STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285257	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COMMUNITY MEMORIAL HEALTH CENTER	P O BOX 340, 1015 F STREET BURWELL, NE 68823

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** License Reference Number: 175 NAC 12-006.17B Based on observations, record reviews and interviews; the facility failed to implement infection control precautions to prevent the spread of COVID-19 as: 1) residents on the Special Care Unit (SCU-secured area used to protect and better meet dementia residents' needs and to address behaviors associated with dementias) did not maintain at least 6 feet distance between residents and/or wear masks (the facility reported 16 residents resided on the SCU); 2) staff failed to disinfect a pulse oximeter (small, clip-like device that attaches to a body part and measures the amount of oxygen in the blood) between resident uses; 3) staff failed to follow contact precautions for 1 (Resident 3) of 7 sampled residents; 4) staff failed to utilize appropriate hand hygiene and gloving when cleaning after the breakfast meal; 5) staff failed to ensure forms were completed for staff screening; and 6) the facility failed to ensure visitors were restricted based on the current guidance. This had the ability to affect all of the residents. The total sample size was 19 and the facility census was 57. Findings are: A. Review of the facility policy Cleaning and Disinfection of Portable Equipment with an implementation date of 5/20/20 revealed it was the policy of this facility to follow infection control principles to prevent the spread of infection through contact with portable equipment in the resident's care environment. The following guidelines were identified: -the manufacturer's guidelines for use, cleaning and disinfection were to be reviewed; -staff were to perform hand hygiene when using equipment, between resident contact and accessing the equipment; -cleaning to be performed daily and between residents; and -staff to use a clean barrier between the equipment and the surface on which the equipment was placed. B. On 6/26/20 at 9:30 AM the following was observed: -without performing hand hygiene, Medication Aide (MA)-E removed a pulse oximeter from the top of the medication cart and approached Resident 7, who was seated at the dining room table with the breakfast meal; -without using a clean barrier, MA-E placed the pulse oximeter directly on the dining table and next to the resident's drinks, silverware and food items; -MA-E proceeded to place the pulse oximeter on the resident's finger to obtain a reading; -after completion of task, MA-E returned to the medication cart and without placing a clean barrier positioned the pulse oximeter directing on the top of the cart; and -MA-E failed to clean the pulse oximeter after use for Resident 7 and to perform hand hygiene before continuing to pass medications. During an interview on 6/26/20 at 9:37 AM, MA-E indicated staff were to perform hand hygiene before and after any resident contact. In addition, MA-E indicated the pulse oximeter was used to check the oxygen levels of all residents on the SCU, the equipment should have been placed on a clean barrier and it should have been cleaned with a disinfectant wipe after use. C. Review of the facility policy COVID-19 Resident in Isolation dated 5/19/20 revealed the staff were to use a gown, gloves, N95 respirator mask and face shield/goggles before entering a resident's room who had been placed on isolation. The following instructions were identified regarding putting on Personal Protective Equipment (PPE): -perform hand hygiene using hand sanitizer; -put on isolation gown (tie all the ties on the gown); -put on N95 mask; -place on face shield or goggles: and -perform hand hygiene before putting on gloves. The following instructions were identified for removal of PPE: -remove gloves; -remove gown; -exit the resident's room; -perform hand hygiene; -remove the face shield/ goggles; and -perform hand hygiene. D. Observations of Nurse Aide (NA)-J on 6/26/20 from 9:42 AM to 9:55 AM revealed the following: -approached Resident 3's room wearing a surgical mask; -removed the surgical mask and placed it on top of a 3 drawer isolation cart outside of the resident's room; -without performing hand hygiene, NA-J removed an N95 mask form the isolation cart and placed on; -put on clean gloves followed by an isolation gown. NA-J failed to secure the ties of the gown and to put on a face shield or goggles before entering Resident 3's room and closing the door; -after completion of cares, NA-J opened the resident's room door and removed and discarded gloves and the isolation gown in a receptacle inside the entrance of the room; -removed N95 mask and donned surgical mask which remained on top of the isolation cart; and -failed to complete hand hygiene before exiting the area. During an interview on 6/26/20 at 10:05 AM, NA-J confirmed the following: -Resident 3 was on isolation precautions as the resident was a new admission; -should have performed hand hygiene before putting on PPE and after removal of PPE; and -failed to secure the isolation gown and to wear a face shield before entering the resident's room per the facility policy. E. Review of the Infection Prevention and Control Assessment Tool (undated) revealed there was to be no communal dining or activities and if a resident was out of their room, they were to practice social distancing and/to wear a mask. F. Observations of the SCU dining room on 6/26/20 at 8:45 AM revealed the following: -8 residents were seated in the dining room; -8 additional place settings were placed at the dining tables; and -the residents were not positioned 6 feet away from each other. An observation on 6/26/20 at 10:30 AM revealed 4 residents were in the SCU activity room, 2 residents were seated in wheelchairs in the corridor and were positioned side by side outside of the activity room, and 3 additional residents were grouped in a sitting area in the middle of the corridor. Residents were not [MEDICATION NAME] social distancing and were not wearing masks. Staff were positioned throughout the corridor but failed to assist the residents with following infection control precautions During an interview on 6/26/20 at 10:35 AM, MA-E confirmed the residents were not wearing masks when out of their rooms or [MEDICATION NAME] social distancing. In addition, MA-E confirmed all 16 residents who resided on the SCU were served meals in the dining room and residents could not be kept 6 feet apart. G. On 6/26/20 at 8:30 AM, the following was observed regarding removal of resident breakfast room trays on the 200 corridor: -MA-L was wearing a pair of disposable gloves and a surgical mask. MA-L propelled a cleaning cart which held a large basin and 2 buckets with a liquid solution. A single dishcloth was identified in one of the buckets; -MA-L entered resident room [ROOM NUMBER] and exited the room with the resident's soiled silverware which were then placed in one of the buckets. MA-L returned to the room and brought out empty glasses, a plate and a small serving bowl then placed items in the basin. MA-L returned to the room a third time with the dishcloth from the second bucket. MA-L used the dishcloth to wipe down the bedside table which had been used for the meal service. MA-L returned to the cart and replaced the dishcloth into the bucket; -MA-L failed to remove gloves and to perform hand hygiene before entering room [ROOM NUMBER] and repeating this process; and MA-L followed this pattern for the remaining resident rooms. During an interview with the Director of Nursing (DON) on 6/26/20 at 11:20 AM, the DON verified MA-L should have removed gloves and performed hand hygiene between entering each resident's room to prevent the potential for cross contamination. H. Review of the Long-Term Care COVID-19 Phasing Guidance dated 6/15/20 revealed in Phase 2 visitation was allowed for [MEDICATION NAME] care situations, including end-of-life and residents with significant changes in condition including psycho-social or medical issues. Review of the Facility Visitor Screening Log revealed 21 visitors had visited from 6/22/20 to 6/25/20. This included visitors for Residents 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, and 19. Review of the form provided by the facility on 6/26/20 identified residents on hospice/end-of-life and residents with a significant change in condition (decline) revealed Resident 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, and 19 were not identified as having met that criteria. I. Review of the Staff Assessment log dated 6/2020 revealed: - On 28 occasions the staff member did not identify if the Health Questionnaire had been completed. - On 9 occasions the staff member marked no for completing the

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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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) Health Questionnaire. - On 53 occasion the nurse completing the staff assessment was not identified. Review of the staff Professional Healthcare Providers Screening Questions forms revealed: - On 6/12/20 Environmental Services (ES)-O failed to actively screen for COVID-19 symptoms. - On 6/12/20 MA-R failed to actively screen for COVID-19 symptoms. - On 6/17/20 Dietary Employee (DE)-Q failed to identify travel history and failed to actively screen for COVID-19 symptoms. - On 6/18/20 ES-O failed to identify travel history and identified a symptom that could be associated with COVID-19, no further screening was noted. - On 6/21/20 MA-P identified a symptom that could be associated with COVID-19, no further screening was noted. - On 6/22/20 ES-O failed to identify travel history and failed to actively screen for symptoms of COVID-19. - On 6/23/20 Staff Member-N failed to identify travel history and failed to actively screen for symptoms of COVID-19. Interview with the Administrator on 6/26/20 at 11:15 AM confirmed staff were to complete the Professional Healthcare Providers Screening Questions form, be assessed, have their temperature checked by the nurse, and document findings on the Staff Assessment log prior to working. Further interview confirmed the facility started allowing visitors for any resident with a scheduled appointment when the facility transitioned to Phase 2 on 6/22/20.