

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 285291	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/20/2020
NAME OF PROVIDER OF SUPPLIER BROOKESTONE ACRES		STREET ADDRESS, CITY, STATE, ZIP 4715 38TH STREET COLUMBUS, NE 68601	
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>Licensure Reference Number 12-006.17A Based on observation, record review and interview, the facility failed to prevent and contain Covid-19 by A) the failure to ensure staff screening was completed, and B) failure to ensure staff who had symptoms of Covid-19 were assessed. This had the potential to affect all residents in the building and the facility census was 59. Observation on 10/19/2020 at 1:15 PM at the front door of the facility revealed a GR-E (Guest Relations employee) stationed at the front door, where upon entering the GR-E explained the screening procedure, and temperature taken. The GR-E had the person fill out both the screening log and the screening checklist, and placed forms in a manilla envelope on the desk. Record review of employee facility screening log for Covid-19 revealed - the screening log for NA-G (nurse aide) had filled out Y (yes) to any of the following: the form reporting they had a cough, and on the Covid 19 screening checklist for visitors and staff and marked yes to the any of the following symptoms chills, shaking, loss of taste or smell, muscle aches, headache, diarrhea, fatigue, congestion, runny nose, sore throat, nausea or vomiting. The Covid-19 screening checklist for visitors and staff revealed this individual had a respiratory symptom of a cough. An interview on 10/20/20 at 09:00 AM with GR-E (guest relations) revealed they are responsible for ensuring all the documents for the screening are complete. An interview on 10/20/20 at 11:14 AM with the DON (Director of Nurses) confirmed the Guest Relation staff are responsible for ensuring the documents for screening are complete. The DON confirmed there is not further follow up to ensure the screening was completes and follow up assessment was done. An interview on 10/20/20 at 11:15 AM with the Administrator revealed the expectation of the staff when entering and screening into the building was to answer the questions at the front if the answers to the questions are no then they would proceed to the front desk and fill out 2 forms, the log and the screening form.</p>		
F 0882 Level of harm - Minimal harm or potential for actual harm Residents Affected - Many	<p>Licensure Reference Number 175 NAC 12-006.17 Based on record review and interview the facility failed to have a certified (Infection Preventionist) IP. This had the potential to affect all resident in the facility. The facility census was 59. Findings are: An interview on 10/19/20 at 12:25 PM with the Administrator reported the facility had a Certified IP. The IP worked limited hours, 4 hours per week. Record review for the IP certification revealed; the survey team requested the certification document for the IP. An interview with the Administrator on 10/19/20 at 2:24 PM confirmed the facility did not have a certificate for the IP. An interview on 10/20/20 at 9:20 AM with RN-A confirmed RN-A were just filling in for the IP since July 2020. The IP left in July 2020 and the DON left in October 2020. RN A reported RN-A spend 1 hour per week gathering information for the QA (Quality Assurance Meeting) during the time they were scheduled as a floor nurse. An interview on 10/20 20 at 10:50 AM with the Administrator confirmed the facility IP had left in July of 2020. The Administrator reported the facility DON (Director of Nurses) was to take the IP class. The DON had resigned and the last day at the facility was 10/2/20. The Administrator reported no staff member had been trained or scheduled for the IP class. Record review for the Key Personnel for the facility revealed there was not an IP on the Key Personnel List.</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.