STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285270	A. BUILDING _____ B. WING _____	**07/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BETHANY HOME, INC.	**515 WEST FIRST STREET MINDEN, NE 68959**

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 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Licensure Reference Number 175NAC 12-006.11E Based on observation, record review, and interview the facility failed to ensure that dietary staff stored dishes in a sanitary manner. This had the potential to affect all facility residents that received food from the facility kitchen; and the facility failed to ensure that dietary staff washed hands and disinfected equipment and utensils during food service to prevent the potential for cross contamination and foodborne illness for 6 residents (Residents 52, 27, 31, 48, 53, and 29). The facility census was 59. Findings are: A. An observation on 7/27/20 at 9:58 AM during the initial tour of the kitchen revealed in the Clean Dish Room the storage of bowls, plates, and saucers that were placed serving side up and had the potential of letting foreign objects, dust and debris to enter the serving areas of the dishes. This had the potential to affect all of the residents eating food served in the kitchen. Review of the Handwashing Policy NEBRASKA FOOD CODE Statute 2-301.14 When to Wash Food service employee shall clean their hands and exposed portions of their arms immediately before engaging in food preparation including working with exposed food, clean equipment and utensils and unwrapped single-services and single-use articles and: - (E) After handling soiled equipment or utensils' (I) after engaging in other activities that contaminate the hands Review of the Hand Hygiene Policy Staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. 1 Hand hygiene is a general term that applies to either handwashing or the use of an antiseptic hand rub, also known as alcohol-based hand rub. 2. Staff will perform hand hygiene when indicated, using proper technique. The procedure for how to use alcohol-based hand rub and soap and water is listed. Under additional considerations: b. The use of gloves does not replace hand washing. Wash hands after removing gloves. An observation on 7/28/2020 at 4:03 PM during an additional tour of the kitchen revealed the dishes in the kitchen's Clean Dish Room were stored with the serving side up which consisted of bowl, plates and saucers in the dish racks. The serving side being exposed had the potential to allow foreign objects, dust and debris to enter the dishes. On 7/29/2020 at 2:00 PM an interview with DM (Dietary Manager) revealed that the dishes should have been covered in the Clean Dish Area. The DM was also informed of the staff on the Memory Care Unit wearing gloves and not changing gloves between residents after touching silverware that was unwrapped by the resident and the staff then cut up the resident's food using the same contaminated gloved hands. The staff would then go, with contaminated hands, and take the plate for the next resident. The DM confirmed that gloves need to be changed then coming into contact with contaminated items and hand hygiene needs to be done when changing gloves. B. Observation on 7/27/20 at 11:55 AM revealed that Dietary Assistant-C (DA-C) pushed a three shelf cart from the facility dining room to the 300 hallway while wearing disposable gloves. DA-C picked up a room meal tray from the top shelf of the cart and delivered the meal to Resident 6. DA-C sat the meal tray on the over bed table in the resident's room and removed the plate cover from the plate and sat it down. DA-C grabbed the over bed table with both gloved hands and repositioned the table in front of Resident 6. DA-C picked up the plate cover and exited the resident's room and sat the cover on the bottom shelf of the cart. DA-C picked up a room meal tray from the top shelf of the cart with the same gloves. DA-C delivered the meal tray to Resident 18. DA-C removed the plate cover from the plate and exited the resident's room and placed the plate cover on the top of the cart. DA-C picked up a room meal tray from the cart wearing the same gloves and delivered the meal tray to Resident 47. DA-C removed the plate cover from the plate on the tray and exited the resident's room and placed the plate cover on the top of the cart. DA-C touched the top of the cart with both gloved hands and moved around the meal tray cards on the top of the cart. DA-C grabbed the handle on the cart with the same gloves and pushed the cart to the 400 hallway. The facility Business Office Manager (BOM) walked to the cart and offered to assist with delivering meals. The BOM picked up a room meal tray from the cart and delivered the meal to Resident 206. The BOM exited the resident's room and performed hand hygiene with ABHR. DA-C picked up the room meal tray for Resident 20 from the second shelf of the cart and sat it on the top of the cart. The BOM offered to deliver the meal to Resident 20 once the medication aide was finished in the resident's room. The BOM picked up the room tray from the cart and sat the meal tray on another cart in the hallway. DA-C grabbed the handle of the meal cart that DA-C had been using with both hands while wearing the same gloves that were worn to deliver room meal trays. DA-C pushed the cart into the facility kitchen and parked the cart near the steam table. DA-C did not remove the disposable gloves that were used while delivering room meal trays. DA-C did not disinfect the cart. Observation on 7/27/20 at 12:04 PM revealed that Dietary Assistant-C (DA-C) was standing in the facility kitchen at the steam table wearing the same disposable gloves that were worn during delivery of room meal trays. DA-C picked up a red plate with the thumb on the top surface of the plate and used the tongs to plate a piece of chicken onto the plate and then plated Alfredo noodles onto the plate and sat the plate on the top of a 3 shelf cart. DA-C picked up a red plate and plated a piece of chicken on the plate and then plated Alfredo noodles on the plate with DA-C's thumb on the top surface of the plate. DA-C sat the plate on the top of a 3 shelf cart and then placed a metal rim on the plate. Dietary Assistant-D (DA-D) picked up the red plate without the metal rim from the top of the cart and delivered the plate to Resident 52 in the facility dining room. DA-D returned to the kitchen and picked up the red plate with the metal rim and delivered the plate to Resident 27 in the facility dining room. Observation on 7/27/20 at 12:08 PM revealed that Dietary Assistant-C (DA-C) picked up the plate covers from the top of the 3 shelf cart that had been used to deliver meal trays to rooms wearing the same gloves that were worn while delivering room meal trays and sat the plate covers on a table in the facility kitchen. The cart had not been disinfected. DA-C did not remove the contaminated gloves. DA-C plated food onto a plate and sat the plate on the top of the 3 shelf cart that had been used to deliver room meal trays. The cart had not been disinfected. Dietary Assistant-F (DA-F) picked up the plate of food from the top of the cart in the kitchen wearing disposable gloves and delivered the plate of food to Resident 31. DA-F returned to the kitchen and picked up a plate from the top of the cart that had been used to deliver meal trays wearing the same disposable gloves and delivered the plate of food to Resident 48. DA-F picked up the fork and knife from the table in front of the resident and cut up the meat for the resident. DA-F then returned to the kitchen. DA-F touched the handle of the cart that had been used to deliver room meal trays with the gloved hands and then picked up a plate of food from the top of the cart. DA-F delivered the plate of food to Resident 53. DA-F returned to the kitchen and grabbed the handle of the cart and pulled the cart into the dining room with the same gloves still on. DA-F picked up a plate of food from the top of the cart wearing the same gloves and delivered the plate of food to Resident 29. DA-F picked up the fork and knife from the table in front of the resident and cut up the meat on the plate for the resident while still wearing the same gloves. Record review of the undated facility policy titled Hand Hygiene revealed Step 6. Additional considerations. b. The use of gloves does not replace hand washing. Record review of the

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 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) facility policy titled Food and Nutrition Management dated 4/2020 revealed Step 15. All foods must be delivered on a clean serving cart and all food items and drinks must be covered during transportation of food items. Step 16. Facility staff serving room trays to residents will ensure that proper infection control techniques are followed during the serving process. Hand hygiene with alcohol-based hand rub should be performed between serving each resident's room tray. Record review of the Nebraska Food Code dated July 21, 2016 revealed section 2-301.14 When to Wash: Food Employees shall clean their hands and exposed portions of their arms as specified under paragraph 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: (E) After handling soiled equipment or utensils. The section titled Preventing Contamination by Employees 3-302.11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation. (A) Food shall be protected from cross contamination by: (3) Cleaning equipment and utensils as specified under paragraph 4-602.11(A) and sanitizing as specified under paragraph 4-703.11 Interview with the facility Dietary Manager (DM) on 7/30/20 at 1:22 PM confirmed that the 3 shelf carts are used to deliver room meal trays and are considered contaminated until cleaned on return to the kitchen. Carts are to be cleaned with the disinfectant in the bucket in the kitchen. The DM confirmed that the 3 shelf carts are then used to deliver plates of food to residents in the dining room after room trays are delivered. The DM revealed that staff do not usually wear gloves when plating food from the steam table. The DM confirmed that if gloves are worn when plating food they should be new gloves. C. 7/27/20 at 11:30 AM Observation of the Dietary Cook (DA-E) getting trays ready to go out on carts to resident rooms, cook started placing food on plate and threw plate away, tongs fell to floor, bent over to pick up the tongs, then started dishing up another tray, dropped paper plate on floor, and bent over to pick it up and throw into garbage container. 11:36 AM The DA-E walked around the kitchen with same gloves on, picked up the telephone and talked on phone for 3 minutes with same gloved hands. 11:39 AM DA-E back to steam table goes to the counter and opens utensil drawer and takes out another pair of tongs. 11:40 AM Removes gloves and puts new pair gloves on. 7/27/20 at 1130 Am Observation of the Dietary Assistant (DA-F) assisting 2 residents in dining room, taking food to table and help get utensils out and assist residents with cutting up meat and getting their trays ready for them, the (DA-F) did not change gloves or use hand hygiene between or after assisting residents. Record review of the Nebraska Food Code dated July 21, 2016 revealed section 2-301.14 When to Wash: Food Employees shall clean their hands and exposed portions of their arms as specified under paragraph 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: (E) After handling soiled equipment or utensils. The section titled Preventing Contamination by Employees 3-302.11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation. (A) Food shall be protected from cross contamination by: (3) Cleaning equipment and utensils as specified under paragraph 4-602.11(A) and sanitizing as specified under paragraph 4-703.11 Interview with the facility Dietary Manager (DM) on 7/30/20 at 2:22 PM confirmed that the 3 shelf carts are used to deliver room meal trays and are considered contaminated until cleaned on return to the kitchen. Carts are to be cleaned with the disinfectant in the bucket in the kitchen. The DM confirmed that the 3 shelf carts are then used to deliver plates of food to residents in the dining room after room trays are delivered. The DM revealed that staff do not usually wear gloves when plating food from the steam table. The DM confirmed that if gloves are worn when plating food they should be new gloves.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Licensure Reference Number 175NAC 12-006.17D Based on observation, record review, and interview the facility failed to ensure that staff removed disposable gloves and 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 residents and health care personnel) between residents during the delivery of room meal trays and serving of food in the facility dining rooms to prevent the potential for cross contamination and foodborne illness for 13 residents observed (Residents 6, 18, 47, 206, 20, 31, 48, 53, 29, 45, 158, 34, and 28). The facility census was 59. Findings are: A. Observation on 7/27/20 at 11:55 AM revealed that Dietary Assistant-C (DA-C) pushed a three shelf cart from the facility dining room to the 300 hallway while wearing disposable gloves. DA-C picked up a room meal tray from the top shelf of the cart and delivered the meal to Resident 6. DA-C sat the meal tray on the over bed table in the resident's room and removed the plate cover from the plate and sat it down. DA-C grabbed the over bed table with both gloved hands and repositioned the table in front of Resident 6. DA-C picked up the plate cover and exited the resident's room and sat the cover on the bottom shelf of the cart. DA-C picked up a room meal tray from the top shelf of the cart with the same gloves. DA-C delivered the meal tray to Resident 18. DA-C removed the plate cover from the plate and exited the resident's room and placed the plate cover on the top of the cart. DA-C picked up a room meal tray from the cart wearing the same gloves and delivered the meal tray to Resident 47. DA-C removed the plate cover from the plate on the tray and exited the resident's room and placed the plate cover on the top of the cart. DA-C touched the top of the cart with both gloved hands and moved around the meal tray cards on the top of the cart. DA-C grabbed the handle on the cart with the same gloves and pushed the cart to the 400 hallway. The facility Business Office Manager (BOM) walked to the cart and offered to assist with delivering meals. The BOM picked up a room meal tray from the cart and delivered the meal to Resident 206. The BOM exited the resident's room and performed hand hygiene with ABHR. DA-C picked up the room meal tray for Resident 20 from the second shelf of the cart with the same gloves and sat it on the top of the cart. The BOM offered to deliver the meal to Resident 20 once the medication aide was finished in the resident's room. The BOM picked up the room tray from the top of the cart and sat the meal tray on another cart in the hallway. DA-C grabbed the handle of the meal cart that DA-C had been using to deliver room meal trays and pushed the cart into the facility kitchen near the steam table. DA-C did not remove the disposable gloves that were used while delivering room meal trays. DA-C did not disinfect the cart. Observation on 7/27/20 at 12:08 PM revealed that Dietary Assistant-C (DA-C) picked up the plate covers from the top of the 3 shelf cart that had been used to deliver meal trays to rooms wearing the same gloves that were worn while delivering room meal trays and sat the plate covers on a table in the facility kitchen. DA-C plated food from the steam table onto a plate and sat the plate on the top of the 3 shelf cart that had been used to deliver room meal trays. The cart had not been disinfected. Dietary Assistant-F (DA-F) picked up the plate of food from the top of the cart in the kitchen wearing disposable gloves and delivered the plate of food to Resident 31. DA-F returned to the kitchen and picked up a plate from the top of the cart that had been used to deliver meal trays wearing the same disposable gloves and delivered the plate of food to Resident 48. DA-F picked up the fork and knife from the table in front of the resident and cut up the meat for the resident. DA-F then returned to the kitchen. DA-F touched the handle of the cart that had been used to deliver room meal trays with the gloved hands and then picked up a plate of food from the top of the cart. DA-F delivered the plate of food to Resident 53. DA-F returned to the kitchen and grabbed the handle of the cart that had been used to deliver room meal trays and pulled the cart into the dining room with the same gloves still on. DA-F picked up a plate of food from the top of the cart wearing the same gloves and delivered the plate of food to Resident 29. DA-F picked up the fork and knife from the table in front of the resident and cut up the meat on the plate for the resident while still wearing the same gloves. Record review of the facility policy titled Food and Nutrition Management dated 4/2020 revealed step 16. Facility staff serving room trays to residents will ensure that proper infection control techniques are followed during the serving process. Hand hygiene with alcohol-based hand rub should be performed between serving each resident's room tray. Record review of the undated facility policy titled Hand Hygiene revealed Step 6. Additional considerations. b. The use of gloves does not replace hand washing. Interview on 7/30/20 at 10:04 AM with the facility Infection Control Nurse (ICN) confirmed that staff are to perform hand hygiene upon exiting a resident room using alcohol based hand gel and rubbing for 15-20 seconds until dry and perform hand hygiene between resident rooms. Gloves are to be removed after finishing a task and hand hygiene is to be performed. Gloves are not to be worn from room to room for any reason. B. An observation on 7/27/2020 at 11:56 AM of the nursing staff in the dining room on the Memory Care Unit revealed the staff were wearing gloves to serve food to the 15 residents present in the dining room on the Memory Care Unit. Staff AA-B (Activity Assistant), who was wearing gloves took a plate of food to an unnamed resident and using that resident's unwrapped silverware cut up the food. Staff AA-B did not change the contaminated gloves or do hand hygiene. Staff AA-B without changing gloves or doing hand hygiene went to Resident 45 and cut up Resident 45's food with the same contaminated gloved hands. Using the same contaminated gloves AA-B continued to serve the other residents in the dining room food with

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) the same contaminated gloves without doing hand hygiene. AA-B continued to cut up food for those residents. An observation on 7/27/2020 at 11:56 AM of MA-A (Medication Aide) revealed MA-A took the plate of food for Resident 45 and touching Resident 45's unwrapped silverware cut up Resident 45's food. MA-A then handed the fork to Resident 45. MA-A then without changing the contaminated gloves or doing hand hygiene cut up the food for Resident 158 using Resident 158's unwrapped silverware. MA-A did not change the contaminated gloves or do hand hygiene. MA-A went to Resident 34 wearing the same contaminated gloves or doing hand hygiene cut up the food for Resident 34. MA-A then obtained a plate of food for Resident 28 with the same contaminated gloved hands and placed the plate of food in front of Resident 28. MA-A then cut up the food with the same contaminated gloved hands for Resident 28. Review of the Handwashing Policy NEBRASKA FOOD CODE Statute 2-301.14 When to Wash Food service employee shall clean their hands and exposed portions of their arms immediately before engaging in food preparation including working with exposed food, clean equipment and utensils and unwrapped single-services and single-use articles and: - (E) After handling soiled equipment or utensils' (I) after engaging in other activities that contaminate the hands Review of the Hand Hygiene Policy Staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. 1 Hand hygiene is a general term that applies to either handwashing or the use of an antiseptic hand rub, also known as alcohol-based hand rub. 2. Staff will perform hand hygiene when indicated, using proper technique. The procedure for how to use alcohol-based hand rub and soap and water is listed. Under additional considerations: b. The use of gloves does not replace hand washing. Wash hands after removing gloves. On 7/29/2020 at 2:00 PM an interview with DM (Dietary Manager) revealed that the dishes should have been covered in the Clean Dish Area. The DM was also informed of the staff on the Memory Care Unit wearing gloves and not changing gloves between residents after touching silverware that was unwrapped by the resident and the staff then cut up the resident's food using the same contaminated gloved hands. The staff would then go, with contaminated hands, and take the plate for the next resident. The DM confirmed that gloves need to be changed then coming into contact with contaminated items and hand hygiene needs to be done when changing gloves. C. 07/27/20 11:30 AM Observation of lack of hand hygiene by Dietary Cook (DA-E) with serving food from steam table to plates to 3 tiered cart, picked utensil from floor with same gloved hand, and using telephone with same gloved hand, then went back to steam table and continued to serve trays. When DA-E finished serving trays, at 11:40 AM removed gloves, and placed another pair of gloves on. 07/27/20 11:45 AM Observation of Dietary Assistant (DA-D) wearing gloves, did not change gloves, touched face and picked up utensils up from floor, assisted residents in dining room ready their trays for lunch, and providing fluids with their lunch from a 3 tiered cart. No hand hygiene seen while observing the DA-D. Record review of the facility policy titled Food and Nutrition Management dated 4/2020 revealed step 16. Facility staff serving room trays to residents will ensure that proper infection control techniques are followed during the serving process. Hand hygiene with alcohol-based hand rub should be performed between serving each resident's room tray. Record review of the undated facility policy titled Hand Hygiene revealed Step 6. Additional considerations. b. The use of gloves does not replace hand washing. Interview on 7/30/20 at 11:14 AM with the facility Infection Control Nurse (ICN) confirmed that staff are to perform hand hygiene upon exiting a resident room using alcohol based hand gel and rubbing for 15-20 seconds until dry and perform hand hygiene between resident rooms. Gloves are to be removed after finishing a task and hand hygiene is to be performed. Gloves are not to be worn from room to room for any reason.