STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285133	A. BUILDING _____ B. WING _____	**06/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HILLCREST HEALTH & REHAB	**1702 HILLCREST DRIVE BELLEVUE, NE 68005**

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** Licensure reference number 175 NAC 12-006.17 Based on observation, interview and record review; 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 related to failing to verify screening results for facility employees and failure to ensure use of Personal Protective Equipment (PPE) in isolation rooms which had the potential to effect all residents. The facility identified a census of 118. Findings are: A A record review of a Team Member Fitness For Duty Screen (TMFFDS, a screening tool for Covid-19 exposure) sheet dated 6/14/20 revealed that Employee A had symptoms of cough, sore throat or shortness of breath. Further review of Employee A's TMFFDS sheet revealed there was no evidence Employee A's symptoms were evaluated prior to allowing Employee A to work. B. A record review of the TMFFDS sheets dated 6/12/20 and 6/14/20 revealed that Employee B had symptoms of cough, sore throat or shortness of breath. Further review of Employee B's TMFFDS sheet revealed there was no evidence Employee B's symptoms were evaluated prior to allowing Employee B to work. C. A record review of the TMFFDS sheet dated 6/14/20 revealed that Employee C had symptoms of cough, sore throat or shortness of breath. Further review of Employee C's TMFFDS sheet revealed there was no evidence Employee C's symptoms were evaluated prior to allowing Employee 3 to work. D. A record review of the TMFFDS sheets dated 6/12/20, 6/15/20 and 6/21/20 revealed that Employee D had symptoms of cough, sore throat or shortness of breath. Further review of Employee D's TMFFDS sheet revealed there was no evidence Employee D's symptoms were evaluated prior to allowing Employee D to work. E. A record review of the TMFFDS sheet dated 6/15/20 revealed that Employee E had symptoms of cough, sore throat or shortness of breath. Further review of Employee E's TMFFDS sheet revealed there was no evidence Employee E's symptoms were evaluated prior to allowing Employee E to work. F. On 6/22/20 at 3:11 P.M. an interview was conducted with the facility Administrator. During the interview, a review of the TMFFDS sheets for Employees A, B, C, D and E dated 6/12/20, 6/15/20 and 6/21/20 was completed. The facility Administrator confirmed there should have been follow up regarding Employee A, B, C, D and E's symptoms and was not. G. On 6/22/20 at 10:25 A.M. an observation revealed Employee F to be exiting a gray zone room, room [ROOM NUMBER], with a bag in hand which was being taken to the dirty utility room. Employee F was observed to have a surgical mask in place with no face shield or eye protection. H. On 6/22/20 at 1:55 P.M an interview with Employee L revealed that face shields were not available for use on the gray zone and that the goggles which the facility had available did not fit over eye glasses, so their eye glasses were considered their protection device. Record review of a CDC Coronavirus Disease 2019 (COVID 19) sheet dated 6-19-2020 revealed the following information: -Eye Protection: -Personal eyeglasses's and contact lenses are NOT considered adequate eye protection.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE