STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285204	A. Building B. Wing	02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Haven	424 Harrison St Beemer, NE 68716

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 0606 Level of Harm - Potential for minimal harm Residents Affected - Many	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 45739 Licensure Reference Number 175 NAC 12-006.04A3b Based on record review and interview; the facility failed to ensure all newly hired staff had the required background screenings were completed for 4 out of 5 employee files reviewed. The facility census was 27. Findings are: Review of the facility policy: Abuse, Neglect, and Exploitation dated 12/21/23 revealed the facility screened potential employees for a history of abuse through background, reference, and credential checks; and the facility would maintain documentation of proof that the screening occurred. Review of employee file for Nursing Assistant (NA)-C revealed NA-C was hired 11/2017 and left the position on 4/10/23. NA-C was re-hired on 10/10/23. Further review revealed no documentation that a background check, Nebraska Adult Protective Services (APS) Central Registry/Nebraska Child Abuse and Neglect (CAN)Central Registry check, or a Sex Offender Registry check was completed upon NA-C's rehire. Review of the nursing schedule for February 2024 revealed that NA-C was currently working as a Nursing Assistant. Review of employee files revealed no documentation that the Nurse Aide Registry was checked upon hire for the following employees: -Staff-P who was hired on 12/6/23, -Staff-Q who was hired on 12/28/23, and -Staff-R who was hired 12/29/23. Interview with the Director of Nursing (DON) on 2/12/24 at 12:50 PM confirmed the Nurse Aide Registry was not checked for Staff-P, Staff-Q, and Staff-R upon their hire. Further interview with the DON on 2/13/24 at 7:00 AM confirmed NA-C did not have a new background check, an APS/CAN check, or Sex Offender Registry check completed upon their rehire.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285204	A. Building B. Wing	02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Haven	424 Harrison St Beemer, NE 68716

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45739 Licensure Reference Number 175 NAC 12-006.09A Based on record review and interview; the facility failed to ensure a new PASARR (Pre-Admission Screening and Resident Review- a tool used to ensure residents receive the care they require for mental illness) screen was completed related to a mental health diagnosis for 1 (Resident 4) of 1 sampled resident. The facility census was 27. Findings are: Review of the facility policy PASARR dated 2017 revealed the following: -the facility would coordinate assessments with the PASARR, -the purpose was to develop guidelines related to those with mental illnesses to ensure they received the care and services they needed in the most appropriate setting, and -the facility would refer all residents with newly evident or possible serious mental illness disorders for a Level II review. Review of Resident 4's Quarterly Minimum Data Set (MDS-a comprehensive assessment tool used in Care Planning) dated 12/5/23 revealed the resident had diagnoses of: Cerebrovascular Accident, Depression, Chronic Lung Disease and Psychotic Disorder; and no documentation that the resident was taking an antipsychotic medication (a type of psychoactive medication which alters chemicals in the brain to effect changes in behavior, mood and emotion. Review of the resident's Annual MDS dated [DATE] revealed the resident did not have a PASARR Level II determination and the resident was receiving an antipsychotic medication routinely. Review of Resident 4's PASARR screen dated 6/25/18 revealed on the resident's screen, it was marked no to the question that asked if the resident had a serious mental illness such as psychotic disorder. Review of Resident 4's Care Plan last revised 12/31/23 revealed no documentation that the resident had a Level II screen completed. Review of the facility facsimile (fax) to Resident 4's physician revealed a diagnosis dated 1/24/23 for Psychosis in absence of Dementia. Interview on 2/8/24 at 2:20 PM with the Director of Nursing (DON) confirmed the resident had a diagnosis of psychosis in absence of dementia and a new PASARR should have been completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285204	A. Building B. Wing	02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Haven	424 Harrison St Beemer, NE 68716

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. 42360 Licensure Reference Number 175 NAC 12-006.17 Based on record review and interview; the facility failed to implement an opportunistic waterborne pathogens plan, to prevent the growth of Legionella and other opportunistic waterborne pathogens in the facility's water system. This had the potential to affect all facility residents. The facility census was 27. Findings are: Reviewed the facility Legionella Management Policy dated 1/18 with a revision date of 1/24 revealed the following; the facility defined and controlled the management of Legionella bacteria in the water systems within the facility, the facility Legionella management team included the facility Administrator, the facility Maintenance Director, and the facility Infection Preventionist and or Quality Assurance Coordinator, the facility used a description of the water system using a flow diagram to identify areas where Legionella bacteria could grow, identified actions to prevent the growth and spread of Legionella and identified who was responsible for maintaining areas and cleaning frequencies. Record review revealed no evidence the facility had identified areas of potential concern through mapping of the facility water system. During an interview on 2/8/24 at 1:00 PM the facility Maintenance Supervisor confirmed no awareness of a facility plan to prevent the growth of waterborne bacteria in the facility water system. In addition, the maintenance department was not aware of any potential areas that had been identified as a potential for stagnant water to occur, or any knowledge of where to test the water system in the event a waterborne illness identified in the facility. In addition, the Maintenance Supervisor was unaware of what waterborne bacteria was, and how to prevent stagnant water from occurring in the facility water system. During an interview on 2/12/24 at 11:12 AM the Infection Preventionist (IP) confirmed the IP was unaware of the facility Legionella policy, had no knowledge of a mapping of the water system to identify potential waterborne illness, and was unaware of any plan for testing the system, should Legionella be identified. Further interview confirmed the IP was not aware what if any measures were in place to identify or prevent stagnant water in the facility water system.