STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285114	A. BUILDING _____ B. WING _____	**06/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FALLS CITY CARE CENTER	**2800 TOWLE STREET FALLS CITY, NE 68355**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure reference number 175 NAC 12-006.17 Based on observation, interview, and record review; the facility failed to implement infection control practices and Centers for Medicare and Medicaid Services (CMS) guidelines to prevent potential cross contamination including the spread of COVID-19 related to failing to verify screening results for facility employees which had the potential to effect all residents and failed to implement isolation procedures for shingles for 1 (Resident 4) of 4 sampled residents. The facility staff identified a census of 57. Findings are: A. Record review of a Admission Record sheet printed on 6-15-2020 revealed Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's Progress Notes (PN) dated 6-07-202 revealed Resident 4 has shingles area . on the right side some areas now raised pus filled blisters . Review of Resident 4's PN dated 6-08-2020 revealed Resident 4's practitioner order a medication for the treatment of [REDACTED]. Record review of Resident 4's PN dated dated 6-12-2020 revealed Resident 4 was on medication [MEDICATION NAME] (a [MEDICAL CONDITION] medication) with the current skin issue identified as shingles. Record review of Resident 4's PN dated 6-14-2020 revealed some of the shingles areas are scabbed over and other blisters are opening with small amounts of drainage. Record review of Resident 4's Medication Administration Record [REDACTED]. Observation on 6-15-2020 at 11:28 AM revealed Nursing Assistant (NA) E and NA F donned gowns and had facial mask. NA E and NA F entered Resident 4's room, washed hands and donned gloves. NA E obtained a wipe and completed personal care for Resident 4 who had been incontinent of urine. NA E with the same soiled gloves touched Resident 4's arm, pants, blouse, clean brief, blanket and Resident 4's leg. NA E removed the soiled gloves and without handwashing or sanitizing,donned new gloves. NA E assisted NA F with transferring Resident to a wheelchair, removed the gloves, a gown and did not handwash and left Resident 4's room. Further observations revealed Resident 4 had 2 open areas to the right forearm that had the appearance of open blister like areas and were uncovered. NA E reported Resident 4 has shingles. On 6-15-2020 at 11:57 AM an interview was conducted with NA E. During the interview NA E confirmed the soiled gloves were not changed and should have been. On 6-15-2020 at 2:13 PM an interview was conducted with the Infection Control Preventionist (ICP). During the interview the ICP confirmed Resident 4 had shingles and should be in isolation. The ICP confirmed there was not signage indicating Resident 4 was in isolation further reported seeing Resident 4's wounds that were not covered and should have been. B. A record review of a Respiratory Illness STAFF Questionnaire (RISQ, a screening for Covid-19 exposure) sheet dated 6/12/20 revealed that NA-H had symptoms of headache, nausea and a sore throat. Further review of NA H's RISQ sheet dated 6/12/20 revealed there was no evidence NA H's symptoms were evaluated prior to allowing NA H to work. On 6-15-2020 at 4:10 PM an interview was conducted with the facility Administrator. During the interview, review of NA H's RISQ sheet dated 6-12-2020 was completed. The facility Administrator confirmed there should have been follow up with NA H's symptoms and was not. C. A record review of a RISQ form for NA-I dated 6/11/20 revealed that NA-I had been in contact with a person who had traveled outside the state in the last 14 days and documented a low grade temperature. Further review of NA I's RISQ sheet dated 6/11/20 revealed there was no evidence of evaluation of NA I's responses prior to NA-I being allowed to work. On 6-15-2020 at 4:10 PM an interview was conducted with the facility Administrator. During the interview, review of NA H's RISQ sheet dated 6-12-2020 was completed. The facility Administrator confirmed there should have been follow up with NA H's symptoms and was not. D. A record review of the RISQ form for dietary aide-J dated 6/12/20 revealed that dietary aide-J had a temperature of 100.2. Further review of dietary aide J's RISQ sheet dated 6/12/20 revealed no evidence dietary aide J's temperature had been evaluated prior to allowing dietary aide J to work. On 6-15-2020 at 4:10 PM an interview was conducted with the facility Administrator. During the interview, review of NA H's RISQ sheet dated 6-12-2020 was completed. The facility Administrator confirmed there should have been follow up with NA H's symptoms and was not. E. A record review of the RISQ form for the Director of Nursing (D.O.N.) dated 6/11/20 revealed that the D.O.N. had a symptom of vomiting. Further review of the D.O.N.'s RISQ sheet revealed there was no evidence that the D.O.N.'s symptoms were evaluated prior to allowing the D.O.N. to work. On 6-15-2020 at 4:10 PM an interview was conducted with the facility Administrator. During the interview, review of the D.O.N.'s RISQ sheet dated 6-11-2020 was completed. The facility Administrator confirmed there should have been follow up with the D.O.N's symptoms and was not.

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.