STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285221	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AZRIA HEALTH BROADWELL	800 STOEGER DRIVE GRAND ISLAND, NE 68803

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 12-006.17B LICENSURE REFERENCE NUMBER 175 NAC 12-006.17D Based on observation, interview, and record review; the facility failed to follow CMS (Centers for Medicare and Medicaid) and CDC (Centers for Disease Control) infection control guidelines to prevent potential cross contamination and prevent the potential spread of Covid-19 by: failing to clean and disinfect the whirlpool and the whirlpool lift scale chair which had the potential to affect 1 resident (Resident 21); failing to clean and disinfect the shower which had the potential to affect all 40 residents who used the shower (Residents 3, 19, 20, 22, 1, 23, 18, 24, 25, 26, 27, 28, 29, 30, 10, 31, 32, 33, 17, 34, 35, 36, 4, 37, 38, 14, 39, 40, 41, 42, 43, 2, 16, 44, 45, 46, 47, 48, 49, and 50); failing to perform hand hygiene (hand washing using soap and water or an alcohol based hand rub (ABHR) to remove germs for reducing the risk of transmitting infection among patients and health care personnel) before and after donning gloves and when hands were soiled before handling care and hygiene products in the bath house which had the potential to affect the 41 residents who were bathed in the bath house (Residents 21, 3, 19, 20, 22, 1, 23, 18, 24, 25, 26, 27, 28, 29, 30, 10, 31, 32, 33, 17, 34, 35, 36, 4, 37, 38, 14, 39, 40, 41, 42, 43, 2, 16, 44, 45, 46, 47, 48, 49, and 50); failing to perform hand hygiene between residents and after hands were soiled during meal service in resident rooms for 9 residents (Residents 14, 15, 16, 17, 18, 40, 5, 6, and 7) and failing to ensure that staff wore the required Personal Protective Equipment (PPE) (protective clothing such as disposable gloves, gowns, face masks, and face shields worn to help prevent the spread of germs) including N95 respirator masks (a particulate-filtering face piece respirator that meets the U.S. National Institute for Occupational Safety and Health N95 classification of air filtration, meaning that it filters at least 95% of airborne particles) when in the rooms of residents under quarantine to prevent the potential for cross contamination and Covid-19. This had the potential to affect 25 residents (Residents 17, 15, 34, 43, 44, 39, 40, 14, 16, 48, 45, 46, 38, 41, 47, 56, 5, 6, 7, 8, 9, 10, 42, 52, and 53). The facility identified a census of 52 at the time of survey. Findings are: A. Review of the undated Penner Spas Cascade document received from the facility Administrator revealed the following: System Cleaning (After Every Bath): Clean and disinfect the tub after every bath with Penner Cleaner/Disinfectant as follows: 1. Close and lock the door. 2. Press the Tub Fill Button and turn the Temperature Control Knob all the way to the left to its warmest level to heat the disinfectant solution and maximize its effective ness. 3. Remove any visible tissue, residue, or fluids from the tub by pressing the Shower Button and rinsing the inside tub surfaces with the shower sprayer. 4. Press the Fill Button again to turn off the water. Allow the tub to drain, and place the drain plug over the drain. 5. On the Aqua-Aire Tubs, press and hold the Disinfect Button located on the left side of the tub. As the button is held down, the properly mixed cleaning solution is running through the air injection system and out all of the air jets. Release the button after you see solution coming out of all the air jets and you have 1 to 1 gallons of disinfectant solution in the foot well of the tub. 6. Using the long-handled brush, available from your Penner distributor, thoroughly scrub all interior surfaces of the tub with the solution that remains in the foot well of the tub. Let disinfectant stay on surface for 10 minutes (Or, as recommended by the instructions on the disinfectant concentrate container.) 7. Remove the plug from the drain. 8. Rinse the tub's interior surfaces thoroughly with the shower sprayer. 9. Press and hold the Rinse button located on the left side of the control panel until clear water runs from all the air jets. Then release the Rinse button. 10. Finish rinsing the interior surfaces of the tub with the shower sprayer. 11. Start the air blower by pushing the Aqua-Aire Button. Allow it to run for 30 seconds. This pushes the rinse water out of the air injection system. If this was the last bath of the day, allow the blower to run for 2 minutes to dry out the system. 12. Stop the Aqua-Air blower by again pushing the Aqua-Aire button. 13. Visibly check that the tub and the reservoir (if applicable) was effectively cleaned during the disinfecting procedure. If not, repeat the procedure. Review of the undated facility procedure Whirpool (sic) Cleaning received from the facility Administrator revealed the following: 1. Wash hands before starting task following Hand Hygiene Procedure. 2. Ensure bath spa door is in locked potion (sic). 3. Press the Tub Fill Button and turn the Temperature Control Knob all the way to the left to its warmest level to heat the disinfectant solution and maximize its effectiveness. 4. Remove any visible tissue, residue, or fluids from the spa by pressing the Shower Button and rinsing the inside spa surfaces with the shower sprayer. 5. Press the Tub Fill Button again to turn off the water. Allow the spa to drain, and place the drain plug over the drain. 6. Press and hold the Disinfect Button located on the control panel on the side. As the button is held down, the properly mixed cleaning solution is running through the air injection system and out all the air jests (sic). Release the button after you see solution coming out of all the air jets and you have 1 to 1 gallons of disinfectant solution in the foot well of the spa. 7. Using scrub brush: was all interior surfaces of the spa. Let disinfectant say on surface for 10 minutes to properly disinfect. Tub MUST stay wet with disinfectant for a full 10 minutes so you may need to spray more disinfectant on the tub with the spray bottle during the 10 minutes. 8. After 10 minutes remove the plug from the drain. 9. Rinse the spa's interior surfaces thoroughly with the shower sprayer. 10. Press and hold the Rinse button located on the control panel on the side until clear water runs from all the air jets. Then release the Rinse button. 11. Finish rinsing the interior surfaces of the spa with the shower sprayer. 12. Start the air blower by pushing the Aqua-Aire button. Allow it to run for 30 seconds. This pushes the rinse water out of the air injection system. If this was the last bath of the day, allow the blower to run for 2 minutes to dry out the system. 13. Stop the Aqua-Aire blower by again pushing the Aqua-Aire button. 14. Visibly check that the spa was effectively cleaned during the disinfecting procedure. If not, repeat the procedure. 15. If there is a delay of one or more hours before the next bath, we recommend using a towel to wipe off all excess water. This will keep your spa looking great for years to come. To change out disinfectant, use small key next to the wall, put pressure under the key whole (sic) while turning to open and close panel. Get a new bottle from the bottom cabinet and unscrew the hose from the top of the old bottle and put the hose in the new bottle, put back in place and throw away the old bottle. On spray bottles follow directions to fill the bottle it is to 1 ounce of disinfectant to 32 ounces of water. Observation on 7/14/2020 at 10:17 AM of NA-B (Nurse Aide) cleaning the facility Penner Spa whirlpool tub revealed the following: NA-B put the plug into the tub and pushed the Tub Fill button. Water flowed into the tub through the tub fill spout. NA-B filled the foot well of the tub with water, then NA-B pushed the tub fill button and the water stopped. NA-B then pushed the disinfect jets button for a few seconds. While NA-B was holding the disinfect jets button, they turned the tub fill button back on and water continued to flow into the tub through the tub fill spout. With the water still running into the tub through the tub fill spout, NA-B picked up a brush from the top of the tub and started scrubbing the tub. The water continued to run into the tub as NA-B scrubbed the sides of the tub with the brush. Interview with NA-B at this time revealed they did not know what the concentration of the whirlpool tub disinfectant was supposed to be. NA-B then turned the aqua air jets on then scrubbed the inside of the tub with the brush. The inside of the tub was wet and the jets were started at 10:20 AM. Observation at this time revealed the whirlpool lift chair was sitting in the hall. NA-B did not put it in the tub or clean it. Interview with NA-B at this time revealed all of the residents used the tub except the residents who were on quarantine. They were receiving bed baths. NA-B shut off the aqua aire button then NA-B rinsed 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) tub at 10:26 AM with the sprayer attachment after NA-B pulled the plug and let the water drain. NA-B then rinsed the jets with the rinse jets button until the water ran clear. NA-B then said they were done cleaning the tub. NA-B did not run the air jets when they were done cleaning the tub. NA-B did not leave the disinfectant on for 10 minutes per the Penner directions and facility directions to clean and disinfect the whirlpool. NA-B did not clean the outside of the tub or the control panels or the shower sprayer. NA-B did not put the concentration of disinfectant on the tub per the manufacturer's directions or through the jets as NA-B had diluted the disinfectant with water by filling the foot well of the tub with water and allowing the water to continue to run into the tub while NA-B dispensed the disinfectant into the tub. Interview with NA-B on 7/14/2020 at 10:27 AM revealed the residents sat on whirlpool chair while being bathed in the tub. NA-B pointed to the chair with a lift that was on wheels sitting in the hallway and confirmed it was the whirlpool bath chair. NA-B confirmed they should have had the chair in the tub to clean it when NA-B cleaned the whirlpool but it was being used on the hall for a scale to weigh the residents. NA-B revealed they were to disinfect the chair before and after they were taking it out of each resident's room when they weighed the residents. At 10:31 AM Surveyor requested NA-B demonstrate how they cleaned the whirlpool chair if they were using it for a scale. At 10:32 AM NA-B took wipes from a tub of MicroKill Bleach Wipes and NA-B wiped the top of the whirlpool chair seat after wiping the handles then NA-B wiped the legs of the chair. NA-B was done wiping the chair at 10:33 AM. NA-B did not wipe the underside of the seat or the inside of the seat opening. Interview with NA-B at this time confirmed the whirlpool lift chair did go into the tub to be submerged in the water and was used for the residents who received whirlpool baths. Interview with the DON (Director of Nursing) on 7/14/2020 at 10:32 AM confirmed the whirlpool bath chair was being used on the halls/units to weigh the facility residents. Interview with RN-A (Registered Nurse) on 7/14/2020 at 10:53 AM revealed 1 resident used the whirlpool tub for bathing. Surveyor requested RN-A provide all of the documentation of every resident in the facility for the last 60 days specifically what they received for a bath as documented in the EHR (Electronic Health Record). Interview with NA-B on 7/14/2020 at 11:39 AM revealed they were using the scale to weigh residents on Cedar Cove and Birch Boulevard. Interview on 7/14/2020 at 11:41 AM with RN-A confirmed the whirlpool chair was being used to weigh the facility residents including the Aspen unit. RN-A revealed the whirlpool chair was supposed to be cleaned after it was used for weighing the residents before being used for the whirlpool bath. On 7/16/2020 at 11:11 AM the facility administrator provided the following response to the question: When the staff person is dispensing the disinfectant into the tub, is there supposed to be water in the tub and are they to continue to run water into the tub while they are dispensing the disinfectant, or does the disinfect jets button release the required concentration of disinfectant to disinfect the tub? (The) disinfect jets button release(s) the required concentration of disinfectant to disinfect the tub. On 7/16/2020 at 10:45 AM the facility Administrator provided the response to the following request for information: (What are) the specific directions on how to apply (the whirlpool disinfectant) and how long it has to remain on the surface for disinfection to occur? We follow the process that is on the sheets previously sent. The tub dispenses the correct amount of disinfectant. Interview with RN-A on 7/14/2020 at 12:05 PM revealed the facility did not keep their bath logs more than a week and they would provide the bathing reports from the EHR. Interview with RN-A on 7/15/2020 at 12:11 AM revealed the facility staff did not document what type of bath the residents received and was unable to provide the documentation from the EHR (Electronic Health Record). RN-A revealed they would send the bath schedule the nursing staff followed when giving baths. Review of the facility Bath List received from RN-A revealed Resident 21 was listed as receiving a W/P (whirlpool tub bath). B. Observation on 7/14/2020 at 11:45 AM revealed NA-B had gloves on. NA-B and NA-E assisted Resident 47 to stand up out of their wheelchair by touching Resident 47's arms, clothing, and fabric gait belt (a belt placed around the waist of a resident for the staff to use to support a resident during transfers) then sit on the whirlpool chair that was sitting out in the hall. The resident was dressed. Resident 47 was sitting on the seat of the whirlpool chair and touching the seat, the back, and the handles on the whirlpool chair. NA-B and NA-E performed a weight then NA-B and NA-E assisted Resident 47 into their wheelchair by touching Resident 47's arms and fabric gait belt, assisting Resident 47 to stand then sit in the wheelchair. NA-B then removed Resident 47's gait belt and draped the gait belt over the back of Resident 47's wheelchair. NA-B then entered the bath house wearing the same pair of gloves NA-B had touched Resident 47's arms, clothing and the gait belt with. The whirlpool chair was then left in the hall without being cleaned. Observation on 7/14/2020 at 11:48 AM revealed NA-B went into the bath house and with the same gloved hands they had used to assist Resident 47 with transferring, picked up a bottle of spray and NA-B sprayed the shower chair and the walls of the shower with the disinfectant. Using the same gloved hands, NA-B picked up 2 washcloths and then rinsed the walls of the shower and the shower chair at 11:50 AM with the shower attachment. NA-B then used the washcloths to dry the shower chair. NA-B did not spray the underside of the seat of the shower chair with the disinfectant. Interview with NA-B at 11:50 AM revealed NA-B followed this procedure between showering the facility residents. NA-B was done spraying, rinsing, and wiping the shower and the shower chair at 11:51 AM. Interview with NA-B at this time revealed they used Virex II 256 disinfectant to spray the shower. At 11:52 AM, NA-B removed the gloves and discarded them, picked up a bag of trash with their bare hands and took the trash into the shower room next door by grasping the door handle to open the door. NA-B then donned new gloves without performing hand hygiene. NA-B then got some MicroKill bleach wipes out of a tub and went out to the hall and wiped the whirlpool chair they had used to weigh Resident 47. NA-B did not wipe the inside of the seat, the underside of the seat or the inner rim of the seat opening. NA-B removed the gloves with the wipes and discarded them into the trash in the bath house. NA-B then picked up a towel with their bare hands and put it in the hamper in the bath house. NA-B then picked up a pen and wrote on a piece of paper that was on a 3 tiered stand next to the whirlpool. NA-B then picked up a bottle of shave cream, body spray, deodorant, lotion, and body wash from the top of the cart next to the whirlpool and put them into a bag sitting on a chair in the bath house. NA-B did not perform hand hygiene before handling the items after they had removed their gloves and used their bare hands to handle soiled linen. Interview with NA-B at this time revealed NA-B used the items for the residents. NA-B then took the trash out of the can in the bath house by pulling up the liner and tying a knot in the bag using their bare hands. NA-B then adjusted 2 boxes of gloves on the stand by the whirlpool. NA-B then put the trash bag on top of the hamper and put a new liner in the trash can with their bare hands. NA-B then got a pair of gloves out of the box and put them on without performing hand hygiene. NA-B then put items away in a cupboard in the bath house then tied the bag of laundry in the hamper. NA-B then went next door and put the trash in the shower room by handling the door knob then NA-B went down the hall with the hamper. Review of the undated facility procedure Shower Cleaning received from the facility Administrator revealed the following: 1. Wash hands before starting task following Hand Hygiene Procedure. 2. Remove any visible tissue, residue, or fluids form the shower by turning on the shower and rinsing the walls, floor, and shower chair surfaces with the shower sprayer. 3. Spray the walls, floors, and shower chair with disinfectant from the spray bottle. 4. Using scrub brush: wash all surfaces of the shower and chair top and bottom. Let disinfectant stay on surface for 10 minutes to properly disinfect. Shower and chair MUST stay wet with the disinfectant for a full 10 minutes so you may need to spray more disinfectant on the surfaces with the spray bottle during the 10 minutes. 5. After 10 minutes rinse the shower wall, floor, and chair surfaces thoroughly with the shower sprayer to remove all disinfectant. 6. Visibly check that the shower and chair was effectively cleaned during the disinfecting procedure. If not, repeat the procedure. Review of the Virex II 256 Reference Sheet revealed the following: For disinfection, all surfaces must remain wet for 10 minutes. Interview with RN-A on 7/14/2020 at 12:05 PM revealed the facility did not keep their bath logs more than a week and they would provide the bathing reports from the EHR. Interview with RN-A on 7/15/2020 at 12:11 AM revealed the facility staff did not document what type of bath the residents received and was unable to provide the documentation from the EHR (Electronic Health Record). RN-A revealed they would send the bath schedule the nursing staff followed when giving baths. Review of the facility Bath List received from RN-A after a list of residents who used the shower was requested revealed the following residents were listed for using the facility shower: Residents 3, 19, 20, 22, 1, 23, 18, 24, 25, 26, 27, 28, 29, 30, 10, 31, 32, 33, 17, 34, 35, 36, 4, 37, 38, 14, 39, 40, 41, 42, 43, 2, 16, 44, 45, 46, 47, 48, 49, and 50. Resident 21 was listed as receiving a W/P (whirlpool tub bath). C. Observation of NA-B on 7/14/2020 at 12:13 PM revealed NA-B wheeled a 3 tiered cart of meal trays down the hall. NA-B stopped in the middle of the hall with the cart and touched their face mask with their bare right hand. NA-B then took the bathhouse key down that was hanging on the outside of the door frame and went into the bath house. NA-B came out of the bath house with gloves in their hand. NA-B put one glove on the left hand then proceeded to push the cart by touching the handle with their right hand. NA-B did not put a glove on their right hand. NA-B then picked up a tray with food, drinks, and silverware and took the tray to into Resident 40 who was sitting in their room. NA-B set up the tray after they put it down on the table next to Resident 40. NA-B touched the items on the tray and handled the silverware. NA-B did not perform hand hygiene after touching their face mask,

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) handling the bath house key, or touching the door knob on the bath house. NA-B then took a tray of food to Resident 14 who resided in a different room. NA-B put the tray of food down in front of Resident 14 who was sitting in their room and touched Resident 14's wheelchair with their bare hand. NA-B then picked up a coffee mug that was sitting on Resident 14's table, brought out the coffee mug, handled it, and then put it on top of the cart that had the food trays on it. NA-B then picked up a tray of food and took food it to Resident 15 who resided in a different room. NA-B did not perform hand hygiene after they had handled Resident 14's wheelchair and the coffee mug that had been in Resident 14's room before taking a tray of food to Resident 15. NA-B still had the glove on the left hand and a bare right hand. NA-B put the food on the table in Resident 15's room, came out, and then NA-B took a tray of food off the cart in the hall to Resident 17 who resided in a different room. NA-B did not perform hand hygiene before taking a tray of food to Resident 17. Observation on 7/14/2020 at 12:10 PM revealed the DON was in the hall and observed NA-B when NA-B came out of Resident 14's room then went into Resident 15's room. The DON left the hall then at 12:17 PM the DON returned with a bottle of ABHR (Alcohol Based Hand Rub-product used to sanitize the hands in place of hand washing) and told NA-B they were supposed to use it and the DON placed the ABHR on the top tier of the tray cart. NA-B picked up the bottle of ABHR and applied a small amount onto their hands and rubbed their hands for 3 seconds then picked up a tray of food off the cart and took it into Resident 16 who was sitting in their room. NA-B did not cover all surfaces of their hands with the ABHR or scrub the hands until they were dry. NA-B then came out of Resident 16's room and took the food tray cart down the hall. NA-B applied a small amount of ABHR to their hands and performed a 3 second hand rub. NA-B did not cover all surfaces of their hands with the ABHR or scrub the hands until they were dry. NA-B then picked up a tray of food, drinks, and silverware and took food in to Resident 18 who was sitting in their room. NA-B handled the items on the tray. NA-B took the trays with food, drinks, and silverware into each resident's room and handled the items on each tray before leaving the trays with all of the items on them in the residents' rooms. The residents were then all observed feeding themselves and handling the items that NA-B had handled without performing hand hygiene. Interview with the DON on 7/14/2020 at 12:19 PM confirmed their expectation was for staff to perform hand hygiene between each resident while passing trays. The DON confirmed NA-B had contaminated their hands in Resident 14's room then took food to Resident 15 without performing hand hygiene. The hand hygiene and glove changing policy, policy for distributing meal trays, and the instructions for use for the ABHR the staff were using was requested from the DON. Interview with the DON on 7/14/2020 at 12:25 PM confirmed there were issues with NA-B's hand hygiene while NA-B was serving meals to the residents. Interview with RN-A on 7/14/2020 at 12:25 PM revealed NA-B had been trained and was expected to perform hand hygiene. Review of the facility policy Handwashing/Hand Hygiene revised August 2015 revealed the following: This facility considers hand hygiene the primary means to prevent the spread of infections. Wash hands with soap and water for the following situations: a. When hands are visibly soiled; and b. After contact with a resident with infectious diarrhea including, but not limited to infections caused by norovirus, salmonella, shigella, and [DIAGNOSES REDACTED]icile. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: b. before and after direct contact with residents; f. before donning sterile gloves; h. Before moving from a contaminated body site to a clean body site during resident care; i. after contact with a resident's intact skin; l. after contact with objects (e.g. medical equipment) in the immediate vicinity of the resident; m. after removing gloves; o. before and after eating or handling food; p. before and after assisting a resident with meals. 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. Washing Hands: 1. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) under a moderate stream of running water, at a comfortable temperature. 2. Rinse hands thoroughly under running water. Hold hands lower than wrists. Do not touch fingertips to inside of sink. 3. Dry hands thoroughly with paper towels and then turn off faucet with a clean, dry paper towel. 4. Discard towels into trash. Using Alcohol-Based Hand Rubs 1. Apply generous amount of product to palm of hand and rub hands together. 2. Cover all surfaces of hands and fingers until hands are dry. 3. Follow manufacturers' directions for volume of product to use. Applying and Removing Gloves 1. Perform hand hygiene before applying non-sterile gloves. 2. When applying, remove one glove from the dispensing box at a time, touching only to the top of the cuff. 3. When removing gloves, pinch the glove at the wrist and peel away from the hand, turning the glove inside out. 4. Hold the removed glove in the gloves hand and remove the other glove by rolling it down the hand and folding it into the first glove. 5. Perform hand hygiene. Review of the ABHR label with directions for use received from the facility Administrator revealed the following: Directions: wet hands thoroughly with product; rub hands together covering all surfaces until hands are dry. Review of the facility procedure Covid-19 Personal Protective Equipment revised 3/12/2020 revealed the following: Donning Step 1: Perform Hand Hygiene: Apply one pump of hand sanitizer to the cupped palm of one hand. Rub hands palm to palm. Rub the right palm over the back of the left hand with interlaced fingers and vice versa. Rub both palms together with fingers interlaced. With the left thumb clasped in the right palm, rub rotationally and switch. Cup the hands and place the back of fingers to opposing palms and rub side to side with fingers interlocked. Rotationally rubbing the clasped fingers of the right hand in a circular pattern on the palm of the left hand and vice versa. Continue to rub both hands together until the sanitizer is dry. Doffing Step 3: Gloves: Remove the gloves utilizing glove in glove technique. Doffing Step 4: Perform hand Hygiene: Perform hand hygiene for a minimum of 20 seconds or until the hand sanitizer is dry. Interview with the facility Administrator on 7/15/2020 at 3:47 PM revealed the facility did not have a policy for the delivery of meals specifically related to sanitation regarding staff hand hygiene between resident while passing trays. On 7/16/2020 at 10:01 AM the facility Administrator provided the responses to the following questions: Question: Are the facility staff expected to clean the whirlpool according to the facility procedure and the manufacturer's specifications? Administrator's response: The check list for whirl pool cleaning is taken from manufactures guidelines. Question: What is your expectation for the staff to clean the whirlpool chair? Administrator's response: Cleaning before and after each use. Question: Are they (facility staff) expected to clean all of the surfaces in contact with the resident after it (the whirlpool chair) is used for weighing residents before it is used to bathe residents? Administrator's response: Yes Question: What is your expectation for the staff to clean the shower chair? Are they expected to follow the facility procedure for cleaning the shower chair? Administrator's response: Yes Question: Do all of the facility residents listed on the bath list for shower use the shower chair? Administrator's response: Yes all use shower chair Question: Do all of the facility residents listed on the bath list for W/P use the whirlpool? Administrator's response: Yes Question: Are the staff expected to follow the contact time for the disinfectant used to disinfect the shower chair and the whirlpool? Administrator's response: They are to follow the check list previously provided Question: What is your expectation for staff to perform hand hygiene prior to donning gloves and after doffing gloves? Administrator's response: Yes Question: What is your expectation for staff to perform hand hygiene after handling garbage and soiled linens? Administrator's response: Wash their hands. Question: What is your expectation for staff to perform hand hygiene while they are passing meal trays between residents and when the staff person's hands come in contact with resident personal items? Administrator's response: They are to use ABHR in between Question: What is your expectation for staff to use the ABHR? (Do you feel a 2-3 second scrub is effective for hand hygiene?) Administrator's response: Follow directions on hand sanitizer to rub hand until dry. D. Record review of the facility document titled COVID-19 Guideline dated 6/11/20 revealed clarification for steps the facility will take to minimize exposures to respiratory pathogens (a bacteria, virus, or other microorganism that can cause disease) and promptly identify residents with clinical features. Prevention Measures: Step 2. Everyday standard precautions and preventive actions should be used and include: a. Appropriate hand hygiene. Observation on 7/14/20 at 11:59 AM revealed that the facility Dietary Manager (DM) pushed a cart of room meal trays to the room of Resident 5 and carried the meal tray into the room of Resident 5 (a resident under quarantine) with a Gray Zone (an area or room for asymptomatic admissions, readmissions, and residents that require out of facility appointments that are in 14 day quarantine) sign on the room door. The DM assisted the resident to open a drink container. The DM exited the resident's room carrying the plate cover and laid it on the cart. The DM did not perform hand hygiene. The DM carried a meal tray into the room of Resident 6 (a resident under quarantine with a Gray Zone sign on the room door). The DM pulled the privacy curtain inside the resident doorway aside to enter the resident's room. The DM exited the resident's room carrying a plate cover and laid the plate cover on the cart. The DM did not perform hand hygiene. The DM exited the hallway and walked toward the facility dining room. Observation on 7/14/20 at 12:11 PM revealed that Medication Aide-D (MA-D) was wearing a surgical mask and put on a face shield and gloves and carried a meal tray into the room of Resident 9 (a resident under quarantine with a Gray Zone sign on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285221	A. BUILDING _____ B. WING _____	**07/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AZRIA HEALTH BROADWELL	**800 STOEGER DRIVE GRAND ISLAND, NE 68803**

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	(continued... from page 3) the room door). MA-D removed the disposable gloves in the resident's room. MA-D exited the resident's room and did not perform hand hygiene. MA-D removed the face shield and wiped it with a Micro Kill Bleach wipe (a disinfectant wipe). MA-D performed hand hygiene with ABHR. MA-D put on the face shield and disposable gloves. MA-D carried a meal tray into the room of Resident 10 (a resident under quarantine with a Gray Zone sign on the room door). MA-D exited the resident's room and walked to the PPE cart. MA-D did not perform hand hygiene. MA-D removed the face shield and wiped it with a Micro Kill Bleach wipe and performed hand hygiene with ABHR. Record review of the facility policy titled Hand Hygiene dated August 2015 revealed that the facility considers hand hygiene the primary means to prevent the spread of infections. The section titled Policy Interpretation and Implementation revealed: Step 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, resident, and visitors. Step 7. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap and water for the fo