

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 285091	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/17/2020
NAME OF PROVIDER OF SUPPLIER INDIAN HILLS MANOR		STREET ADDRESS, CITY, STATE, ZIP 1720 NORTH SPRUCE OGALLALA, NE 69153	
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	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Licensure Reference Number: 175 NAC 12-006.17B Based on observations, interviews and record review, the facility failed to place seven residents (Residents 1, 2, 4, 5, 8, 9, and 10) in droplet precautions for two weeks following admission to the facility to prevent the potential spread of COVID-19. Facility census was 38. Sample size was 10. Findings are: On 6/17/2020 at 10:50 AM, an interview with the facility's Administrator and DON (Director of Nursing) revealed that between 3/13/2020 and 6/1/2020 Residents 1, 2, 4, 5, 8, 9, and 10 were admitted to the facility from the local area hospital, assisted living facility, or community. They reported that these residents were all placed in private rooms, but droplet precautions for 14 days of quarantine were not put in place per CMS (Centers for Medicare and Medicaid Services) memo QSO-20-14-NH which was dated 3/13/2020 although the facility did have a copy of that document in their COVID-19 manual. The Administrator stated that because there was no COVID-19 in the local area and because all residents were being isolated in their rooms or wearing face masks when out of their rooms, they did not believe that droplet precautions were necessary. The Administrator also verified that of this group only Resident 1 had been tested for COVID-19 before admission to the facility, and Resident 1 was only tested once and had a negative result. The Administrator did provide a list of both staff and residents who had been tested for COVID-19, and all results were negative. Two residents who were admitted to the facility in June had two negative tests for COVID-19 either before being admitted to the facility or before being taken out of droplet precautions. On 6/17/2020 at 12:00 PM observations by surveyor P. Ramirez showed some residents eating lunch in their rooms while those in the dining room were seated one person to a table with the tables positioned to keep residents 6 feet apart. Residents in dining room waiting for the meal were not wearing masks. Review of the Progress Notes for Resident 5 from 3/13/2020 to 3/27/2020 showed that the resident was admitted for skilled nursing care following a cerebral infarction or stroke affecting the right side. A note on 3/18/2020 by therapy indicated the resident was receiving PT (Physical Therapy), OT (Occupational Therapy), and ST (Speech Therapy) several times per week but did not specify if this was being done only in the resident's room. A note on 3/19/2020 at 11:15 AM revealed that the resident had been left in the wheelchair in their room since being pushed back to the room after breakfast indicating that the resident was not being kept in a private room at all times to avoid possibly exposing others to COVID-19. None of the Progress Notes during that time period indicated any effort to isolate this resident to their private room or to use droplet precautions to prevent the possible spread of COVID-19. Review of the Progress Notes for Resident 8 from 3/13/2020 to 3/27/2020 showed that the resident was admitted for cancer of the esophagus with weakness following [MEDICAL CONDITION] and [MEDICAL CONDITION]. Progress Notes on 3/15, 16, and 17/2020 all stated eating meals at own table and keeping 6 feet distance from other residents. This demonstrated that the resident was not kept in isolation in a private room for 14 days after admission. A Progress Note on 3/18/2020 showed that the resident had been going to the dining room for meals. Notes on 3/20 and 22/2020 showed staff assist to and from dining room. Notes on 3/24, 25, 26, and 27/2020 also indicated that the resident had gone to the dining room for meals. None of the Progress Notes during that time period indicated any effort to confine this resident to the private room or to use droplet precautions to prevent the possible spread of COVID-19. Review of the Progress Notes for Resident 2 from 3/20/2020 to 4/3/2020 showed that the resident was admitted for cerebral infarction or stroke and also had a history of [REDACTED]. A Progress Note on 3/22/2020 revealed the resident was brought to the lobby yesterday to call a family member and although the resident had a cell phone it was difficult to hear. The note also indicated that when the resident's spouse called staff brought the resident to the phone. A Progress Note on 3/25/2020 indicated that the resident was working with PT, OT and ST multiple times per week but did not specify whether this was being done only in the resident's room. A Progress Note on 3/27/2020 revealed that the resident had breakfast in their room and lunch in the dining room. None of the Progress Notes during that time period indicated that this resident was confined to a private room, and no mention of the use of droplet precautions to prevent the possible spread of COVID-19 was seen. Review of the Progress Notes for Resident 10 from 3/25/2020 to 4/9/2020 showed that this resident arrived at the facility via family car with a family member on 3/25/2020 for unspecified injury of the muscle/fascia (connective tissue beneath the skin) and tendon of the abdomen following a fall. Two Progress Notes on 3/27/2020 at 12:19 PM and 12:21 PM related to medication administration revealed that while on an outing with family, the resident's family decided to take them to Kearney to get a neck brace before returning to the facility. A Progress Note at 6:45 PM on 3/27/2020 showed that the resident had returned from an outing with family with a neck brace in place. A Progress Note on 3/30/2020 stated that the resident was encouraged to come to the dining room as they ate better there. A Progress Note on 4/1/2020 indicated that the resident was working with PT and OT multiple times per week with no mention of whether this was done only in the resident's room. A Progress Note on 4/4/2020 revealed that the resident had their morning meal in the dining room. None of the Progress Notes during that time period indicated the use of droplet precautions or isolation in a private room to prevent the possible spread of COVID-19. Review of the Progress Notes for Resident 4 from 4/8/2020 to 4/22/2020 showed that the resident was admitted to the facility on [DATE] for a urinary tract infection and hypertension with an existing [DIAGNOSES REDACTED]. Progress Notes on 4/14 and 15/2020 showed that the resident was moved to the dining room for meals and did seem to eat better there. A Progress Note on 4/15/2020 indicated the resident was working with PT, OT, and ST multiple times per week but did not state whether this was done only in the resident's room. None of the Progress Notes during that time period indicated that the resident remained in a private room or that droplet precautions were used to prevent the possible spread of COVID-19. Review of the Progress Notes for Resident 9 from 5/6/2020 to 5/17/2020 showed that the resident came to the facility on [DATE] accompanied by a family member. A Progress Note at 3:42 PM on that date revealed that the resident was going up and down the hall in a wheelchair looking at the names on the doors to see if they knew anyone. Another note at 5:14 PM of the same day indicated that the resident was staying by the nurse's side to keep the resident safe as the resident was attempting to stand up and walk unassisted. Progress Notes on 5/7, 8, 11, 14 and 15/2020 revealed the resident was sitting in a wheelchair by the nurses station. A Progress Note on 5/14/2020 at 10:16 PM showed that the resident got up and ambulated in the hall 8 times before settling down. A Progress Note on 5/15/2020 revealed that the resident was moved to another room on that date but the note did not state whether this was a private room or whether transmission precautions were being used either before or after this move. A Progress Note by the dietician on 5/18/2020 stated that the resident dined at a verbal cue/assist table to encourage to consume maximum quantity of meals. None of the Progress Notes during this time period indicated that the resident was placed in transmission based precautions or confined in a private room to prevent the possible spread of COVID-19. Review of the Progress Notes for Resident 1 from 5/27/2020 to 6/8/2020 showed that this resident returned to the facility on [DATE] after being hospitalized for [REDACTED]. The list of residents tested for COVID-19 showed that Resident 1 had a negative test on 5/23/2020 but had not had a second negative test done before returning to the facility. A Progress Note on 6/8/2020 indicated that the resident had returned at 6:00 PM that day from an appointment to have her eye injected. During the interview with the Administrator and DON at 10:50 AM on 6/17/2020, the DON clarified that this resident was placed in transmission based</p>		
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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<p>F 0880</p> <p>Level of harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>(continued... from page 1)</p> <p>precautions following a visit to the eye doctor which was out of the local area. Observations on 6/17/2020 at 2:50 PM showed staff using gown, gloves, mask, and goggles when entering this resident's room for droplet precautions. The resident was in a private room. None of the Progress Notes reviewed between 5/27/2020 and 6/8/2020 indicated the use of droplet precautions or isolation in a private room to prevent the possible spread of COVID-19. A Progress Note on 6/9/2020 indicated that the resident had refused to get dressed that morning due to not wanting to wait while staff get all gowned up before entering the room. None of the previous Progress Notes indicated the use of transmission based precaution or the need for the resident to remain in a private room. These concerns were reviewed during an exit conference on 6/17/2020 at 5:25 PM, and at 5:45 PM the Administrator provided a written note of the facility's plan to continue to place all residents into isolation for 14 days when admitted or upon return to the facility from any appointment.</p>		