STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285197	A. BUILDING _____ B. WING _____	08/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOOD SAMARITAN SOCIETY - ALBION	P O BOX 271, 1222 SOUTH 7TH STREET ALBION, NE 68620

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 ensure infection control practices were in place to prevent the potential spread of COVID-19 related to residents not wearing masks in common areas in which they had the potential and/or were within 6 feet of others. This had the ability to affect all residents. The total sample size was 33 and the facility census was 55. Findings are: A. Review of the Long-Term Care COVID-19 Phasing Guidance dated 6/15/20 revealed facilities could move to Phase 3 if they met certain criteria. Further review revealed certain mitigation steps were to be implemented in Phase 3. The guidance revealed: - Communal dining was allowed with residents social distancing at least 6 feet apart or with appropriate barriers in place. - Limited group activities were allowed and expanded group activities were allowed with appropriate social distancing and the use of a cloth face covering or facemask. - Universal source control pertained to everyone in the facility. Residents and visitors were to wear cloth face coverings or facemasks, if able to tolerate and wear safely. B. On 8/24/20 at 7:30 AM 3 residents were seated together watching television in the day area. The residents (Residents 40, 21, and 17) were seated less than 6 feet apart and none of them were wearing a face covering or facemask. On 8/24/20 at 7:45 AM Residents 40, 21, and 17 remained in the day area watching television less than 6 feet apart without face coverings or facemasks on. No staff were observed encouraging/assisting residents to put on face coverings or facemasks. C. On 8/24/20 at 7:41 AM Resident 49 was observed pushing Resident 51 to the breakfast table. Resident 49 then assisted Resident 51 with putting on a clothing protector. The residents were less than 6 feet apart and neither resident had a face covering or facemask on. D. On 8/24/20 at 7:52 AM Resident 36 went up to Resident 27 (who was seated in a wheelchair in the hallway with eyes closed). Resident 36 got within 6 feet of Resident 27 and encouraged the resident to wake up and head out to breakfast. Neither resident had a face covering or facemask on. A staff member walked by and thanked Resident 36. No staff were observed encouraging/assisting residents with face coverings or facemasks and/or social distancing. E. Interview with the Director of Nursing (DON) on 8/24/20 at 11:45 AM confirmed the facility had transitioned to Phase 3. F. Observations on 8/24/20 from 7:30 AM to 8:40 AM revealed the following: - At 7:33 AM Resident 35 was seated in a wheelchair and was assisted from the resident's room out to the Nurse's Station by Medication Aide (MA)-D. Resident 35 was not wearing a mask; - At 7:47 AM Resident 43 self-propelled wheelchair from the resident's room, down the corridor and into the main dining room for the breakfast meal. Resident 43 was not wearing a mask. Resident 43 passed directly by Resident 35 who remained seated at the Nurse's Station and remained without a mask; - At 7:52 AM Resident 1 ambulated independently from the resident's room, down the corridor to the main dining room and was not wearing a mask. Resident 1 ambulated directly by Resident 35 who remained at the Nurse's Station; - At 7:55 AM Resident 41 was assisted out of the resident's room by MA-D and positioned across from Resident 35 in the corridor. Neither of the residents were wearing masks. MA-E was standing at the medication cart which was parked next to where the residents were seated. MA-E passed by both Resident 35 and 41 multiple times while passing medications but made no attempts to assist the residents with putting on a mask; - At 7:56 AM Resident 15 without wearing a mask ambulated out of the resident's room, down the length of the corridor and out to the main dining room. Resident 15 walked by both Resident 35 and Resident 41 who remained by the Nurse's Station without masks; - At 8:03 AM MA-D assisted Resident 35 from the Nurse's Station and out to the main dining room, the resident remained without a mask. MA-D passed by Resident 41 but failed to assist the resident with putting on a mask; - At 8:06 AM Resident 4 ambulated independently from the resident's room to the sitting area at the end of the hallway by the entrance to Memory Lane. The resident was not wearing a mask; - At 8:07 AM MA-D assisted Resident 19 out of the resident's room and then to the main dining room. The resident's wheelchair was propelled directly by Resident 41. Neither of the residents were wearing masks; and - At 8:38 AM Resident 41 propelled self out of the main dining room, through the corridors and back to the Nurse's Station on the resident's hallway. Resident 41 passed directed by MA-E who was at the medication cart. Resident 41 was not wearing a mask and MA-E failed to cue or to assist the resident with putting on a mask. During an interview on 8/24/20 at 9:37 AM, MA-D confirmed residents were to wear a mask when out of their rooms except when sitting in the dining room for meals. MA-E further confirmed staff should assist residents with placement of masks or should cue the residents to make sure masks were in place. G. Observation of Resident 3 on 8/20/20 at 10:30 AM revealed the resident was riding a stationary bike located in the common entry way area to Memory Lane and the resident was wearing a surgical mask below the chin and not covering the mouth and nose. Observation of Resident 14 on 8/20/20 at 1:05 PM revealed the resident sitting in a wheelchair and being pushed down the hall of Memory Lane by a nurse aid and not wearing a mask. Observation of Resident 28 on 8/20/20 at 1:12 PM revealed the resident was self-propelling a wheel chair down the hall of Memory Lane not wearing a mask. Observation of Resident 16 on 8/24/20 at 8:00 AM revealed the resident sitting in the hallway of Memory Lane in a wheel chair and not wearing a mask. Observation of Resident 6 on 8/24/20 at 8:05 AM revealed the resident sitting in a chair in the lobby area of Memory Lane reading a newspaper and not wearing a mask. Observation of Resident 28 on 8/24/20 at 8:05 AM revealed the resident sitting in a wheel chair within 2 feet of another resident having a conversation with another resident who was seated at a table preparing for breakfast. Resident 28 was not wearing a mask. Observation of Resident 3 on 8/24/20 at 9:00 AM revealed the resident wheeling through the hallway and between 2 tables set up for breakfast with one resident present at each table finishing breakfast. Resident 2 was not wearing a mask. Interview with Resident 24 on 8/20/20 at 1:30 PM confirmed that the resident was not aware that masks should be worn outside of resident rooms and the resident was not encouraged by staff to wear a mask when outside of resident rooms.

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