STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285067	A. BUILDING _____ B. WING _____	**07/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HOLDREGE MEMORIAL HOMES, INC	**1320 11TH AVENUE HOLDREGE, NE 68949**

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** Based on observation, interview, and record review, the facility failed to implement CMS and CDC recommended infection control practices in order to control and prevent the potential spread of COVID-19 amongst residents and staff. The facility failed to thoroughly screen staff reporting for work, and failed to ensure that staff did not enter resident areas, such as dining rooms, prior to being screened. The facility failed to implement quarantine measures for one resident (R1) who attended multiple appointments outside of the facility. Additionally, the facility failed to ensure that social distancing took place in two dining areas. Findings include: - Review of a nursing note, dated 6/24/20 at 9:58am, documented that R1 was out of the facility for an appointment with her physician. Facility staff educated R1 on COVID-19 precautions, and provided her with a facemask. Review of a nursing note, dated 7/1/20 at 10:02am, documented that R1 was out of the facility at an appointment with her physician. Facility staff educated R1 on COVID-19 precautions, provided a facemask, and educated direct care staff to wash R1's hands and clean her wheelchair when she returned. Review of a nursing note, dated 7/13/20 at 1:00pm, documented that facility staff transported R1 to [MEDICAL CONDITION] center for an appointment. Review of a nursing note, dated 7/15/20 at 9:30am, documented that R1 attended an appointment at her physician's office. Facility staff educated R1 on COVID-19 precautions, provided a facemask, and educated direct care staff to wash R1's hands and clean her wheelchair when she returned. On 7/15/20 at 11:07am, R1's room had no quarantine signage or personal protective equipment (PPE) available at the doorway. On 7/15/20 at 11:12am, facility staff escorted R1 in her wheelchair back to her room, after her physician's appointment outside the facility. R1 had a disposable surgical facemask in her lap, but did not wear it. Facility staff wore a disposable surgical mask. On 7/15/20 at 11:16am, Nurse Aide (NA1) entered R1's room to provide her personal cares. NA1 wore a disposable surgical facemask as they entered the room. At 11:21am, NA1 exited R1's room, performed hand hygiene with alcohol-based hand sanitizer, and walked down the hall. On 7/15/20 at 11:34am, NA1 indicated that R1 had returned from a doctor's appointment, and that NA1 assisted R1 with toileting. NA1 indicated that staff must wear a disposable surgical mask and gloves when providing direct care to residents. NA1 indicated that R1 was not on any kind of isolation or quarantine, because only residents who developed symptoms of COVID-19 were placed on quarantine. If a resident was on quarantine, facility staff were expected to wear an isolation gown, eye protection, a facemask, and gloves when entering the room. NA1 indicated that facility staff received training on the proper wearing of PPE a couple weeks ago. NA1 indicated that the facility had a good supply of PPE, located downstairs where staff could access it if needed. On 7/15/20 at 11:45am, Licensed Practical Nurse (LPN1) indicated that if any residents went out of the facility for physicians appointments, that those residents were not required to be put on isolation. LPN1 indicated that when a resident returned from an appointment, the facility staff would wash the resident's hands and wipe down the resident's wheelchair with disinfectant wipes. LPN1 indicated that new residents without symptoms were also not put on isolation. LPN1 indicated that the only time a resident would be placed on isolation would be if they developed symptoms similar to those of COVID-19. On 7/15/20 at 1:22pm, the Director of Nursing (DON) indicated that when a resident went out to a physician's appointment, facility staff provide the resident with a facemask. The physician's office screens all visitors, and upon return, facility staff would wipe down the resident's wheelchair with disinfectant wipes. The DON indicated that there was low spread of COVID-19 in the county. The DON indicated that residents would not be placed on isolation, but would be observed for development of any symptoms that could be related to COVID-19. If a resident developed symptoms, they would be placed on isolation. The DON indicated that the facility had a sufficient supply of PPE. Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options may include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. Residents could be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their exposure (or admission). Testing at the end of this period could be considered to increase certainty that the resident is not infected. If an observation area has been created, residents in the facility who develop symptoms consistent with COVID-19 could be moved from their rooms to this location while undergoing evaluation. Review of CDC recommendations, dated 4/15/20, titled Preparing for COVID-19: Long-term Care Facilities, Nursing Homes, documented: All recommended PPE should be worn during care of residents under observation; this includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. Cloth face coverings are not considered PPE and should not be worn by HCP. - On 7/15/20 at 8:15am, multiple residents sat in the first floor dining area within six feet of each other. Residents sat two to a table, failing to maintain appropriate social distancing. On 7/15/20 at 11:56am, in the third floor dining area, multiple residents sat at dining tables within six feet of each other, failing to maintain social distancing. At three tables, there were three residents seated at the table. Five additional tables had two residents at the same table. On 7/15/20 at 12:59pm, the Dietary Manager (DM) indicated that the larger dining room tables were five feet across, and that the smaller dining room tables were four feet across. On 7/15/20 at 1:22pm, the DON indicated that the facility attempted to practice social distancing among the residents, but could not always do so. The DON indicated that the residents of the facility all ate in the dining room during meals to increase socialization. Review of CDC recommendations, located in Preparing for COVID-19 in Nursing Homes, under the section Additional Strategies Depending on the Facility's Reopening Status, documented the following: Implement Social Distancing Measures Implement aggressive social distancing measures (remaining at least 6 feet apart from others): Cancel communal dining and group activities, such as internal and external activities. Remind residents to practice social distancing, wear a cloth face covering (if tolerated), and perform hand hygiene.

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