STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285297	A. BUILDING _____ B. WING _____	**08/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKESTONE VIEW	**850 LAUREL PARKWAY DRIVE BROKEN BOW, NE 68822**

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 12-006.17 LICENSURE REFERENCE NUMBER 175 NAC 12-006.17D Based on (observations/interviews/record review), the facility failed to (properly prevent and/or contain - or other appropriate statement) COVID-19. Based on observation, interview, and record review; the facility staff failed to perform hand hygiene, change gloves when they were contaminated, and perform hand hygiene after removing gloves to prevent potential cross contamination which affected 3 of 10 residents observed during medication administration (Residents 18, 3, and 18) and failed to maintain insulin to prevent potential cross contamination for 1 of 1 sampled residents (Resident 29). The facility identified a census of 45 at the time of survey. Findings are: A. Observation on 8/11/2020 at 8:09 AM revealed LPN-A (Licensed Practical Nurse) gave Resident 39 medications in the lounge. LPN-A handled the medication souffle cup, spoon, and plastic water glass they used to administer Resident 39's medication. LPN-A then discarded the cup, spoon, and plastic water glass. LPN-A then pushed the medication cart to Resident 18's room. LPN-A then dispensed medication from medication cassettes into a medication cup and gave the medications to Resident 18 by handling the med cup. LPN-A did not do hand hygiene after handling Resident 39's medication souffle cup, spoon, and plastic water glass before administering medication to Resident 18. B. Observation on 8/11/2020 at 8:16 AM revealed LPN-A took a plastic cup from Resident 18 that Resident 18 was observed handling and drinking from and tossed it in the trash. LPN-A then set up medications for Resident 3 by handling the med cup and cassettes. LPN-A then proceeded to give the medications to Resident 3. LPN-A did not perform hand hygiene after handling Resident 18's plastic glass before administering medication to Resident 3. B. Observation on 8/11/2020 at 11:20 AM revealed LPN-B donned gloves and removed the glucometer (a machine used to test blood sugar levels), test strip, and a lancet from a drawer and put them on the counter. LPN-B then removed gloves and touched the computer mouse on top of the medication cart to look at the EHR (electronic health record). LPN-B did not do hand hygiene after removing their gloves before handling the computer mouse. At 11:23 AM LPN-B donned gloves and checked Resident 29's blood sugar with the glucometer. LPN-B removed the gloves and performed hand hygiene. LPN-B then touched the computer mouse again to review the EHR. LPN-B then donned gloves and drew up insulin into a syringe. LPN-B withdrew the needle from the bottle of insulin and the needle was bent. LPN-B put the same needle back into the bottle and injected the insulin back into the insulin bottle without cleaning the rubber septum then LPN-B withdrew the needle and discarded the syringe. LPN-B then removed their gloves, discarded them, and put on another pair. LPN-B did not do hand hygiene after they removed their gloves before donning a new pair. LPN-B then obtained another syringe out of the drawer and drew up the insulin again by inserting the needle into the rubber septum. LPN-B withdrew the needle from the bottle of insulin and looked at it. The dose was less than the required amount. LPN-B then put the same needle back into the insulin bottle, injected the insulin back into the bottle and drew up the insulin again with the same syringe. LPN-B did not clean the rubber septum on the insulin vial or obtain a new syringe before drawing up the insulin again. At 11:30 AM LPN-B injected the insulin into Resident 29's right arm. Interview with the DON (Director of Nursing) on 8/11/20 at 1:32 PM revealed staff were expected to do hand hygiene after they handled items residents have used, including med cups, spoons, and water glasses before they gave medications to other residents. The DON revealed the staff were expected to do hand hygiene after they removed their gloves. The DON revealed the staff should not re-inject the insulin back into the bottle after it had been removed from the bottle. It was also the DON expectation that gloves did not replace hand hygiene. Review of the facility Skills Checklist Subcutaneous Injection dated 2019 revealed the following: Perform hand hygiene. Review of the facility Hand Hygiene Competency dated 12/2019 revealed the following: When to wash: After touching a resident or handling their belongings. Whenever hands are soiled. After any contact with body fluids. After handling contaminated items. Before and after gloving. Whenever indicated. Hand Hygiene Using Hand Sanitizer: When can hand sanitizer be used: Hands should be free of dirt or organic material. Examples: Before/after direct contact with resident. Preparing or handling medications. After contact with resident's intact skin. After contact with inanimate objects, such as medical equipment in resident' room or vicinity. After removing gloves or between changing gloves. Review of the CDC (Centers for Disease Control) Injection Safety Information for Providers revealed the following: [MEDICATION NAME] (injectable) medications should be accessed in an aseptic (free from contamination) manner. This includes using a new sterile syringe and sterile needle to draw up medications while preventing contact between the injection materials and the non-sterile environment. Proper hand hygiene should be performed before handling medications and the rubber septum should be disinfected with alcohol prior to piercing it.

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.