STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285203	A. BUILDING _____ B. WING _____	**08/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOOD SAMARITAN SOCIETY - BEATRICE	**401 S 22ND STREET BEATRICE, NE 68310**

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 -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.17B Based on observations, record reviews, and interviews; the facility failed to ensure staff donned doffed personal protective equipment (PPE) in a manner to prevent potential spread of infection. This had the potential to affect the residents in the 200 Hall. The facility census was 68. Findings are: A. An observation on 8/17/20 at 12:00PM revealed LPN (Licensed Practical Nurse) B put on isolation gown and went into room [ROOM NUMBER]. Within 2 minutes, LPN B exited the room with isolation gown, N95 mask and face shield on and wiped down face shield and walked back and forth in the hallway with isolation gown on. LPN B then removed isolation gown in the hallway and then went back into room [ROOM NUMBER] and disposed of gown in room. An interview on 8/17/20 at 5:05 PM with DON (Director of Nursing) revealed isolation gowns should be removed before leaving an isolation room. Record review of CDC (Center for Disease Control and Prevention) Preparing for COVID-19 in Nursing Homes Nursing Homes & Long-Term Care Facilities Updated June 25, 2020 revealed the following information: Position a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room. B. Observation on 8/17/20 at 3:40 PM revealed LPN -D walked out of room [ROOM NUMBER] with blue plastic gown into hallway. An interview on 8/17/20 at 3:40 PM with LPN-D revealed that when taking resident's vitals on the 200 unit, PPE gown and gloves are donned at nurse's station and then go to resident room. Blue gowns are worn in and out of resident rooms. Gowns are not changed due to only taking vital signs. Observation on 8/17/20 at 3:45 PM revealed LPN-D walked to nurse's station and into room [ROOM NUMBER] with same blue plastic gown on. An observation on 8/17/20 at 3:55 PM revealed LPN-D take resident 215's vitals. LPN-D then removed gloves, touched inside of gown tore the neck area open, slide gown down length of LPN-D body then stepped out of gown. LPN-D stated it's just so hard to get out of these gown I know I can only touch the inside of the gown and found this method to work best for me Record review of an undated Facility policy of putting on and taking off PPE revealed, Remove all PPE before exiting the patient room except a respirator; if worn. Remove the respirator after leaving the patient room and closing the door. The steps include remove gloves, Face shield, Gown, mask or respirator. The Gown's front and sleeves are contaminated. Unfasten gown ties, take care that sleeves don't contact your body when reaching for ties, pull gown away from neck and shoulders, touching inside of gown only, turn gown inside out, fold or roll into a bundle and discard in a waste container. Per the CDC (Center for Disease Control and Prevention) Preparing for COVID-19 in Nursing Homes Nursing Homes & Long-Term Care Facilities Updated June 25, 2020 revealed the following information: Position a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room. An interview on 8/17/20 at 5:0 6 PM with DON confirmed LPN-D should have removed gown before exiting each residents room and the LPN-D did not follow Infection Control Standards of practice when doffing of gown in room [ROOM NUMBER].

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.