STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285259	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BLUE VALLEY LUTHERAN NURSING HOME	P O BOX 166, 220 PARK AVENUE HEBRON, NE 68370

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 12-006.17A and 12-006.17B Based on observation, interview, and record review, the facility failed to disinfect a Hoyer lift before reuse on another resident (Resident 7) and maintain at least 6 feet distance between residents eating in the dining rooms at meals to prevent the potential spread of COVID-19. The facility reported 50 residents eat in the dining rooms for meals. The facility also failed to screen 91 facility staff members and 1 contracted staff (OT-H) for signs and symptoms of COVID-19 immediately upon entrance to the facility. This had the potential to affect all residents that resided in the facility. The facility had a census of 55 residents. The findings are: Disinfecting Reusable Equipment A. An observation on 6/16/20 at 11:33 AM revealed CNA (Certified Nursing Assistant)-C and CNA-D exiting Resident 6's room. CNA-D was pushing Resident 6 in a wheelchair and CNA-C was pushing a Hoyer lift (an assistive device used to help move residents from surface to surface) out of the room. Continued observation revealed CNA-C pushed the Hoyer lift across the hall and into Resident 7's room and stopped next to Resident 7's bed. In an interview on 6/16/20 at 11:34 AM, CNA-C and CNA-D reported the Hoyer lift was not disinfected prior to reuse for Resident 7. CNA-D stated it was supposed to be disinfected in between use on different residents. In an interview on 6/16/20 at 1:45 PM, the DON (Director of Nursing) and Administrator confirmed the Hoyer lift was supposed to be disinfected before reuse on another resident. A review of the facility's Cleaning and Disinfection of Resident-Care Items and Equipment Policy dated 4/7/2020 revealed the following: -Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard. -3) Durable Medical Equipment (DME) must be cleaned and disinfected before reuse by another resident. Dining B. Observations of meals on 6/16/20 between 7:56 AM and 12:16 PM revealed the following: -Activity Room dining area had 5 round tables set up with 2 residents observed sitting across from each other at 4 of the 5 tables. -Sunroom dining area had 4 round tables set up with 2 residents observed sitting across from each other at 1 of the 4 tables. -Memory Care dining area had 5 round tables set up with 3 residents observed sitting next to each other at 1 table and 2 residents observed sitting across from each other at 3 of the tables. -Main Dining dining area had 8 round tables and 2 square tables set up with 2 residents observed sitting across from each other at 4 of the round tables and 1 of the square tables. An observation on 6/16/20 at 8:10 AM revealed signage posted outside of the dining areas stated residents are supposed to sit 2 to a table, 6 feet apart. An observation and interview with the Administrator and Maintenance Supervisor on 6/16/20 at 9:15 AM revealed the round tables measured approximately 4 feet in diameter and the square tables measured approximately 3.5 feet across. The Administrator confirmed that would not keep the residents separated by at least 6 feet while dining. Staff Screening C. A review of an email dated 3/23/20 from the Administrator to Facility Department Heads revealed the following: -All employees are to be screened daily for risk of coronavirus infection. It will be your job as department heads to do this to each of your employees daily. You will be given the sheet with the questions to be asked of each employee daily as they prepare to start their shift. You will need to take and record their temperature daily before they start their shift. It will be the responsibility of the office manager to screen and check all office, administration staff, and essential health care staff daily during business hours. It is the responsibility of the charge nurse during non-business hours. -You will be given stickers that the employee is to wear on the front of their shirt that will show that they have been screened for that day. -In absence of the department head (such as weekend or a scheduled day off), in dietarty the responsibility would fall to the assistant dietary manager or the head cook or first cook. All others will fall under the responsibility of the charge nurse. In interviews on 6/16/20 at 9:15 AM and 10:15 AM, RN (Registered Nurse)-A reported staff are screened in their respective department areas in the building. Nursing staff are screened in the nursing office in the memory care unit. In an interview on 6/16/20 at 12:20 PM, CNA-J reported that nursing staff are all screened at the nurses' station in the memory care unit. An observation and interview on 6/16/20 at 12:21 PM with Dietary Staff B revealed the dietary staff screening log was kept in the middle of the kitchen. Dietary Staff B reported dietary staff take their own temperatures upon arrival to work in the kitchen and fill out the screening form. An observation on 6/16/20 at 1:15 PM revealed OT (Occupational Therapist)-H walked in the front door of the facility and to the business office where (gender) was screened by the Office Manager. Observations during this time revealed OT-H walked by 2 residents sitting in the great room on the way to the business office. An observation on 6/16/20 at 1:40 PM revealed CNA-I walked in the front door of the facility and to the business office where (gender) was screened by the Office Manager. Observations during this time revealed CNA-I walked by 1 resident sitting in the great room on the way to the business office. An observation and interview with the ADON (Assistant Director of Nursing) on 6/16/20 at 1:25 PM revealed the screening log for the nursing staff was kept in the nursing office located at the end of the hall in the memory care unit. The ADON reported that staff come to the nursing office when they arrive for their shift and are screened by the charge nurse. In an interview on 6/16/20 at 1:43 PM, the DON stated the Office Manager does staff screening in the business office from 7:30 AM until 4:00 PM and outside of those hours the staff have to go down to the nursing office on the memory care unit to be screened. The DON also reported most of the nursing staff change shifts at 6:00 AM and 6:00 PM. In an interview on 6/16/20 at 1:45 PM, the Administrator and DON confirmed that staff walking through the building and into resident care areas to be screened could be a potential infection control issue. The DON and Administrator also confirmed staff should not be screening themselves.

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