STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285285	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOOD SAMARITAN SOCIETY - GRAND ISLAND VILLAGE	4061 TIMBERLINE STREET & 4055 TIMBERLINE STREET GRAND ISLAND, NE 68803

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 -** Actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.17B LICENSURE REFERENCE NUMBER 175 NAC 12-006.17D LICENSURE REFERENCE NUMBER 175 NAC 12-006.18C LICENSURE REFERENCE NUMBER 175 NAC 12-006.11E Based on observation, interview, and record review; the facility staff failed to implement measures to prevent the potential spread of Covid-19 by failing to store disposable PPE (Personal Protective Equipment) to prevent potential cross contamination which had the potential to affect 2 of the 23 residents residing on the Cottonwood unit (Residents 14 and 15); failing to change gloves and perform hand hygiene during cares for Resident 11; failing to clean the STS (Sit to Stand) lift between residents to prevent potential cross contamination which had the potential to affect 10 of 37 residents residing on the Cottonwood and Ash Grove units (Residents 16, 9, 17, 18, 11, 20, 12, 21, 22, and 8); failing to distribute clean clothing to prevent potential cross contamination for 1 of 3 residents observed (Resident 13); failing to clean the whirlpool bathtub to prevent potential cross contamination for 6 of 6 residents who used the whirlpool bathtub on the Cottonwood unit (Residents 19, 11, 20, 13, 21, and 23); failing to cover drinks during the distribution of meal trays which affected all 22 of the residents on the Cottonwood unit who received a meal tray; and the facility failed to ensure that staff used N95 masks (a filtering facemask worn to protect healthcare professionals from inhaling infectious particles and preventing the spread of respiratory infection between healthcare professionals and patients) to prevent the potential for cross contamination of Covid-19 for 3 residents (Residents 1, 5, and 6) in the facility gray zone (a dedicated unit in the facility used to quarantine newly admitted residents who are at higher risk of getting exposed to COVID-19 but have no known exposure to COVID-19). The facility identified a census of 43 at the time of survey. Findings are: A. Observation on 6/17/2020 at 10:03 AM revealed 2 blue plastic gowns were hanging outside the door of Residents 14 and 15 (who resided in the room together) and 1 blue gown was hanging over the hand rail by their room that was touching the floor. The blue gowns hanging on the wall were touching each other. Observation on 6/17/2020 at 10:55 AM revealed the gowns were still hanging touching each other by the door and the gown was hanging over the hand rail touching the floor by the room occupied by Residents 14 and 15. Observation on 6/17/2020 at 11:31 AM revealed LPN-F (Licensed Practical Nurse) took one of the gowns off the wall hanging outside the door of the room occupied by Residents 14 and 15. It was a blue thin plastic gown that was hanging on the wall touching another gown hanging on the wall next to it. LPN-F put it on over their head and had to adjust the face shield they were wearing to get the gown on over it. LPN-F entered the room and did a BS (Blood Sugar) check for Resident 14. LPN-F then left the room and stopped outside the room door. LPN-F removed the gown from over their head and hung it back up on the wall, touching the gown hanging next to it. Interview with LPN-F at this time revealed they had to wear a gown and gloves in addition to a face shield and surgical mask when they went into the room being occupied by Resident 14 and 15 because Resident 15 went out of the facility to [MEDICAL TREATMENT] 3 times a week so the staff always had to gown up when they entered that room. Observation on 6/17/2020 at 12:30 PM revealed the blue gowns were still hanging by the door touching each other and over the hand rail touching the floor by the room occupied by Residents 14 and 15. B. Observation on 6/17/2020 at 10:23 AM revealed NA-H (Nursing Assistant) using the STS lift to transfer Resident 11. NA-H took a STS lift from the hall and wheeled it into Resident 11's room. NA-H donned gloves. NA-H touched Resident 11's control on Resident 11's power wheelchair and the STS lift. NA-H tried to put shoes on Resident 11's feet by handling the bottom and sides of the shoes. They did not fit over the thick socks Resident 11 was wearing so NA-H took them off as they were tight. NA-H felt the bottom of Resident 11's foot which had a sock on it and said Resident 11 has the grippers on their socks. NA-H helped Resident 11 sit up by touching their shoulders and arms then NA-H grabbed the lift. NA-H then put the sling around Resident 11's mid torso. NA-H still had the same gloves on. NA-H was touching the sling, the resident, and the lift with the same gloves NA-H touched Resident 11's shoes and the bottom of their socks with. Resident 11 then grabbed the hand rails on the lift. NA-H then adjusted NA-H's face mask with the same gloved hands. NA-H then touched Resident 11's hand when NA-H was helping Resident 11 get into the STS. NA-H touched the controls to stand Resident 11 and positioned Resident 11 in front of their power wheelchair. Resident 11 let go of the STS lift after they were seated in their wheelchair and NA-H removed the sling with the same gloved hands. NA-H then touched Resident 11 on the shoulder to help Resident 11 slide back into the wheelchair. NA-H then removed the gloves and got Resident 11 a blanket. NA-H did not perform hand hygiene after removing their gloves. NA-H then tucked the blanket around Resident 11's waist and legs. NA-H touched the STS lift with bare hands to move it so NA-H could get into the bathroom as the lift was in front of the bathroom door. NA-H then went into the bathroom and washed hands. NA-H touched the door knobs on the room door and bathroom door and put the lift back out into the hall. NA-H did not clean the STS lift. NA-H put the STS lift in the hall and left it after NA-H and Resident 11 touched it. NA-H did not have Resident 11 do any hand hygiene. Resident 11 then used the control on the power wheelchair to drive down the hall. NA-H reported they were headed to the bath house for Resident 11's whirlpool bath. Review of the EZ Way Floor Lift & Stand Cleaning Guide revised 8/14/18 revealed the following: To keep your EZ Way floor lifts and stands clean and in good condition, recommend that you use a standard germicidal spray, Sani-Wipe, or similar product and that you follow these guidelines: Do not spray product directly on the machine. Spray the cleaner onto a cloth or paper towel then wipe the unit to clean it. The germicidal spray, Sani-Wipe, or similar product and be used on the control panel and front panel graphics. If not using a wipe, make sure to spray the cleaner onto a cloth or paper towel then wipe the unit to clean it. Review of the undated facility Safe Resident Handling Equipment Competency Validation Checklist revealed the following: Clean Sit-to Stand after use. Interview on 6/17/2020 at 10:35 AM with NA-K revealed they used the lifts for more than 1 resident. The unit had two STS lifts and they used whichever one was available for the residents. Observation on 6/17/2020 at 11:14 AM the STS that NA-H had not cleaned was still sitting in the hall on Cottonwood east. Observation on 6/17/2020 at 11:16 AM revealed Resident 11 was going down the hall with NA-H. Resident 11 was touching the control on their power wheelchair and driving down the hall. Observation on 6/17/2020 at 12:30 PM revealed the STS lift was in the hall on the Cottonwood unit. Record review of the list of residents who used the STS lift on Cottonwood received from the facility Administrator on 6/18/2020 revealed these residents used the STS on the Cottonwood unit: Residents 16, 9, 17, 18, 11, 20, 12, 21, and 22. Review of the facility policy Hand Hygiene and Handwashing date reviewed/revised 4/14/2020 revealed the following: The goal is to prevent the spread of infection between residents. Handwashing and changing gloves occurs after care is delivered to prevent the spread of organisms to other residents. During Patient Care: Wash hands with plain soap and water or with anti-microbial soap and water: if hands are visibly soiled, if hands are visibly contaminated with blood or body fluids. If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based hand rub for routinely cleaning hands: before having direct contact with residents, patients and children; after having direct contact with another person's skin; after having contact with body fluids, wounds or broken skin; after touching equipment or furniture near the resident/patient; after removing gloves. Review of the facility policy Putting On and Taking Off Personal Protective Equipment (PPE) revised 2/18 revealed the following: Gloves should be worn any time there is reasonably anticipated occupational exposure. Disposable gloves should be replaced as soon as practical when contaminated or as soon

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 -** Actual harm **Residents Affected -** Few	(continued... from page 1) as feasible. When performing care services, remove gloves after contact with resident, patient and children and/or the surrounding environment using proper technique to prevent hand contamination. Change gloves during resident, patient and child care if the hands will move from a contaminated body site to a clean body site. Always wash hands between gloving. C. Observation on 6/17/2020 at 10:55 AM revealed HA-L (Housekeeping Assistant) was in Resident 12's room touching the drawers to put clothes away. HA-L came back out of Resident 12's room and retrieved a shirt from the clothing cart in the hall and took it into Resident 12's room and hung it up in the closet. HA-L exited Resident 12's room and did not do any hand hygiene. HA-L then removed clothing from the cart and entered Resident 13's room doorway then brought the clothes back out and hung them back on the cart as Resident 13 was trying to get up unassisted. After HA-L got assistance for Resident 13, HA-L went back out to the cart and retrieved the clothes hanging on the cart and took them into Resident 13's room. As HA-L was waiting to get to the closet, HA-L draped the clothing over their arm and held the clothing up against their smock/top. HA-L also touched Resident 13's walker as Resident 13 was being assisted by another staff member. HA-L then hung the clothes in Resident 13's closet and gave Resident 13 the call light. HA-L then took clothing out of a bin that was in Resident 13's room and opened the drawers before placing the clothing into the drawers. Review of the facility policy Laundering and Drying Clothes and Linens date reviewed/revised 1/1/2018 revealed the following: Package, transport and store clean clothes and linens to ensure their cleanliness and to reasonably protect them from dust and soil. D. Observation on 6/17/2020 at 11:20 AM revealed NA-H cleaned the Penner Spa whirlpool bathtub in the bath house on the Cottonwood Cottage. Interview with NA-H at this time revealed more than 1 resident used the whirlpool. NA-H revealed they gave a couple of whirlpool baths a day. NA-H donned gloves then NA-H pushed the disinfect jets button and filled the reservoir in the bottom of the whirlpool. NA-H scrubbed the inside of the tub and the whirlpool chair with a brush at 11:21 AM. NA-H got all surfaces on the inside of the tub and the seat and back portion of the whirlpool lift seat wet which was completed at 11:22 AM then NA-H drained the whirlpool. NA-H rinsed the whirlpool and shower chair with the sprayer attachment on the whirlpool at 11:23 AM. NA-H was done rinsing the inside of the tub at 11:24 AM. NA-H rinsed the jets on the whirlpool for 3 seconds. NA-H did not run the air blower, clean the outside of the tub or the lift part of the chair and NA-H did not allow the disinfectant to sit on the tub and chair surfaces. NA-H removed gloves and did hand hygiene at 11:25 AM and reported they were done cleaning the whirlpool. NA-H then left the bath house. Review of the facility policy Bathing date reviewed/revised 11/1/2019 revealed the following: Procedure for Cleaning Tub and Shower Stall: 1. Wearing gloves, use cleaning brush and spray bottle of approved cleaner/disinfectant solution. 2. Spray walls of tub or shower stall with disinfectant and brush across surfaces. Allow disinfectant to remain on surfaces for at least 10 minutes or according to manufacturer's recommendations. 3. Rinse walls with hot water for faucet/shower head. 4. Remove gloves, dispose of equipment and perform hand hygiene. Review of the undated Penner Manual on System Cleaning revealed the following: System Cleaning (After Every Bath) Note. Penner Cleaner/Disinfectant is a special non-abrasive cleaning and disinfecting solution that will not harm the tub's fiberglass surface. Penner Cleaner/Disinfectant is the only cleaning solution designed and recommended for use with your Cascade Contour Tub. 1. With the Swivel Lift position inside the tub. 2. Close and lock the door. 3. Press the Tub Fill Button and turn the Temperature Control Knob all the way to the left to its warmest level to heat the disinfectant solution and maximize its effectiveness. 4. Remove any visible tissue, residue, or fluids from the tub by pressing the Shower Button and rinsing the inside tube surfaces with the shower sprayer. 5. Press the Fill Button again to turn off the water. Allow the tub to drain, and place the drain plug over the drain. 6. Press and hold the Disinfect Button located on the control panel. As the button is held down, the properly mixed cleaning solution is running through the air injection system and out all of the air jets. Release the button after you see solution coming out of all the air jets and you have 1 to 1 gallons of disinfectant solution in the foot well of the tub. 7. Using the long-handled brush, available from your Penner distributor, thoroughly scrub all interior surfaces of the tub and Swivel Lift chair with the solution that remains in the foot well of the tub. Let disinfectant stay on surface for 10 minutes (or, as recommended by the instructions on the disinfectant concentrate container.) 8. Remove the plug from the drain. 9. Rinse the tub's interior surfaces thoroughly with the shower sprayer. 10. Rinse most of the soapy water away with the shower sprayer. 11. Press and hold the Rinse button located on the control panel until clear water runs from all the air jets. Then release the Rinse button. 12. Finish rinsing the interior surfaces of the tub with the shower sprayer. 13. Start the air blower by pushing the Aqua-Aire Button. Allow it to run for 30 seconds. This pushes the rinse water out of the air injection system. If this was the last bath of the day, allow the blower to run for 2 minutes to dry out the system. 14. Stop the Aqua-Aire blower by again pushing the Aqua-Aire button. 15. Visibly check that the tub and reservoir was effectively cleaned during the disinfecting procedure. If not, repeat the procedure. 16. If there is a delay of one or more hours before the next bath, we recommend using a towel to wipe off all excess water. Review of the undated Instructions for Classic Whirlpool Disinfectant Cleaner revealed the following: For broad spectrum disinfection of gram negative and gram positive bacteria, including Pseudomonas aeruginosa and Staphylococcus aureus, add two ounces Classic Whirlpool Disinfectant Cleaner to one gallon of water. Remove heavy soil or gross filth from the surface to be disinfected, then apply properly diluted solution with a mop, cloth, sponge, or hand pump trigger sprayer so as to wet the surface thoroughly. Allow to remain wet for 10 minutes and then let air dry. If higher detergency is desired, increase dilution to 4 to 6 ounces per gallon of water. Prepare a fresh solution for each use or when solution becomes visibly dirty. To disinfect hard, non-porous, inanimate surfaces (such as fiberglass and stainless steel tubs and chair surfaces, chrome plated intakes and lefts, etc.), apply properly diluted Classic Whirlpool Disinfectant Cleaner so as to wet all surfaces thoroughly. For routine disinfection, proper dilution is 1:64 (2 ounces of product per gallon of water). Allow to remain wet for 10 minutes, then let air dry. For heavily soiled areas, a pre-cleaning step is required. Prepare a fresh solution of reach use as above. For cleaning bath and therapy equipment: after using the whirlpool unit, drain the water and refill with fresh water to just cover the intake valve. Add 2 ounces of Classic Whirlpool Disinfectant Cleaner for each gallon of water in the unit at this point. Briefly start the pump to circulate the solutions. Turn off pump. Wash down the unit sides, seat of the chairlift and any/all related equipment with a clean swab or sponge. After the unit has been thoroughly cleaned, drain solutions from the unit and rinse any/all clean surfaces with fresh water. Review of the facility Monthly Infection Control Reports revealed the following UTI (Urinary Tract Infection) rates: April 2020: 10 nosocomial (facility acquired) UTI (Urinary Tract Infection). May 2020: 6 Nosocomial UTI. June 2020: 5 Nosocomial UTI. Record review of the list of residents who used the whirlpool on Cottonwood received from the facility Administrator revealed the following residents used the whirlpool bath: Residents 19, 11, 20, 13, 21, and 23. Review of Resident 21's Order Summary Report for Active Orders as of 5/28/2020 revealed an order for [REDACTED]. Review of Resident 21's Progress Notes from April 1st to June 18, 2020 revealed documentation of a UTI on 5/27/2020: Received order from PCP (Primary Care Provider) for a urinalysis (UA) .5/28/2020 UA results called to PCP office. Awaiting orders from PCP. Orders received from PCP for [MEDICATION NAME] (antibiotic) 100 mg PO BID (by mouth twice daily) for 10 days. On 6/1/2020 it was documented Resident 21 was on antibiotic for UTI. Review of the POC (Point of Care) Response History Type of Bath for 5/19/2020 to 6/19/2020 revealed documentation Resident 21 received a whirlpool bath on June 1, 4, 8, 11, 15, and 18. Review of Resident 20's Progress Notes dated 6/1/2020 revealed the following documentation: Resident has a UTI (Urinary Tract Infection). Dr ordered [MEDICATION NAME] (antibiotic) twice daily until C&S (Culture & Sensitivity) is back from lab. Review of Resident 20's quarterly MDS (Minimum Data Set-a comprehensive assessment tool used to develop a resident's care plan) dated 5/20/2020 revealed Resident 20 was dependent upon staff for bathing. Review of Resident 20's MAR (Medication Administration Record) for June 2020 revealed documentation [MEDICATION NAME] (antibiotic) Capsule 100 mg by mouth two times a day for UTI was administered to Resident 20 from 6/1/2020 to 6/4/2020 and [MEDICATION NAME] (antibiotic) 1 tablet by mouth two times a day for UTI was administered to Resident 20 from 6/4/2020 to 6/14/2020. Review of Resident 20's Order Summary Report for June 1, 2020 revealed an order for [REDACTED]. Review of Resident 21's quarterly MDS dated [DATE] revealed Resident 21 was dependent upon staff for bathing and had a UTI in the last 30 days. Review of the POC (Point of Care) Response History Type of Bath for 5/19/2020 to 6/19/2020 revealed documentation Resident 13 received a whirlpool bath on June 18. Review of the POC (Point of Care) Response History Type of Bath for 5/19/2020 to 6/19/2020 revealed documentation Resident 19 received a whirlpool bath on May 22, 26, 29; June 2, 5, 9, 12, 16 and 19. Review of the POC (Point of Care) Response History Type of Bath for 5/19/2020 to 6/19/2020 revealed documentation Resident 11 received a whirlpool bath on May 22, 25, 27, 29; June 1, 3, 5, 8, 10, 12, 15, 17 and 19. E. Observation on 12:03 PM revealed NA-I, NA-J, and NA-K were lined up at the meal tray line at the kitchen area on the Cottonwood unit. NA-K was wearing a surgical mask and their face shield was flipped up and not covering their eyes or surgical mask. NA-K was not wearing any other eye protection. NA-K was observed pouring the drinks on the trays. At 12:08 PM all of the drinks were poured onto 22 trays. The drinks were not covered. At 12:11 PM the cook started plating the

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F 0880 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) food then put the plates of food onto the trays. NA-I, NA-J, and NA-K covered the plates of food and took them down the hall to the residents. All of the trays had drinks on them and none of the drinks were covered. By 12:30 PM all 22 trays had gone out to the resident rooms without the drinks covered. Review of the facility policy Room-Tray Service-Food and Nutrition date reviewed/revised 5/18/2020 revealed the following: Deliver room/tray service in a sanitary manner (covered during transport, plated at the proper serving temperature by employees who have washed their hands, etc.) Interview with the facility Administrator on 6/18/2020 at 9:43 AM confirmed the whirlpool was used for more than 1 resident and the facility staff were expected to clean the whirlpool in between use of residents. The Administrator confirmed the lifts, including the STS lifts, were used for more than 1 resident and the staff were expected to clean them between residents. The Administrator revealed it was their expectation the facility staff changed gloves when they were contaminated and performed hand hygiene with both soap and water or hand sanitizer when hands were contaminated. The Administrator revealed the blue plastic gowns were disposable; however, based on need versus supply, the facility was utilizing conservation with gowns following the guidance. The Administrator revealed the room that had the PPE by the doors belonged to residents who had been outside of the facility for a medically necessary appointment within the last 14 days and as an extra precautionary measure, they were utilizing gowns for high contact cares. The Administrator revealed the expectation for staff was to deliver the meals covered to the residents' rooms. At 11:21 AM the Administrator revealed the facility staff were expected to follow the manufacturer's instruction for the contact or wet set time on the disinfectant for the whirlpool. The Administrator revealed facility staff were not allowed to hang the blue gowns touching each other or hanging over the hallway hand rails touching the floor. The Administrator revealed the facility staff were not allowed to hold clean resident clothing up against their smocks/scrub tops. F. Observation on 6/17/20 at 11:22 AM on the Ash Grove household revealed that Resident 8 had the resident's legs over the side of the bed. NA-D asked Resident 8 if they needed to use the bathroom. NA-C performed hand hygiene with alcohol based hand sanitizer (ABHR) and put on disposable gloves. NA-D performed hand hygiene with ABHR and put on disposable gloves. NA-D brought the sit to stand lift (a mechanical assistive device used to transfer a resident with difficulty standing up on their own from a seated position) from the hallway into the resident's room. NA-C and NA-D placed the sit to stand lift sling (a fabric device with straps that is placed around the back of a resident when a sit to stand lift is used to transfer a resident with difficulty or inability to stand up on their own from a seated position) around Resident 8 and connected the sling to the sit to stand lift. NA-C connected the leg strap around the resident's shins. NA-C instructed Resident 8 to hold onto the hand grips on the lift and to look up. NA-C operated the sit to stand lift and Resident 8 was transferred from a seated position on the bed to a standing position on the lift. NA-C and NA-D transferred Resident 8 from the bed into the bathroom with the sit to stand lift and lowered Resident 8 onto the toilet. NA-C and NA-D exited the bathroom and closed the bathroom door approximately half way. Resident 8 notified NA-C and NA-D that the resident was finished on the toilet. NA-C and NA-D reentered the resident's bathroom. NA-C and NA-D each performed hand hygiene with ABHR and each put on disposable gloves. NA-D assisted the resident with wiping the private areas of the resident. A new brief was placed on the resident. NA-D removed the disposable gloves and performed hand hygiene using soap and water. NA- C removed the disposable gloves and performed hand hygiene with soap and water. NA-C and NA-D transferred Resident 8 from the bathroom to the bed with the sit to stand lift. The resident was lowered to a sitting position on the edge of the bed and the lift sling was removed. Resident was assisted from a sitting position on the edge of the bed to lying on the bed by NA-C and NA-D. NA-C performed hand hygiene with ABHR as NA-C exited the resident's room. NA-D removed the sit to stand lift from the room of Resident 8 and parked the lift along the wall between the rooms of Resident 8 and the empty room across the hall from Resident 8. NA-D did not disinfect the sit to stand lift. NA-D walked to the kitchen area and performed hand hygiene with ABHR and placed cups on resident meal trays. Record review of the facility policy titled SAFE RESIDENT HANDLING EQUIPMENT COMPETENCY VALIDATION CHECKLIST dated 4/20 revealed section D: Transfers Surface to Surface with Stand Aid Competency Validation Checklist step 15. Clean stand aid after use. Interview on 6/18/20 at 3:15 PM with the facility administrator (FA) confirmed that the expectation for cleaning the lifts is that staff perform cleaning of the lift between resident use. G. Record review of the Nebraska Infection Control Assessment and Promotion Program (ICAP) document titled Cohorting (an imposed grouping of residents within a similar risk status) Plan For Long Term Care Facilities (LTCF) dated 4/17/20 revealed that facilities should plan to identify red, yellow and green zones where the residents can be cohorted based on their symptoms and exposure risks to COVID-19. Facilities are also recommended to establish a transitional zone (gray zone) for asymptomatic patients who are being transferred from other healthcare facility. Establishing Transitional (Gray) Zones: -All nursing homes should consider establishing a transitional zone for new admissions, returning residents from the hospital or those who are travelling in and out of the nursing home (such as the residents who are on [MEDICAL TREATMENT]). Transitional zones/units are established to quarantine those residents who are at somewhat higher risk of getting exposed to COVID-19 but have no known exposure to COVID-19. -Facilities should also consider dedicating separate staff to take care of residents in transitional (gray) zone/unit. -Facilities should implement COVID-level precautions for the residents admitted to the transition unit. If PPE supply is inadequate, nursing homes can consider limiting COVID-level precautions to only high-contact resident care-activities or aerosol generating procedures within the transition zone. -These units should be established even when no COVID-case is identified at the facility and may consist dedicating a geographically distinct area/unit/rooms to returning residents. -The residents are usually kept in this zone for 14 days and if remains asymptomatic at the end of 14 day will be moved to the Green zone. Interview on 6/17/20 at 8:57 AM in the west parking lot of the facility with the Facility Administrator revealed that the Cedar Creek cottage is a gray zone for new residents to the facility. An Email received on 6/17/20 at 6:22 PM from the Facility Administrator (FA) confirmed that the facility is working with the Central District Health Department, ICAP, and the Department of Health and Human Services to perform covid testing for all staff and residents. The FA confirmed that the facility began to isolate new admissions to the facility on [DATE]. Record review of the Centers for Disease Control (CDC) guidance titled Preparing for COVID-19 in Nursing Homes updated 6/19/20 revealed the section Core Practices: Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown. oDepending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. Health Care Professionals (HCP) should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. Testing at the end of this period can be considered to increase certainty that the resident is not infected. Interview on 6/17/20 at 9:38 AM Licensed Practical Nurse-A (LPN-A) at the treatment cart outside of the nurse's station in the Cedar Creek cottage revealed that LPN-A was wearing a surgical mask (not an N95 mask) and face shield. LPN-A revealed that the residents in the Cedar Creek cottage are new admissions to the facility and that the residents are isolated for 14 days to monitor them for Covid-19. Interview 6/17/20 at 9:38 AM with Nursing Assistant (NA-B) outside of the nurse's station in the Cedar Creek cottage revealed that NA-B was wearing a surgical mask (not an N95 mask) and face shield. NA-B revealed that NA-B cares for the residents in this cottage. Observation on 6/17/20 at 9:30 AM in the Cedar Creek cottage (the facility gray zone quarantine unit) revealed that the facility Social Services Director (SSD) was wearing a surgical mask (not an N95 mask) and a face shield. The SSD put on a gown and no gloves while outside of the room of Resident 1. SSD entered the room of Resident 1. The SSD sat on a chair in the resident's room and talked to the resident seated in the recliner. The facility Therapy Director (TD) was observed in Resident 1's room wearing a surgical mask (not an N95 mask), face shield, gown, and gloves. TD assisted Resident 1 to ambulate from the recliner to the room door and back to the recliner with a walker. Observation on 6/17/20 at 11:05 AM in the Cedar Creek cottage revealed that Licensed Practical Nurse-A (LPN-A) wore a surgical mask (not an N95 mask) and face shield and put on a gown and gloves while outside of the room of Resident 5. LPN-A entered Resident 5's room with a glucometer (a medical device used to measure and display the amount of sugar in the blood for residents with diabetes) and supplies used for obtaining the resident blood glucose (sugar) level. LPN-A pricked a finger on the resident's right hand and obtained a blood sample for the glucometer. LPN-A told the resident that the blood sugar level was high at 227 today. Resident 5 stated that the resident had eaten some cookies. LPN-A carried the glucometer to the treatment cart in the hall and sat the glucometer on the top of the cart and removed the disposable gloves. LPN-A 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) using ABHR. LPN-A removed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285285	A. BUILDING _____ B. WING _____	**06/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOOD SAMARITAN SOCIETY - GRAND ISLAND VILLAGE	**4061 TIMBERLINE STREET & 4055 TIMBERLINE STREET GRAND ISLAND, NE 68803**

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 -** Actual harm **Residents Affected -** Few	(continued... from page 3) gown and hung the gown on the handrail in the hallway outside of the resident's room. LPN-A performed ABHR and put on disposable gloves. LPN-A wiped all surfaces of the glucometer with a Sani Cloth (disinfectant) wipe. LPN-A placed a new Sani Cloth wipe on the top of the treatment cart and sat the glucometer on the Sani Cloth wipe on the cart. Observation on 6/17/20 at 11:12 AM in the Cedar Creek cottage revealed that LPN-A pushed the treatment cart from the nurse's station to the doorway of the room of Resident 6. LPN-A had a surgical mask (not an N95 mask) and face shield on. LPN-A put on a gown that was hanging on the handrail beside the Personal Protective Equipment (PPE) cart (a storage container for equipment that includ