

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 285293	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2020
NAME OF PROVIDER OF SUPPLIER HILLCREST COUNTRY ESTATES-COTTAGES		STREET ADDRESS, CITY, STATE, ZIP 6082 GRAND LODGE AVENUE PAPILLION, NE 68133	
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 - Few	Provide and implement an infection prevention and control program. Licensure Reference Number: 175 NAC 12-006.17 Based on observation, interview and record review, the facility failed to implement infection Control Practices and Center for Medicare and Medicaid Services (CMS) guidelines to prevent the potential for cross contamination including the spread of Covid-19 related to failure of staff to wear approved eye protection in resident room for 1 Resident (Resident 1) of 3 residents reviewed. The facility Census was 34. Findings are: Interview on 6/22/2020 at 8:25 AM with the Assistant Administrator revealed the facility is working with Infection Control Assessment and Promotion Program (ICAP- a CDC-funded efforts with the primary objective to prevent health care-associated infections) . All resident rooms are private rooms and signs on nameplates denote gray zone (area for residents that are being quarantined to assess for Covid-19) residents. Observation on 6/22/2020 at 10:00 AM revealed Resident 1 had a gray sign on the door indicating Resident 1 was in a gray zone. Review of Gray Zone sign on Resident 1's door revealed Team members PPE to include surgical mask, gloves, gown and goggles (if available) Interview on 6/22/2020 at 1:30 PM with the administrator revealed the facility had an adequate supply of Personal Protective Equipment (PPE) including eye protection. Observation on 6/22/2020 at 12:40 PM revealed Certified Occupational Therapy Assistant (COTA) A in Resident 1's room working with Resident 1. COTA A was within 3 feet of Resident 1 and was not wearing eye protection only prescription glasses. Interview on 6/22/2020 at 12:40 PM with Clinical Consultant revealed COTA A was wearing only prescription glasses with no eye protection in Resident 1's room. Review of the facilities Covid-19 Cohorting plan dated 5/6/2020 revealed that in the gray zone eye protection is required. Review of the Center for Disease Control article Titled: Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (Covid-19) Healthcare Setting dated June 19, 2020 revealed personal eyeglasses and contact lenses are NOT considered eye protection		

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.