STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285106	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EMERALD NURSING & REHAB LAKEVIEW	1405 WEST HWY 34 GRAND ISLAND, NE 68801

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 -** Immediate jeopardy **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 ,[DATE].17B LICENSURE REFERENCE NUMBER 175 NAC ,[DATE].17D Based on observation, interview, and record review; the facility staff failed to follow the CMS (Centers for Medicare and Medicaid) guidelines to prevent the potential spread of Covid-19 by failing to follow the guidelines for quarantine of a resident newly admitted to the facility (Resident 11). The failure to follow quarantine guidelines for residents newly admitted to the facility had the potential to affect the 7 residents who had not tested positive for Covid-19 and still had the potential to contract Covid-19 (Residents 17, 18, 1, 19, 20, 8, and 21) and 1 of 2 newly admitted residents who had not been tested for Covid-19 (Resident 11). The facility staff also used the same face shield when entering a resident room under quarantine placing them at risk for cross contamination between Resident 11 and the 7 facility residents who had not contracted Covid-19 (Residents 17, 18, 1, 19, 20, 8, and 21). The facility staff also failed to perform hand hygiene to prevent potential cross contamination during insulin administration which affected 5 of 5 residents (Resident 22, 4, 5, 7, and 10); failed to change gloves and perform hand hygiene during BS (blood sugar) checks which affected 8 of 8 residents (22, 4, 6, 12, 7, 8, 10, and 9); failed to clean the blood glucose monitoring machine between residents to prevent potential cross contamination which affected 8 of 8 residents (22, 4, 6, 12, 7, 8, 10, and 9); failed to perform hand hygiene to prevent potential cross contamination when exiting resident rooms for 6 of 6 residents (Residents 12, 13, 14, 7, 15, and 16), and before putting on gloves and after taking off gloves for 2 of 2 residents (Residents 19 and 20). The facility identified a census of 50 at the time of survey. Findings are: A. Interview with the facility Administrator on [DATE] at 11:09 AM revealed the following: The facility had Covid-19 cases with the facility and the staff in the past. The facility is considered Green right now. The facility nurse consultant was working with the local health department and DHHS (Department of Health and Human Services) on their cases and that determination has been made at this time. The facility did not have any active Covid-19 cases at this time. The administrator revealed the facility currently had a quarantine unit for any residents who returned from the hospital and they resided in quarantine on that unit for 14 days. They are currently not accepting any residents who are confirmed positive for Covid-19. The administrator revealed the entire facility did not have any Covid-19 positive residents at this time. All staff were required to wear masks when entering resident rooms and residents were to wear a mask if they came out of their room. Interview with RN-I (Registered Nurse) on [DATE] at 11:30 AM revealed the 500 unit was the quarantine unit where residents were required to reside for 14 days when they were admitted to the facility. Observation of the quarantine unit on [DATE] at 11:35 AM revealed there were no residents observed residing on that unit. There were signs on some of the doors dated [DATE] that read: 500 Hallway-will be required to wear all PPE (Personal Protective Equipment) which is N95 (a type of mask), gown, gloves, and face shield while working with residents. Interview with the facility Administrator on [DATE] at 12:30 PM revealed 1 resident was scheduled to be admitted to the facility from the hospital tomorrow and they would reside on the quarantine unit for 2 weeks. Interview on [DATE] at 1:06 PM with Resident 1 who was sitting out in the hall in the green Zone in a power wheelchair revealed they had not tested positive for Covid-19. Observation of NA-H (Nursing Assistant) on [DATE] at 8:40 AM revealed they were working on the quarantine unit. Interview with NA-H at this time confirmed they were working on the quarantine unit today. NA-H revealed there was 1 resident who was admitted to the facility after NA-H had left the facility last night. NA-H revealed the procedure for entering the resident's room was that it was their understanding that the staff were protecting the resident from the staff so they just wore a mask and a face shield. NA-H revealed it was their understanding that the resident had a TIA ([MEDICAL CONDITION]) and had been in the hospital for a year before coming to the facility. Interview with NA-H on [DATE] at 8:58 am revealed they did float to other units in the facility to provide care to residents. NA-H revealed they helped get people up this morning on the other units. NA-H revealed no one in the building was considered contagious so NA-H understood they could provide care to the residents on the other units as well as caring for the residents on the quarantine unit. Observation on [DATE] At 9:00 revealed NA-H went into Resident 11's room where the new resident was residing on the Gray or quarantine unit after using hand sanitizer and donning a face shield. NA-H did not don gown or gloves. NA-H was already wearing a surgical face mask. NA-H talked to Resident 11 then left the room, took the face shield off and laid it on top of the PPE cart sitting outside of Resident 11's door and used hand sanitizer for hand hygiene from a dispenser hanging on the wall. Observation on [DATE] at 9:26 AM revealed MA-J (Medication Aide) walked to the doorway of Resident 11. MA-J was wearing a face mask and donned the face shield that was laying on the top of the PPE cart. MA-J did not don a gown or gloves. MA-J then entered Resident 11's room. MA-J then came out of Resident 11's room and put the same face shield on top of the cart, do hand hygiene with hand sanitizer and walked down the hall to the other units in the facility that were Green. Observation of Resident 11's room on [DATE] at 9:00 AM revealed a sign on the door that read: 14 Day Admission Precaution. Staff Mask (May wear face shield). Resident mask when in room. Resident to wear mask when outside of room. There were no other directions for other PPE use or precautions on the sign. Interview on [DATE] at 9:32 with RN-K revealed the quarantine hall Resident 11 was residing on was a Gray Zone. RN-K revealed Resident 11 had been in the hospital for 8 months and the facility felt the staff were to protect that resident from the staff; not protect the staff from the resident. RN-K revealed the facility had tested all of the residents for Covid-19 but not the staff. RN-K revealed the facility had 5 residents who had never tested positive for Covid-19 and they had been directed by the SIP (State Infection Preventionist) to monitor those 5 daily for signs and symptoms of Covid-19. When RN-K was asked if the Resident 11 had been tested for Covid-19 prior to admission RN-K said they did not know and would need to look into that. Interview on [DATE] at 9:54 am with RN-K confirmed Resident 11 did not have a baseline Covid-19 test, or was not tested prior to admission. Interview with RN-K on [DATE] at 11:00 AM revealed the staff were only using a face mask and face shield to enter Resident 11's room as RN-K said Resident 11 was kind of an exception. RN-K revealed the facility typically didn't get a resident who had been 8 months in the hospital. RN-K reported they did not feel Resident 11 could have had any potential exposure as Resident 11 did not come from home. RN-K confirmed the facility still had residents who never tested positive and not all of the staff tested positive either and the staff were leaving the facility and returning ad lib. RN-K revealed the facility as a whole was on the downhill slide of the Covid-19 disease. RN-K revealed they did not feel Resident 11 was a risk for transmission because Resident 11 had been in the hospital for 8 months. RN-K revealed they had not consulted with the health department regarding the situation with Resident 11 and they would do that. Record review of an email sent by RN-K revealed they had sent an email to the SIP (State Infection Preventionist) at 11:27 AM on [DATE] for clarification on required PPE for the facility Gray Zone. Response by the SIP was returned to RN-K at 12:09 PM on [DATE] and indicated the facility needed to follow the Gray Zone guidelines for Resident 11. Facility began mitigation to place Gray Zone in full PPE prior to response from SIP was received. Observation on [DATE] at 12:12 PM Revealed NA-H wearing N95 mask, face shield, gown, and gloves when they took a meal into Resident 11's room. NA-H then removed the gown and gloves and face shield and performed ABHR (Alcohol Based Hand Rub) after they left Resident 11's room. NA-H then donned new gloves and cleaned the face shield. NA-H removed gloves and performed ABHR. NA-H then donned a new gown, face shield, and gloves

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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) then delivered a meal to Resident 22 indicating the facility had abated the immediate jeopardy. On [DATE] at 12:20 PM the RDO (Regional Director of Operations) expressed concern with the requirement for staff to wear gloves, gown, mask, and face shield when in the rooms of the newly admitted residents residing in the facility quarantine unit. The RDO revealed that Resident 11 had been hospitalized for [REDACTED]. The RD stated that the facility and staff had put much thought into how to care for the newly admitted residents. The facility administrator was present. At 12:40 PM RN-K revealed that they had e-mailed the SIP for clarification on the required PPE use for newly admitted residents. The email response from the SIP confirmed that any new resident was to be put into a Gray Zone (a transitional or quarantine unit used to monitor residents admitted to the facility for Covid-19 to prevent the potential for spread of Covid-19 in the facility) for 14 days and that the facility was to follow the PPE requirement for a Gray Zone (Gown, Gloves, Eye protection and N95 mask). The facility changed their procedure and all staff will don full PPE (gown, gloves, mask, face shield) when they enter the rooms of newly admitted residents on the Gray Zone. At 12:45 PM the DON revealed that the Gray Zone guidelines were implemented and that the staff was educated. On [DATE] an e-mail was sent to the administrator with a request for the documentation of when they did the transition on the Gray unit and when they educated staff and what this entailed for the corrective action to abate the situation on site [DATE]. The administrator was also asked for a list of staff who had never tested positive to determine if there was still a risk of staff bringing it into the facility or contracting it from another resident in the facility and passing it on to residents including the new resident and the 7 residents who never tested positive. Review of the undated list of staff Covid-19 test results revealed 22 of 117 staff listed tested positive. MA-J was not on the list at all and NA-H was not listed as testing positive so there was the potential they could become infected and spread to the residents in the Gray unit or the other residents in the facility who had not tested positive by working on both the Gray and Green units without using the PPE per guidelines. Review of the staff training dated [DATE] revealed the staff were trained that all admissions will be on a 14 day droplet precautions (Gray Zone). Full PPE is to be worn when in room with resident for droplet precautions. This was documented as completed at 12 PM. Review of the e-mail communication with the SIP dated [DATE] at 12:09 PM revealed the facility was directed to follow the Gray Zone procedure for the new residents on the Gray Zone for 14 days. The SIP directed the facility that Gray Zone PPE should be worn: N95, eye protection (face shield or goggles), gown, gloves. Review of the facility Covid-19 Line Listing report revealed 20 residents who were Covid-19 positive had expired during the time frame from [DATE] to [DATE]. 43 of the residents currently residing in the facility had tested positive for Covid-19 and had recovered. Review of the list of residents who have tested negative identified by the facility as the residents who had never tested positive for Covid-19 were: Residents 17, 18, 1, 19, 20, 8, and 21. These residents had never had Covid-19 or tested positive so they were still at risk for contracting it. Review of the ICAP (Infection Control and Prevention) Review of Zones and PPE (Personal Protective Equipment) revealed the following guidelines for the zones and PPE: Gray Zone: Residents who are being transferred from the hospital/outside facility (but have no known exposure to Covid-19) are usually kept in this Zone for 14 days, and if remains asymptomatic at the end of 14 days will be moved to Green Zone. PPE to be used: Gown, gloves, eye protection and N95 mask (N95 mask preferred if no N95 then surgical mask with face shield). Green Zone (Covid-19 free Zone): Asymptomatic residents without any exposure to Covid-19: PPE to be used: Surgical mask and PPE per standard precautions. The facility abated the Immediate Jeopardy by implementing the Gray Zone precautions and educating staff by 12:00 PM on [DATE]; however, the new resident (Resident 11) and the 7 residents who had not contracted or tested positive for Covid-19 (Residents 17, 18, 1, 19, 20, 8, and 21) were placed at risk for contracting Covid-19 due to the staff failure to follow the Gray Zone precautions and working on both the Gray and Green Zones. Therefore, the Immediate Jeopardy was abated to an E, as the residents were still at risk for contracting Covid-19 due to the 14 day incubation period. B. Observation on [DATE] at 9:00 revealed NA-H went into Resident 11's room where the new resident was residing on the Gray or quarantine unit after using hand sanitizer and donning a face shield. NA-H did not don gown or gloves. NA-H was already wearing a surgical face mask. NA-H talked to Resident 11 then left the room, took the face shield off and laid it on top of the PPE cart sitting outside of Resident 11's door and used hand sanitizer for hand hygiene from a dispenser hanging on the wall. NA-H then walked away from the cart and left the face shield on top of the cart. The face shield was not cleaned. Observation on [DATE] at 9:26 AM revealed MA-J (Medication Aide) walked to the doorway of Resident 11. MA-J was wearing a face mask and donned the face shield that was laying on the top of the PPE cart, which was the same face shield that had been used and not cleaned by NA-H. MA-J then entered Resident 11's room. MA-J then came out of Resident 11's room and put the same face shield on top of the cart, do hand hygiene with hand sanitizer and walk down the hall to the other units in the facility that were designated as green. The face shield was not cleaned. C. Observation of LPN-G (Licensed Practical Nurse) on [DATE] at 11:33 MA revealed LPN-G (Licensed Practical Nurse) was doing BS (Blood Sugar) checks and administering insulin to residents using supplies from a treatment cart with several drawers and the computer was sitting on top of it with a mouse on a mouse pad. Interview with LPN-G at this time revealed the facility residents shared a glucometer (a portable machine used to check BS levels at the bedside). The glucometers LPN-G were using were labeled Assure Platinum. Observation on [DATE] at 11:35 AM revealed LPN-G donned gloves. The glucometer was sitting on top of the cart on a piece of paper. It was not wrapped with a disinfectant wipe. LPN-G gathered an alcohol wipe, cotton ball, lancet and glucometer test strip from the drawer by touching the drawer with the gloved hands, picked up the glucometer and went into Resident 22's room and checked Resident 22's blood sugar. LPN-G pricked Resident 22's finger with the lancet and placed a drop of blood on a test strip that was inserted into the glucometer. LPN-G touched Resident 22's hand with the gloves and the glucometer as well as a cotton ball LPN-G placed on Resident 22's finger after LPN-G lanced it and placed a drop of blood from Resident 22's finger onto the test strip. After the result appeared on the screen of the glucometer, LPN-G left the room, put the lancet into the sharps container, then LPN-G used a Clorox non-bleach wipe and cleaned the glucometer with the wipe and placed it on a paper square on top of the cart. LPN-G wiped the glucometer quickly and discarded the wipe. The glucometer was dry in seconds. LPN-G then used the same gloved hands to open the drawer on the cart and get out an insulin pen that was in a clear plastic bag. LPN-G then opened a drawer and retrieved a pre-packaged insulin pen needle. LPN-G opened the needle, placed it on the insulin pen, primed the pen, dialed the dose, entered Resident 22's room and injected the insulin into Resident 22's arm. LPN-G then came out of the room with the same gloves on, discarded the needle in the sharps container, put the insulin pen in a bag that was lying on top of the cart. LPN-G then removed the gloves and did hand hygiene with ABHR (Alcohol Based Hand Rub). LPN-G then placed the insulin pen in the bag back into the drawer. Observation on [DATE] at 11:40 AM revealed LPN-G donned gloves, opened the drawer and got a test strip, cotton ball, alcohol wipe, and lancet out of the drawer. LPN-G touched the same drawer LPN-G had touched with the gloved hands LPN-G had used for Resident 22. LPN-G picked up the glucometer off the top of the cart and went into Resident 4's room and checked their blood sugar by lancing their finger and placing a drop of blood on the test strip that LPN-G had inserted into the glucometer. LPN-G touched Resident 4's hand while obtaining the blood sample. LPN-G then left Resident 4's room with the glucometer, took a Clorox non-bleach wipe out of the container on the cart, wiped the glucometer, threw the wipe away and placed the glucometer on a barrier on top of the cart. The glucometer was dry in seconds. LPN-G still had the same gloves on. LPN-G documented the BS by touching the computer mouse on top of the cart. LPN-G then used keys to open the cart then opened a drawer on the cart and got Resident 4's insulin pen bag out of the drawer. LPN-G then removed a pre-packaged needle from the drawer, opened it and put it on the insulin pen. LPN-G still has the same gloves on. LPN-G then went in and gave Resident 4 the insulin by injecting it into their left arm. LPN-G then left Resident 4's room and went back to the cart and put the insulin pen back into the bag after discarding the needle into the sharps container. LPN-G then unlocked the cart with their keys. LPN-G then removed the gloves, opened the drawer, and put the bag with the insulin pen back into the drawer. LPN-G then charted on the computer on the cart by touching the mouse and the keyboard. LPN-G then gave keys to the administrator who had come up and requested a set of keys to get into the storeroom. LPN-G did not do hand hygiene after removing their gloves. LPN-G then got gloves out of a box and laid them on top of the cart. LPN-G did hand hygiene with ABHR and put on the gloves. Observation on [DATE] at 11:45 AM revealed LPN-G got a bag containing and insulin pen out of the drawer for Resident 5. LPN-G touched the drawers with the same gloved hands and the bag the insulin was in. LPN-G retrieved a prepackaged insulin pen needle and alcohol swab from the cart. LPN-G opened the needle and placed it on the insulin pen. LPN-G then entered Resident 5's room and wiped their site on their skin with alcohol and injected the insulin using the same gloved hands. LPN-G then left Resident 5's room and put the needle in the sharps container, placed the cap back on the insulin pen, removed gloves, put the insulin pen in the bag, opened the drawer on the cart, put the bag with the insulin pen into the drawer, then touched the computer. LPN-G then did hand hygiene using ABHR hand sanitizer and LPN-G charted touching the computer mouse. Observation on [DATE] at 11:50 AM revealed LPN-G took the glucometer not wrapped and

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) put it into the drawer. LPN-G took the wipes to a different cart and got a glucometer out of the drawer. At 11:53 AM LPN-G donned gloves then got an alcohol wipe, test strip, lancet, and cotton ball out of the drawer. LPN-G took the glucometer into Resident 6's room and checked Resident 6's BS by lancing their finger, placing a drop of blood on the machine then wiping their finger with a cotton ball using the gloved hands. Observation on [DATE] at 11:57 AM revealed LPN-G brought the glucometer out of Resident 6's room, wiped it with the Clorox non-bleach disinfectant wipe and discarded it. The glucometer surface was dry in seconds. LPN-G then removed their gloves and charted touching the computer mouse. LPN-G then did hand hygiene with ABHR. LPN-G then retrieved supplies from the cart out of the drawer including an alcohol wipe, test strip, lancet, and cotton ball. LPN-G then donned gloves and took the same glucometer into Resident 12's room and checked Resident 12's BS at 12:00 PM. LPN-G then took the glucometer out of the room, wiped it with the Clorox non-bleach wipe and discarded the wipe. LPN-G wiped the glucometer very quickly and it was visibly dry in seconds. At 12:02 PM LPN-G took the same glucometer and put a test strip in after donning gloves and opening the drawer to retrieve the alcohol wipe, cotton ball, and lancet. Observation on [DATE] at 12:03 PM revealed LPN-G took the glucometer into Resident 7's room and checked Resident 7's BS. LPN-G came out the room and got keys out of their pocket with the same gloves hands. LPN-G then dropped the keys on the floor then picked them up with the same gloved hands and laid them on top of the cart. LPN-G then changed gloves with no hand hygiene, charted by touching the mouse then opened the drawer and got an insulin pen out that was in a plastic bag. LPN-G then opened another drawer and got a prepackaged needle and put it on the insulin pen, took it into Resident 7 and administered the insulin to Resident 7 at 12:06 PM by injecting them. LPN-G then came out of Resident 7's room and used the same gloved hands to open the drawer after unlocking it with the keys. LPN-G quickly wiped the glucometer with the Clorox bleach free wipe and discarded into their gloves when they removed them. The glucometer was dry in seconds. Observation on [DATE] at 12:10 PM revealed LPN-G discarded an empty alcohol wipe box in trash can on the cart. LPN-G touched the inside of the trash can with their bare hand and did not perform hand hygiene. LPN-G then touched the computer mouse, opened the drawer and retrieved a lancet, alcohol wipe, and cotton ball. LPN-G then donned gloves and took the glucometer into Resident 8's room and checked Resident 8's BS. LPN-G then brought the glucometer out of Resident 8's room at 12:13 PM and wiped it with the Clorox non-bleach wipe and discarded the wipe in their gloves. The glucometer was dry in seconds. Observation on [DATE] at 12:16 PM revealed LPN-G went back to the other cart. LPN-G handled the keys and unlocked the cart. LPN-G then opened the drawer with bare hands that LPN-G had not cleaned and retrieved an alcohol wipe, cotton ball, and lancet from the drawer. LPN-G picked up the glucometer and donned gloves. At 12:17 PM LPN-G took the glucometer into Resident 10's room and checked Resident 10's blood sugar. At 12:18 PM LPN-G brought the glucometer out of Resident 10's room to the cart and wiped the glucometer with the Clorox non-bleach wipe and discarded the wipe. It was dry in seconds. LPN-G then used the same gloved hands to open the drawer and get 2 prepackaged needles and Resident 10's insulin out of the drawer that was in a bag. Using the same gloved hands, LPN-G opened the needles and placed them on 2 insulin pens and took them into Resident 10 and administered the insulin at 12:21 PM. LPN-G came out of Resident 10's room and used the same gloved hands to unlock the cart with their keys, open the drawer and put the bag with the insulin pens back into the cart by opening the drawer. LPN-G then removed the gloves. LPN-G touched the computer mouse to chart then did hand sanitizer. At 12:23 PM LPN-G put a test strip into the glucometer. LPN-G then donned gloves then opened the drawer to get an alcohol wipe, cotton ball and lancet. LPN-G then went into Resident 9's room at 12:24 PM checked their BS using the glucometer. Review of the facility policy Glucometer Disinfection dated ,[DATE] revealed the following: 1. Retrieve disinfectant wipe from container. 2. Cleanse the glucometer with the disinfectant wipe. 3. Discard disinfectant wipe in waste receptacle. 4. Allow device to dry for minimum of five (5) minutes or per manufacturer recommendations. 5. Wash hands or use alcohol gel as appropriate. Review of the facility policy Blood Glucose Sampling-Capillary (Finger Sticks) revised [DATE] revealed the following: The purpose of this procedure is to guide the safe handling of capillary-blood sampling devices to prevent transmission of blood borne diseases to residents and employees. Steps in the procedure: 1. Wash hands. 2. Don gloves. 3. Place blood glucose monitoring device on clean field. 4. Wipe the area to be lanced with an alcohol pledget. 5. Obtain the blood sample, following the manufacturer's instructions for the device. 6. Discard lancet into the sharps container. 7. Following the manufacturer's instructions, clean and disinfect glucose monitoring device after each use with 10% bleach preparation. 8. Remove gloves, and discard into appropriate receptacle. 9. Wash hands. 10. Replace blood glucose monitoring device in storage area after cleaning. Review of the undated Guidelines for Cleaning and Disinfecting the Assure Platinum Meter revealed the following: To minimize the risk of transmitting blood-borne pathogens, the cleaning and disinfecting procedure should be performed as recommended in the instructions below. The Assure Platinum Blood Glucose Monitoring System may only be used for testing multiple patients when standard precautions and the manufacturer's disinfecting procedures are followed. The meter should be cleaned and disinfected after use on each patient. The cleaning procedure is needed to clean dirt, blood and other bodily fluids off the exterior of the meter before performing the disinfecting procedure. The disinfecting procedure is needed to prevent the transmission of blood-borne pathogens. ARKRAY recommends using these wipes to clean and disinfect the Assure Platinum meter: Clorox Healthcare Bleach Germicidal Wipes. Option 1: Obtain a commercially available EPA-registered disinfectant detergent or germicide wipe. Carefully review the manufacturer's instructions. Clean and disinfect the meter following step-by-step instructions. Options 2: Clean the outside of the blood glucose meter with a lint-free cloth dampened with soapy water or [MEDICATION NAME] alcohol. Disinfect the meter by diluting 1 ml of household bleach (,[DATE]% hypochlorite solutions) in 9 ml water to achieve a 1:10 dilution. Use a lint-free cloth dampened with the solution to thoroughly wipe down the meter. Cleaning and Disinfecting Procedures: Open the cap of the disinfectant container and pull out 1 towelette and close the cap. Wipe surface of the meter to clean blood and other body fluids. Carefully wipe around the test strip port by inverting the meter so that the test strip port is facing down. This prevents disinfectant liquid from entering the meter. Dispose of the used towelette in a trash bin. The meter should be cleaned prior to each disinfection step. Pull out 1 new towelette and wipe the entire surface of the meter horizontally and vertically to remove blood borne pathogens. Carefully wipe around the test strip port by inverting the meter so that the test strip port is facing down. This prevents disinfectant liquid from entering the meter. Treated surface must remain wet for recommended contact time. Please refer to wipe manufacturer's instructions. Do not wrap the meter in a wipe. Dispose of the used towelette in a trash bin. Record review of the label on the Clorox non-bleach wipes read the following: Wipe surface to be disinfected. Use enough wipes for treated surface to remain visibly wet for 4 minutes. Interview with RN-K on [DATE] at 12:34 PM revealed staff were expected to throw the face shield away after use and get a new one or clean it and use for 1 staff person only. The staff were not to use the same face shields. The staff were also expected to clean the face shield and wait for the disinfectant for work if they were going to re-use it and for only 1 staff person. RN-K revealed the staff were expected to follow the package directions on the disinfectant for contact or wet set time when cleaning the glucometers. Staff were expected to do hand hygiene after they removed gloves and change the gloves when they were contaminated. Interview with DON-A (Director of Nursing) on [DATE] at 12:34 PM revealed the staff were expected to disinfect the glucometers with the wipes for 5 minutes or whatever it read on the package of the disinfectant. D. Observation on [DATE] at 8:49 AM revealed that Housekeeping Aide-D (HA-D) removed cleaned laundry from the rack on the laundry cart in the hallway. HA-D carried the laundry into the room of Residents 12 and 13 and hung the laundry in the closet. HA-D exited the resident room carrying empty hangers from the resident closet and hung the used hangers on the rack of the laundry cart. HA-D did not 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). HA-D removed cleaned laundry from the rack on the laundry cart and carried the laundry into the room of Residents 14 and 7. Resident 14 took the hanger from HA-D and removed the cleaned laundry item and HA-D carried the empty hanger out of the resident room and hung it on the rack of the laundry cart. HA-D did not perform hand hygiene. HA-D removed cleaned laundry from the rack on the laundry cart and carried the laundry into the room of Residents 15 and 16 and hung the laundry in the closet. Resident 16 told HA-D that the resident had placed several empty hangers on the end of the rack in the closet and requested that HA-D remove the empty hangers. HA-D removed the empty hangers from the closet and exited the resident room and hung the empty hangers on the rack of the laundry cart. Interim Director of Nursing-F (DON-F) walked up to HA-D and told HA-D something that this surveyor was unable to hear. HA-D responded oh, sorry to DON-F and then performed hand hygiene with alcohol based hand rub. HA-D removed cleaned laundry from the rack on the laundry cart and carried the laundry into the room of Residents 2 and 17. HA-D exited the room carrying empty hangers from the resident closet and hung the used hangers on the rack of the laundry cart. HA-D performed hand hygiene using alcohol based hand rub. Record review of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285106	A. BUILDING _____ B. WING _____	**06/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EMERALD NURSING & REHAB LAKEVIEW	**1405 WEST HWY 34 GRAND ISLAND, NE 68801**

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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) facility policy titled Infection Prevention and Control Program dated [DATE] revealed step 4. Hand Hygiene Protocol: a. All staff shall wash their hands when coming on duty, between resident contacts, after handling contaminated objects, after Personal Protective Equipment (PPE- gloves, gowns, masks) removal, before/after eating, before/after toileting, and before going off duty. Step 10. Linens: a. Laundry and direct care staff shall handle, store, process, and transport linens so as to prevent the spread of infection. E. Observation on [DATE] at 1:57 PM revealed that Nursing Assistant-B (NA-B) and Nursing Assistant-C (NA-C) entered the room of Resident 20 with a sit to stand lift (a mechanical assistive device used to transfer a resident with difficulty standing up on their own from a seated position) to transfer Resident 20 from the wheelchair to the recliner. NA-B and NA-C put on disposable gloves without performing 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) prior to putting the gloves o