STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285226	A. BUILDING _____ B. WING _____	**06/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKEFIELD PARK	**1405 HERITAGE DRIVE ST PAUL, NE 68873**

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 12-006.17D Based on observation, interview, and record review the facility failed to ensure that staff performed 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 putting on gloves to prevent the potential for cross contamination for 5 residents (Residents 3, 4, 5, 6, and 7) and failed to assist residents with performing hand hygiene to prevent the potential for illness for 1 resident (Resident 5). The facility census was 48. Findings are: A. Record review of the facility document titled COVID-19 Guidelines dated 5-19-2020 revealed: Prevention Measures: -The facility maintains an Infection Prevention and Control Program. Everyday standard precautions and preventive actions should be used and include appropriate hand hygiene. Record review of the facility Hand Hygiene Competency dated 12.2019 revealed the Procedure Hand Hygiene section When to wash hands: -Before each resident contact -After touching a resident or handling their belongings -After handling contaminated items (linens/garbage/briefs, etcetera). -Before and after gloving Observation on 6/10/20 at 10:27 AM revealed that Nursing Assistant-A (NA-A) and Nursing Assistant-B (NA-B) entered the room of Resident 3. Resident 3 was lying on the bed. The Nursing Assistants checked the resident's brief and pulled up the resident's pants. The Nursing Assistants placed the lift sling (a fabric device with straps that is placed underneath a resident when a mechanical assistive device is used to transfer a resident with difficulty or inability to stand up on their own from a seated or lying position) underneath Resident 3. The Nursing Assistants connected the lift sling to the mechanical total body lift (a mechanical assistive device used to transfer a resident with difficulty standing up on their own) and transferred Resident 3 from the bed into the wheelchair. NA-A removed the disposable gloves and did not perform hand hygiene. NA-A removed the mechanical total body lift from the room and parked the lift just outside of the resident's room. NA-A re-entered the resident's room and straightened the bedding and pillow on the resident's bed. NA-A exited the resident's room and pushed the mechanical total body lift toward the room of Resident 4 and performed hand hygiene with ABHR. Observation on 6/10/20 at 10:45 AM at the room of Resident 4 revealed that NA-A and NA-B transferred the resident to the wheelchair with the mechanical total body lift. NA-B performed hand hygiene with ABHR and put on disposable gloves and wiped the total body lift with a disinfectant wipe. NA-B removed the disposable gloves and did not perform hand hygiene. NA-B pushed the total body lift to the storage area near the nurse's station. NA-A picked up the used trash bag from the trash can in the resident's room and carried the trash to the soiled room by the nurse's station, opened the soiled room door and disposed of the trash. NA-A then performed hand hygiene with ABHR. Observation on 6/10/20 at 10:48 AM in the room of Resident 5 revealed that NA-A and NA-B performed hand hygiene with ABHR. NA-B pushed the mechanical sit to stand lift (a mechanical assistive device used to transfer a resident with difficulty standing up on their own from a seated position) into the room. NA-A placed the mechanical sit to stand lift sling (a fabric device with straps that is placed around the back of a resident when a mechanical assistive device is used to transfer a resident with difficulty or inability to stand up on their own from a seated position)around the back of Resident 5 and the nursing assistants connected the mechanical lift sling to the sit to stand lift. The nursing assistants transferred Resident 5 into the bathroom. At 10:58 AM on 6/10/20 Resident 5 was transferred from the bathroom into the wheelchair beside the bed. NA-A removed the sit to stand lift sling from behind the resident and moved the sit to stand lift out of the room and parked it just outside of the resident's room. NA-A put on disposable gloves without performing hand hygiene. NA-A wiped the sit to stand lift using a disinfectant wipe. NA-A removed the disposable gloves and performed hand hygiene with ABHR. Observation on 6/10/20 at 11:01 AM in the room of Resident 6 revealed NA-A and NA-B transferred Resident 6 out of the bathroom using the sit to stand lift and seated the resident in the wheelchair. NA-A handed a doll to the resident. NA-B removed the lift sling from behind the resident and entered the bathroom and performed hand washing with soap and water. NA-B moved the sit to stand lift toward the door and picked up the used trash bag. NA-B pushed the sit to stand lift outside of the resident's room and put on gloves with no hand hygiene performed. NA-B wiped the lift with a disinfectant wipe. NA-A exited the resident's room and performed hand hygiene with ABHR. NA-B removed the disposable gloves and did not perform hand hygiene. NA-B pushed the lift to the lift storage area near the nurse's station. NA-B performed hand hygiene with ABHR. Observation on 6/10/20 at 11:37 AM revealed Licensed Practical Nurse-C (LPN-C) at the treatment cart outside of Resident 7's room. LPN-C placed a paper towel on the top of the treatment cart and removed the glucometer (a medical device used to measure and display the amount of sugar in the blood for residents with diabetes) from a drawer of the treatment cart. LPN-C wiped off the glucometer with a disinfectant wipe and laid the glucometer on the paper towel. LPN-C removed the insulin pen (a medication device used to inject insulin for the treatment of [REDACTED]. LPN-C reviewed the insulin order for Resident 7 and verified the order for 12 units of [MEDICATION NAME] insulin. LPN-C put on disposable gloves without performing hand hygiene and entered Resident 7's room and obtained a finger stick blood sample and applied a drop of blood on the test strip of the glucometer. The blood sugar level was noted to be 152 for Resident 7. LPN-C exited the resident's room and placed the glucometer on the paper towel and removed the disposable gloves and did not perform hand hygiene. LPN-C put on disposable gloves without performing hand hygiene and wiped off the glucometer with a disinfectant wipe and placed the glucometer in the drawer of the treatment cart with the disinfectant wipe underneath the glucometer. LPN-C removed the disposable gloves and performed hand hygiene with ABHR. Interview on 6/10/20 at 11:47 AM with the facility Director of Nursing (DON) confirmed that the expectation for performing hand hygiene is for staff to perform hand hygiene before putting on gloves and immediately after removing gloves. Staff should not do any tasks after removing gloves without performing hand hygiene immediately. B. Record review of the facility document titled Infection Prevention Audit dated 9/2017 revealed item 11. Team members encourage and assist residents to complete handwashing when appropriate. Observation on 6/10/20 at 10:48 AM in the room of Resident 5 revealed that Nursing Assistant-A (NA-A) and Nursing Assistant-B (NA-B) transferred Resident 5 into the bathroom using the sit to stand mechanical lift. At 10:58 AM on 6/10/20 Resident 5 was transferred from the bathroom into the wheelchair beside the bed. NA-A removed the sit to stand lift sling from behind the resident and moved the sit to stand lift out of the room and parked it just outside of the resident's room. Interview with Resident 5 on 6/10/20 at 11:05 AM revealed that the resident was seated in the wheelchair working on a word puzzle book while holding a pen. Resident 5 confirmed that the resident was assisted by staff to use the bathroom with the sit to stand lift. Resident 5 confirmed that hand washing was not provided by staff after using the bathroom. Resident 5 confirmed that hand washing is not provided for the resident prior to meals. Interview on 6/11/20 at 4:10 PM with the facility Director of Nursing (DON) confirmed that the expectation for resident hand hygiene when being assisted by staff is to perform resident hand hygiene upon resident wakening, at mealtimes, when hands are visibly soiled, at bedtime or anytime needed, and with toileting.

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