STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285115	A. BUILDING _____ B. WING _____	**07/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARBOR CARE CENTERS-FULLERTON LLC	**PO BOX 648, 202 NORTH ESTHER FULLERTON, NE 68638**

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.** LICENSURE REFERENCE NUMBER 175 NAC 12-006.17 Based on observations, interviews and record reviews, the facility failed to implement infection control practices and Centers for Medicare and Medicaid Services (CMS) guidelines to prevent potential cross contamination including the spread of COVID-19 (a mild to severe respiratory illness that is caused by a coronavirus) related to the facility failure to ensure staff wore surgical masks within the facility, failure to ensure staff were able to identify eye protection was required when caring for residents in a grey zone (a transitional zone for asymptomatic residents who have been in an outside facility), failure to ensure staff temperatures were accurate, failure to follow up on questions indicated on screening sheets, and failure to ensure accurate information was documented on the screening tool. The facility failure had the potential to affect all residents in the building. The facility identified a census of 69. Findings are: A. Observation on 7/14/20 at 8:05 AM revealed the DON (Director of Nursing) was wearing a cloth mask. A box of cloth masks and a bin labeled for disposal of used cloth masks was noted near the screening station. The DON offered the surveyors a cloth mask after being screened. An observation on 7/14/20 at 8:20 A.M. revealed Employee E to have a cloth mask on. Observation on 7/14/20 at 8:45 AM revealed the ADM (Administrator) was wearing a cloth mask. Observation on 7/14/20 at 9:10 AM - 9:20 AM revealed some staff were wearing cloth masks and some staff were wearing surgical masks. Observation on 7/14/20 at 9:19 AM revealed Employee A was wearing a cloth mask. Interview on 7/14/20 at 9:19 AM with Employee A revealed they had been wearing cloth masks since staff were told cloth masks were acceptable to wear in the facility. Interview on 7/14/20 at 10:15 AM with Employee B revealed cloth masks were acceptable to wear in the facility, but Employee B preferred a surgical mask due to being easier to breathe. Interview on 7/14/20 at 1:25 PM with the ADM revealed the facility switched to using cloth masks in the past few weeks to conserve PPE (Personal Protective Equipment). The ADM revealed the facility did have enough PPE in the facility, and the facility's home office also has a stockpile that would be dispersed to the facility as required. The ADM revealed a PPE calculation was sent to the facility's home office every Friday. Review of the Establishing Zones COVID Policy dated 6/2020 revealed Green Zone (COVID free zone) PPE included surgical or cloth masks. Review of the Optimizing PPE policy dated 4/20 revealed cloth masks are a barrier, not personal protective equipment. Review of the CDC's Preparing for COVID-19 in Nursing Homes website page dated 6/25/20 revealed HCP (Healthcare Personnel) included nurses, nursing assistants, and persons not directly involved in patient care, but who could be exposed to infectious agents that could be transmitted in the healthcare setting, including dietary, laundry, environmental services, and administration. CDC guidance revealed HCP should wear a facemask at all time while they are in the facility, and cloth face covering should not be worn by HCP instead of a respiratory or facemask if PPE is required. B. The interview with Employee E on 7/14/20 at 8:20 A.M revealed that staff would wear a surgical mask in the gray zone with no mention of eye protection or face shield. Interview on 7/14/20 at 10:15 AM with Employee B revealed PPE required to care for residents in a Grey Zone included N95 masks, gloves, and gown, but eye protection was not required. Review of the undated facility education for Recommendations for PPE revealed the Standard Precaution heading listed mask, eye protection, and/or face shield recommended for procedures and patient care activities likely to generate splashes or sprays of blood, body fluids, and secretions. No note of eye protection was listed under the Contact, Droplet, or Airborne Precaution headings. Review of the undated Droplet Precaution sign revealed eye protection was not included in the list of required PPE. Review of the undated Airborne Precaution sign revealed eye protection was not included in the list of required PPE. Review of the undated facility Phasing Plan revealed the facility would isolate residents in a Grey Zone and PPE (Personal Protective Equipment) required for the Grey Zone include gown, gloves, eye protection, and N95 mask. If an N95 mask was not available, the facility would use surgical masks with a face shield. Review of the undated Review of Zones and PPE information sheet revealed the Grey Zone required gown, gloves, eye protection, and N95 mask. If an N95 mask was not available, the facility would use surgical masks with a face shield. C. A record review of the facility Covid-19 screening logs titled Staff Screening Sign In Sheet (SSSIS) dated 7/9/20 through 7/14/20 revealed staff documenting if the screening occurred upon entry to the facility or exit of the facility by an in or out response. The review of the SSSIS's revealed staff were placing this information in the column that was intended to address Covid-19 symptoms of Headache or Dizziness. A review of the SSSIS's for 7/10/20 revealed an entry with an illegible name and no temperature documented. The review revealed an SSSIS on 7/10/20 with no staff name documented. The review of the SSSIS's dated 7/9/20 through 7/14/20 revealed temperatures below 95.0 F had been documented 25 times with no evidence of a follow up evaluation. The review of the SSSIS's dated 7/9/20 through 7/14/20 revealed no date indicated on 10 occurrences. The review of the SSSIS's dated 7/9/20 through 7/14/20 revealed no time indicated on 3 occurrences D. An interview on 7/14/20 at 10:10 A.M. with the Administrator consisted of reviewing the facility staff screening sheets. During the interview, the Administrator confirmed that some forms were missing information such as a name or temperature readings. During the interview the Administrator confirmed that one of the thermometers had consistently low readings but was still being used. The interview confirmed that the facility required the staff to screen upon entering the facility but also prior to leaving the facility. The Administrator confirmed that several of the second temperature columns were blank. During the interview it was confirmed that the staff were indicating if the screen was upon entering or leaving the facility by documenting an in or out on the screening sheets. The interview confirmed that staff were writing their in or out in the column provided to address the symptom of Headache/Dizziness and that the symptom of Headache/Dizziness had not been answered.

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.