STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285116	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clarkson Community Care Center Inc	212 Sunrise Drive Clarkson, NE 68629

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45613 Licensure Reference Number 175 NAC 12.006.09B Based on observation, interview, and record review; the facility failed to code the Minimum Data Set (MDS -a comprehensive assessment of each resident's functional capabilities used to develop a resident's plan of care) assessment to reflect the behavior of 1 (Resident 21) of 5 sampled residents. The facility census was 33 at the time of survey. Findings are: Record review of the Resident Assessment Instrument (RAI) User's Manual dated October 2023 revealed the following: -Code 1, behavior of this type occurred 1-3 days. -Steps for Assessment: -Review the medical record for the 7-day look-back period. -Interview staff, across all shifts and disciplines, as well as others who had close interactions with the resident during the 7-day look-back period, including family or friends who visit frequently or have frequent contact with the resident. -Observe the resident in a variety of situations during the 7-day look-back period. Record review of Resident 21's Admission Record revealed an admission to the facility on [DATE]. Review of Admission MDS dated [DATE] in Section C revealed a Brief Interview for Mental Status (BIMS - a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function) score of 14, which indicated a mild cognitive impairment. Record review of Resident 21's MDS dated [DATE] in Section E behaviors not exhibited was marked for physical behaviors towards others and verbal behaviors: (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Clarkson Community Care Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 212 Sunrise Drive Clarkson, NE 68629	

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No coded to the question: physical behavioral symptoms directed toward others. -No coded to the question: Verbal behavioral symptoms directed toward others. -No coded to the question: Other behavioral symptoms not directed toward others. Record review of Resident 21's nursing progress notes dated 8/7/24 revealed the resident had physical and verbal behaviors toward staff and other residents. Record review of Resident 21's Comprehensive Care Plan - (CCP- written instructions needed to provide effective and person centered care of the resident that meet professional standards of quality care) date initiated 4/18/22 revealed the resident has impaired thought processes. CCP date initiated 5/1/24 revealed behavior related to sexual phrases and inappropriate touching of other residents and staff. Record review of Resident 21's behavior monthly flow sheets for August 1-20th, 2024 revealed physical and verbal behaviors towards others documented on 8/7/24. Interview on 08/21/24 at 9:14 AM Licensed Practical Nurse (LPN) - E (who also completed the MDS) confirmed that Resident 21's behaviors documented on 8/7/24 were not marked on the MDS dated [DATE] and should have been. Interview on 08/21/24 at 9:19 AM the Director of Nursing (DON) confirmed that they use the RAI manual to ensure MDS accuracy. Interview on 08/21/24 at 09:21 AM the Social Services Director (SSD) confirmed the social work completed section E of the MDS and it was completed before the Assessment Reference Date (ARD) date and it did not include the behaviors that were documented on 8/7/24 and should have. It was further confirmed that the SSD does not look at the behavior monthly flow sheets or the target behaviors and there was no family or staff interviews done. Also confirmed there was no Social Service progress note during the assessment period of 8/1/24 through 8/8/24.

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. 45613 Licensure Reference Number NAC 12-006.090D Based on record reviews and interviews; the facility failed to obtain physician discharge orders, failed to prepare the resident and document plans for discharge, and failed to complete the discharge summary for 1 (Residnet 28) of 1 sampled resident prior to discharging the resident. The facility census was 33 at the time of survey. Findings are: Record review of the facility's policy titled Discharge Summary and Plan, dated December 2016 revealed that when a resident's discharge is anticipated a discharge plan will be completed. Record review of the facility's policy titled Discharge Documentation, dated December 2016 revealed that when a resident is discharged details of the discharge will be documented in the medical record. Record review of the facility's policy titled Discharge Summary and Plan, dated December 2016 revealed that a final summary of the resident's status will be completed at the time of discharge and will include a post discharge plan completed by the Interdisciplinary Team (IDT) and the resident/representative will be involved in the planning process. Record review of Resident 28's Discharge Summary dated 6/17/24 revealed the resident discharged from the long term care facility to assisted living on 6/17/24. Record review of Resident 28's Minimum Data Set (MDS-a comprehensive assessment of each resident's functional capabilities used to develop a resident's plan of care) dated 5/8/24 revealed a Brief Interview for Mental Status (BIMS-a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function) score of 14, which may indicate a mild cognitive impairment. Record review of Resident 28's Comprehensive Care Plan (CCP-written instructions needed to provide effective and person centered care of the resident that meet professional standards of quality care) dated 2/2/18 revealed plans for long term care placement. Record review of Resident 28's physician orders dated 6/17/24 revealed no physician order for discharge for Resident 28. Record review of Resident 28's Care plan meeting note dated 3/14/24 revealed the careplan team met with the resident and the resident's representative and did not discuss plans to discharge. Interview on 08/21/24 at 11:42 AM the Director of Nursing (DON) confirmed there was no discharge orders or transfer sheet completed for Resident 28 prior to discharge and there should have been. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/21/24 at 03:04 PM the Social Services Director (SSD) confirmed that there was no discharge planning for Resident 28 to move from the long term care to the assisted living. It was further confirmed that discharge was not discussed in the care plan meetings for Resident 28 and that the discharge summary was not completed upon discharge for Resident 28. Interview on 08/22/24 at 08:03 AM with the resident representative revealed that (gender) was not involved in any discharge planning assistance or teaching. It was further confirmed that discharge plans were not discussed in the careplan meetings for Resident 28.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 50348 Licensure Reference Number 175 NAC 12-006.18B Licensure Reference Number 175 NAC 12-006.17D Based on observation, record review, and interviews; the facility failed to utilize handwashing and gloving techniques to prevent the potential for cross contamination during the provision of care for 3 (Residents 2,11, and 14) of 12 residents sampled. The facility also failed to develop and implement policies and procedures to prevent and protect residents from an onset of the communicable disease Legionella (a bacteria that thrives in water, that has the potential to cause Legionnaires Disease, a type of pneumonia). This had the potential to affect all the residents. The facility failed to prevent the potential for cross contamination for staff testing for Covid. The facility census was 33. Findings Are. A. A review of the facilities Infection Prevention and Control Program policy dated 7/9/2024 revealed the following for Standard Precautions practice: -All staff should assume that all residents are potentially infected or colonized with an organism. -Hand hygiene is to be performed per facility policy -PPE should be used per facility policy. A review of the facilities Handwashing/Hand Hygiene policy dated 2001 revealed that hand hygiene must be performed: -Before and after performing any nonsurgical invasive procedures or an invasive device. -Before handling clean or soiled dressings, gauze pads etc. -Before moving from a contaminated body site to a clean body site during res care. -After contact with res intact skin, blood, or bodily fluids, -After contact with objects in the immediate vicinity of the resident. -Before and after isolation precaution settings. -After handling used or contaminated dressings or equipment. -After removing gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility competency Matrix-Finger Stick -Glucose Level Competency dated 2006, revealed the following steps for the procedure: -Perform Hand Hygiene and gather supplies. -Place glucose meter on a clean barrier. -Put on gloves prior to procedure and obtaining the blood. -Remove gloves and wash hands when procedure completed. A review of the policy Glucometer Disinfection dated 2020 revealed the following: -Glucometers should be cleaned and disinfectant wipe after each use leaving the disinfectant on the machine so that it dries. An observation on 8/20/24 at 11:30 AM the Liscensed Practical Nurse (LPN)-A placed a glucometer on Resident 11's table without a barrier. LPN-A performed a finger stick (a minimally invasive procedure that involves pricking the fingertip to collect a small amount of blood for testing) for Resident 11 glucose reading without gloves on. LPN-A then placed the blood drop onto the glucometer testing strip, and then removed the testing strip with blood and held it in [gender] bare hand while walking to the medication cart located in the hallway. LPN-A then opened the sharps container lid and placed the testing strip in the container. LPN then placed the glucometer in the medication cart draw. Observation did not reveal LPN-A cleaning the glucometer prior to storage. Next LPN-A touched the following without performing hand hygiene: -sides of the med cart, -top of the med cart, -computer keyboard, -computer screen, -keys to the med cart, -med cart lock, -drawer for the glucometer storage. An Interview conducted on 8/20/24 at 12:21 PM with LPN-A confirmed the following: -The glucometer was not placed onto a barrier. -No gloves were worn with Resident 11 while perfoming a fingerstick and appliying blood onto the test strip. -No gloves were worn to carry the used testing supplies back to the medication cart for disposal. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-That the glucometer machine was not cleaned after use nor prior to storage in medication cart drawer. LPN-A also confirmed the following items were then touched prior to performing any hand hygiene was completed: -The sharps container, -The top and sides of the med cart, -The computer keyboard and screen, -The keys and lock to the med cart, -The drawer for the glucometer storage. An interview on 08/21/24 at 1:00 PM with LPN-E revealed LPN-A should have completed hand hygiene and wore gloves prior, during and after residnet cares per facility policy and CDC recommendations. LPN-E further revealed that the facility follows CDC guidelines and standards of care. An interview on 8/21/24 at 1:15 PM with the DON confirmed that it is the expectation that items used for glucose testing should be disposed of while wearing gloves, and the glucometer is to be disinfected prior to storage. DON also confirmed it is the expectation of all the staff to complete hand hygiene and use gloves prior to, during, and after any procedure involving resident cares, or any process in which Standard Precautions would be applied. B. An observation on 8/20/24 at 12:30 PM of LPN-A administering medications through a Gastrostomy tube (GT a tube placed into the stomach that can be accessed on the outside of the body, used for nutrition and medication administration) for Resident 2 was completed. The LPN-A did not perform hand hygiene nor complete a glove change between the following steps of the procedure: -After auscultation (listen to) for the GT placement and before checking a wound dressing site surrounding the GT. -When LPN-A touched a wound dressing (that was saturated with a thick greenish red drainage, and the GT port entry was a strawberry red color), replacing it, then gathered wound care supplies. -When LPN-A gathered wound care supplies to change the wound dressing. -When LPN-A changed a wound dressing, and then completed medication administration per GT. The following items in the resident's room were touched while LPN-A was gathering supplies and in the process of a procedure wore the same gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The bedside table. -The residents gown. -The residents' linens. -The resident pillow -The closet door. -The cartons that the dressings were in. -The clean dressing supplies. -Drawer to the bedside stand. -The GT port access. -The abdominal binder. An interview on 08/21/24 at 1253 AM with LPN -A confirmed that the following noted steps/procedures were completed without hand hygiene and that the same gloves at been worn for the following: -From GT auscultation to GT wound care, - When obtaining supplies - When changing the GT wound dressing - When administering the medications through a GT. LPN-A then confirmed that the following items in the resident's room were touched with the contaminated gloves. -The bedside table. -The residents gown. -The residents' linens. -The resident pillow -The closet door. -The cartons that the dressings were in. -The clean dressing supplies. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Drawer to the bedside stand. -The GT port access. -The abdominal binder. -The bedside table. An interview on 08/21/24 at 1:00 PM with LPN-E confirmed that per facility policy and CDC recommendations, that LPN-A was to use hand hygiene and wear gloves before any procedure that involves blood or body fluids. LPN-E states that the facility follows CDC guidelines and standards of care. An interview on 8/21/24 at 1:15 PM with the DON confirmed that it is the expectation that items used for glucose testing should be disposed of while wearing gloves, and the glucometer is to be disinfected prior to storage. DON also confirmed it is the expectation of all the staff to complete hand hygiene and use gloves prior to, during, and after any procedure involving resident cares, or any process in which Standard Precautions would be applied. C. A review of the undated Catheter Care Policy revealed the following: -perform hand hygeine and don clean gloves prior to procedure, -pull back the foreskin and use a clean wipe to wipe around the meatus with an outward motion, then continue on down the penis shaft, -Remove gloves and perform hand hygiene. An observation on 8/21/24 at 10:15 AM of Nurse Aide-B providing perineal and catheter cares on Resident 14. NA-B completed the upper body bathing and dressing. The supplies were gathered for the resident cares. NA-B did not remove gloves after bathing Resident 14. During the observation NA-B touched the bed frame, headboard, call light, bed remote, and the packages containing the supplies for cares using the same gloves. NA-B then removed Resident 14's brief for disposal touching the inside of the brief while removing it from underneath the resident The brief was soiled with urine. NA-B put the brief in the trash and then performed peri care (the practice of washing the genital and anal areas of the body). NA -B completed the peri care, dried the areas with a towel and then stated to provide foley catheter cares. There was not a doffing (taking off) of gloves and hand hygiene in between procedures. NA-B then completed peri cares. When these procedures were completed, the NA gathered the supplies and placed the on the bedside table and the sink located in the resident's room. NA-B then doffed gloves and washed hands. An interview on 8/21/24 at 10:30, with NA-B confirmed that there was not a glove change prior to providing peri care, and that again gloves were not changed prior to catheter cares. NA-B confirmed that gloves worn throughout both provisions were used initially for the bathing and dressing of Resident 14's upper body. The NA also confirmed [gender] touched or handled of the following with dirty gloves: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The residents headboard and bedframe. -The residents call light. 'The remote to the bed. -The packages that contained the cleansing supplies. NA-B also confirmed that there was contact with her gloved hands to the inner portion of the soiled brief and hand hygiene was not completed. An interview on 08/21/24 at 1:00 PM with LPN-E confirmed that per facility policy and CDC recommendations, staff are to use hand hygiene and wear gloves before any procedure that involves blood or body fluids, or the possibility of a communicable disease. LPN-E states that the facility follows CDC guidelines and standards of care. An interview on 8/21/24 at 1:15 PM with the DON confirmed that it is the expectation for all the staff to complete hand hygiene and use gloves prior to, during, and after any procedure that they are performing resident cares and may be exposed to blood, body fluids, and/or a communicable disease. That the facility follows the CDC recommendations for Standard Precautions and infection control. D. A review of the Infection Prevention and Control Program policy dated 2024 revealed under #17-Water Management: - A water management program has been established as part of the overall infection prevention and control program -Control measures and testing protocols are to be in place to address potential hazards An interview on 08/20/24 at 8:47 AM with the Maintenance Director (MD) confirmed that there is not a Water Management Program for Legionella at the facility. An interview on 8/21/24 at 1330 with the DON confirmed that there is not a water management program for Legionella at this time. A review of the policy Coronavirus testing dated 2020 and under the section Conducting Testing #5 states the following: -The facility will maintain proper infection control and use recommended personal protective equipment (PPE). E. A further review of the policy under Documentation of Testing letter H revealed the following: -The facility will document staff test results in a secure manner. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation on 8/22/24 at 08:15 AM of the facilities nurse's station (located just inside the entrance of the facility) revealed the following: -Covid testing kits located behind the counter and accessible to anyone. -2 used tests on the desk top complete with name of staff member, results showing in plain sight, and no barrier underneath the used tests. -A list of employee's names that had tested , as well the test results. In plain sight. -No hand sanitizer, no gloves, no other forms of PPE (Personal Protective Equipment) (supplies used to protect one from communicable disease.). were located near where the employees were completing these tests. -No disinfecting wipes of any kind located near the covid station. -No staff were within eyesight. An interview on 8/22/24 at 8:30 AM with LPN-E confirmed that the testing station was not in an appropriate location, and that there was a list of documented staff information with the results of testing laying on top of the desk in view of Covid testing supplies, used covid tests long the nurse's station, and no barrier underneath. Also confirmed that there was not appropriate testing equipment out as missing was the antibacterial wipes or cleansing solution, no Personal Protective Equipment (PPE) (Protects a person from communicable disease). 48271 F. Observation on 08/22/24 07:15 AM Upon entering the facility the Dietary Manager was at the nurse's desk with 2 other staff members testing for COVID. The Test kits were sitting behind the nurse's desk. Staff then opened the COVID test kit and without gloves tested themselves. No gloves were used when they tested themselves and no barrier was placed down on the nurse's desk where they laid their test after swabbing their noses. There was no sanitizer anywhere by the nurse's desk. The sign in sheet on the desk with names of staff and results of the COVID test had 10 staff members on the list. An interview on 8/22/24 at 8:30 AM with the Infection control nurse confirmed that the testing for COVID was not to be done at the nurse's desk and that barriers and gloves should have been used and the barriers and gloves was not used.

Printed: 10/31/2024
Form Approved OMB
No. 0938-0391

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48271 Licensure Reference Number 175 NAC 12-007.04D Based on observations and interviews; the facility failed to ensure bathroom ventilation systems were functioning, preventing lingering odors from permeating for 11 (rooms 201, 202, 203, 204, 205, 207, 209, 210, 211, 212-and 214) of 12 rooms sampled. The facility census was 33. Findings are: Observations of the ventilation system in the residents bathroom's 201, 202, 203, 204, 205, 207, 209, 210, 211, 212-and 214 on 8/19/24 at 8:00 AM using 1 square ply of toilet paper revealed the ventilation system in the bathrooms were not functioning. Observations of the ventilation system in the residents bathroom's 201, 202, 203, 204, 205, 207, 209, 210, 211, 212-and 214 on 8/20/24 at 8:00 AM using 1 square ply of toilet paper revealed the ventilation system in the bathrooms were not functioning. Observations of the ventilation system in the residents bathroom's 201, 202, 203, 204, 205, 207, 209, 210, 211, 212-and 214 on 8/21/24 at 8:00 AM using 1 square ply of toilet paper revealed the ventilation system in the bathrooms were not functioning. Interview on 8/22/24 at 1:30 PM with the Maintenance Director confirmed that the ventilation system did not draw a 1 square ply of toilet paper in the bathrooms in room [ROOM NUMBER], 202, 203, 204, 205, 207, 209, 210, 211, 212-and 214. The maintenance director confirmed that the system is checked monthly as a safety check but that there is no documentation that the ventilation system in residents bathrooms were checked regularly to ensure they were operational.