation of Resident 6 room was completed. The DON confirmed Resident 6 did not have a scoop mattress in place or a fall mat. E. Record review of Resident 7's CCP revealed Resident 7 had actual falls on 4-14-2021 and 1-07-2021. The goal identified for Resident 7 was to resume usual activities without further incident. intervention identified to meet this goal included non skid pads on floor and bed in lowest position except during check and change. Observation on 6-27-2022 at 1:05 PM revealed Resident 7 was seated in wheelchair with the bed at waist height. Observation on 6-27-2022 at 2:20 PM revealed Resident 7 was in bed and the bed was positioned at waist height. Observation on 6-28-2022 at 5:50 AM revealed Resident 7 was in bed and the bed was at waist height. Observation on 6-28-2022 at 10:15 AM revealed Resident 7 bed was at waist height. On 6-28-2022 at 10:15 AM an interview was conducted with NA E. During the interview NA E confirmed Resident 7's bed was not in the lowest position.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21492 Based on record review and interview; the facility staff failed to ensure 3 (Resident 11, 12 and 15) of 13 residents had a physician visit every 30 days for the first 90 days and then every 60 days thereafter. A physician can alternate visits by a physician assistant, nurse practitioner or clinical nurse specialist after the initial visit. The facility staff identified a census of 60. Findings are: A. Record review of an Admission Record sheet printed on 6-29-2022 revealed Resident 11 was admitted to the facility on [DATE]. Review of Resident 11's medical record that included progress notes, practitioner notes and fax sheet revealed Resident 11 did not have a second 30 day practitioner visit. On 6-29-2022 at 12:28 PM an interview was conducted with Advanced Practice Registered Nurse (APRN) F. During the interview APRN F confirmed Resident 11 did not have the required practitioner visits. B. Record Review of an Admissions Record Sheet printed on 6-29-2022 revealed Resident 12 admitted to the facility on [DATE]. Review of Resident 12's medical record that included practitioner notes revealed Resident 12 had not been seen since 10-25- 2021. On 6-29-2022 at 12:28 PM an interview was conducted with APRN F. During the interview APRN confirmed Resident 12 did not have the required practitioner visits. C. Record review of an Admission Record sheet printed on 6-29-2022 revealed Resident 15 admitted to the facility on [DATE]. Record review of Resident 15's medical record that included practitioner notes revealed Resident 15 had missed two 30 day visits. On 6-29-2022 at 1:35 PM an interview was conducted with Medical Record Manager (MRM). During the interview the MRM confirmed 2, 30 visit had been missed for Resident 15.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 21492 LICENSURE REFERENCE NUMBER 175 NAC 12-006.04C1b Based on observations, record review and interview; the facility staff failed to ensure the Director of Nursing (DON) did not work as a charge nurse with a daily census average of over 60. This had the potential to affect all residents in the building. The facility staff identified a census of 60. Finds are: Record review of the facility Nursing schedule from 6-09-2022 through 6-26-2022 revealed the Director of Nursing worked as a Charge nurse on 6-03-2022, 6-04-2022, 6-08-2022, 6-13-2022, 6-14-2022, 6-17-2022, 6-18-2022, 6-19-2022, 6-27-2022. Observation on 6-27-2022 at 2:33 PM revealed the facility DON was working as the charge nurse on the west side of the building. On 6-27-2022 at 2:33 PM an interview was conducted with the DON. During the interview the DON reported the daily average census in the building was 63. The DON reported working as a charge nurse multiple times in the last 30 days. Observation on 6-28-2022 at 6:50 AM revealed the DON was working as the Charge Nurse on the west section of the building.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21492 LICENSURE REFERENCE NUMBER 175 NAC ,d+[DATE].02 Based on observations, record review, and interviews; the facility administration failed to ensure effective management of facility resources to maintain the highest practical well being of residents and the facility environment as evidenced by 1) failure to implement an effective plan of action to maintain correction for cited areas of deficient practice, 2) failure to implement plans of action to identify multiple issues of deficient practice. The facility staff identified a census of 60. Findings are: Review of the following information revealed: -F678, the facility staff failed to perform Cardiopulmonary Resuscitation (CPR) for 1 (Resident 3) of 1 resident, failed to identify a residents Advance Directive (AD) upon admission for 2 (Resident 3 and 8) of 2, failed to ensure residents medical records matched residents AD for 3 (Resident 3, 8 and 9) of 4 sampled residents, failed to ensure the facility transportation drive was CPR certified and failed to have a facility process that identified each resident AD and where the location of the information well be located. B. On [DATE] at 7:00 AM an interview was conducted with the facility Administrator. During the interview the Administrator reported being aware of issues with Advance Directive information and accuracy and did not implement a plan of action due to the Director of Nursing and Assistant Director of nursing working the floor. -F689, the facility staff failed to identify and implement interventions to prevent falls resulting in harm for a resident. -F712, the facility staff failed to ensure residents had a physician visit every 30 days for the first 90 days and then every 60 days thereafter. -867, the facility Quality Assessment and Performance Improvement (QAPI) program failed to identify ongoing issues relevant to F678, F689, F712 and F880 and implement plans of action to identify and correct the deficient practice. F947, the facility staff failed to ensure 7 (Nursing Assistants (NA) had completed continuing education for Infection Control, Dementia and Abuse and neglect. F655, the facility staff failed to develop a base line care plan for a newly admitted resident.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 21492 LICENSURE REFERENCE NUMBER 175 NAC 12-006.07C Based on record review and staff interviews; the facility Quality Assessment and Performance Improvement (QAPI) program failed to identify ongoing issues relevant to F678, F689, F712 F947, F655 and F880 and implement plans of action to identify and correct the deficient practice. This had to potential to affect all residents in the facility. The facility staff identified a census of 60. Findings are: A. Record review of a Quality Assurance and Performance Improvement (QAPI) policy dated 11-2017 revealed the following information: -Policy: It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of outcomes and quality of life. -Policy Explanation and Compliance Guideline: -2c. Develop and implement appropriate plans of action to correct identified quality deficiencies. -8a. The facility will draw data from multiple sources, including input from all staff, residents, families, and others as appropriate. -11e. QAPI training that outlines and informs staff of the elements of QAPI and goals of the facility will be mandatory for all staff. B. On 6-29-2022 at 2:35 PM an interview was conducted with Registered Nurse (RN) A. During the interview RN A reported not being aware of what the QAPI committee was working on or being informed. C. On 6-30-2022 at 6:42 AM an interview was conducted with Nursing Assistant E. During the interview NA E reported not being aware of what the QAPI committee was working on or being informed. D. On 6-30-2022 at 6:45 AM an interview was conducted with NA N. During the interview NA N reported not being aware of what the QAPI committee was working on or being informed. E. On 6-30-22 at 6:50 AM an interview was conducted with NA O. During the interview NA O reported not knowing what the QAPI committee was working on or being informed. F. On 6-30-2022 at 7:00 AM an interview was conducted with the facility Administrator. During the interview the Administrator reported being aware of issue with Advance Directives information and accuracy and did not implement a plan of action due to the Director of Nursing and Assistant Director of nursing working the floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285239	A. Building B. Wing	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Nursing & Rehab Legacy Pointe LLC	3110 Scott Circle Omaha, NE 68112

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 - 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** 21492 LICENSURE REFERENCE NUMBER 175 NAC 12-006.17 Based on observations, record review and interview; the facility staff failed to wear the required mask in a manner to prevent the potential spread of COVID-19. This had the potential to affect all residents in the facility. The facility staff identified a census of 60. Findings are: A. Record review of the COVID-19 Policy revision#22 dated 3-16-2022 revealed the follow information: -Purpose: -The purpose of this guideline is to provide clarification for steps the facility will take regarding the novel Coronavirus (COVID-19), minimize exposures to respiratory pathogens and promptly identify residents with clinical feathers and risk for COVID-19. -Objective: -Decrease the prevalence and incident of residents being exposed to COVID-19 signs and symptoms and to prevent the spread of COVID within the facility. -Zoning: -Facilities that reside in states that follow Zoning will follow accordingly when determining Personal Protective Equipment (PPE) usage. -Green Zone: Surgical mask and PPE standard precautions. -Yellow zone: Exposure to COVID-19. Gown, gloves, eye protection and N95 mask. Implemented for a resident who has been exposed to COVID-19 and are up-to-date. B. Record review of a CDC COVID-19 Summary of Recent Changes dated 1-28-2022 of types of Mask and Respirators revealed procedure mask (sometimes referred to as surgical mask) are to cover the nose, mouth and chin. C. Observation on 6-27-2022 at 2:05 PM revealed the Assistant Director of Nursing (ADON) was seated at the east nursing station wearing a surgical mask below the chin. D. Observation on 6-28-2022 at 11:02 AM revealed the ADON was seated at the east nursing station with a surgical mask below the chin. E. Observation on 6-28-2022 at 11:46 AM revealed the Director of Nursing (DON) was seated at the west nursing station with a surgical mask below the chin. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285239	A. Building B. Wing	06/30/2022

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(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 - Minimal harm or potential for actual harm Residents Affected - Many	F. Observation on 6-28-2022 at 12:20 PM revealed Nursing Assistant (NA) I was seated in the secured unit dinning room with a surgical mask below the nose. G. Observation on 6-28-2022 at 12:22 PM revealed the facility ADON was in the east main hall administering medications and did not have a mask on. H. On 6-22-2022 at 9:32 AM an interview was conducted with the DON. During the interview the DON reported a staff member had tested positive for COVID-19 and the facility was in a zone. I. Observation on 6-29-2022 at 6:20 AM revealed a sign on room [ROOM NUMBER] indicating the resident was in a yellow zone. The sign posted on the indicated upon entering staff were to wear eye protection, a N95 mask and to complete hand hygiene. Further observation revealed NA J did not complete hand hygiene and was wearing a surgical mask and entered room [ROOM NUMBER]. J. On 6-29-2022 at 6:30 AM an observation with Licensed Practical Nurse (LPN) K of room [ROOM NUMBER] was completed, LPN K confirmed NA J was not wearing an N95 mask and should have been.