STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175346	A. BUILDING _____ B. WING _____	**06/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALMA MANOR	**234 MANOR CIRCLE ALMA, KS 66401**

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.** The facility reported a census of 30 residents. The sample included three residents reviewed for infection control practices. Based on observation, interview, and record review, the facility failed to follow the Center for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prevent transmission of COVID-19 during cares for one of the three sampled residents (R) 2. The facility failed to ensure appropriate use of personal protective equipment (PPE) and hand hygiene, to prevent cross-contamination during donning and doffing of PPE after use in R2's room, who was a new admission to the facility. The facility also failed to provide R2 with a facial covering during cares by staff to prevent the transmission of COVID-19 to the residents of the facility. Findings included: - On 06/30/2020 at 09:27 AM, observation revealed an uncovered cloth mask hanging on the handrail outside an isolation room for R2. Certified Nurse Aides (CNA) M and N, exited the isolation room into the hallway after providing the resident with cares. CNA M was wearing a face shield and CNA N was wearing goggles. The CNAs removed those items and placed them in the middle drawer of a PPE cabinet, located outside the resident's isolation room in the hallway. After doffing the face shield, CNA M placed the soiled cloth face mask that hung on the handrail back on her face. CNA N donned her cloth face mask after removing it from a paper bag. Neither CNA performed hand hygiene between mask changes. The CNAs did not clean the contaminated goggles and face shield after use in the isolation room and left them in the drawer to be reused later by staff. On 06/30/2020 at 09:37 AM, Certified Nurse Aide (CNA) M reported that the face shield and goggles should probably be cleaned before putting them back into the PPE cabinet. She also reported that the cloth mask should have been put in a container and hand sanitizer used between mask changes. On 06/30/2020 at 10:17 AM, Administrative Nurse D reported that the staff should be cleaning the face shields and goggles after every use and sanitizing their hands when changing masks. On 06/30/2020 at 05:32 PM, Administrative Nurse D reported that it would be her expectation that the CNAs perform hand hygiene between mask changes, were cleaning the face shields and goggles with Microkill wipes after every use in an isolation room, and to put their cloth masks in a paper bag for storage before donning a paper mask and entering an isolation room. The staff should not be hanging face masks on the handrail. Furthermore, on 06/30/2020 at 01:01 PM, observation of R2's care by CNA M and CNA N revealed after appropriate donning of PPE, the staff knocked on the door to answer the resident's call light. The resident requested to be toileted. The CNAs proceeded to assist the resident out of his wheelchair with use of a gait belt to stand with his walker. Neither CNA asked the resident if he wanted to use a face mask or tissue to cover his face. The CNAs assisted the resident to the bathroom and helped him transfer to the toilet. The resident toileted independently and the CNAs assisted him to stand and pull his pants up. He was then assisted and appropriately transferred to his bed where he laid down to rest. The CNAs removed their gowns, gloves, and paper face masks and discarded them in the biohazard trash. Before they left the room, they performed hand hygiene with alcohol rub. During this observation the room revealed the lack of a facial mask present for the resident's use when staff provided cares to him. On 06/30/2020 at 01:15 PM, Certified Nurse Aide (CNA) M and CNA N, reported that neither one of them knew they were supposed to offer the resident a mask before providing direct care to them. On 06/30/2020 at 05:32 PM, Administrative Nurse D reported that the facility was unaware of the recommendations by CMS about resident face mask use during care from the staff. The undated facility policy How To Safely Remove Personal Protective Equipment (PPE), directs the staff to use hand sanitizer and apply clean gloves before removing goggles or face shields. The equipment should be placed on the dirty cart just outside the room. To disinfect the goggles and face shield the staff should use the appropriate wipes to clean the inside and then the outside of the goggles and face shield and place them on the clean cart. The facility policy Standard Precautions, revised November 28, 2017, directs the staff to handle resident care equipment soiled with blood, body fluids, and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of other microorganisms to other residents and environments. The facility lacked a policy for resident mask use in the rooms when staff provided them with any direct cares. The Centers for Medicare and Medicaid Services reccomendation letter, dated 04/02/2020, documented that long-term care facilities, .when possible, all long-term care facility residents, whether they have COVID-19 symptoms or not, should cover their noses and mouths when staff are in their room. Residents can use tissues for this. They could also use cloth, non-medical masks when those are available. Residents should not use medical facemasks unless they are COVID-19 positive or assumed to be COVID-19 positive . The facility failed to ensure appropriate use of personal protective equipment (PPE) and hand hygiene, to prevent cross-contamination of possible COVID19 to the residents of the facility, during donning and doffing of PPE after resident care in R2's isolation room, and also failed to offer a face mask or tissue to cover his mouth/nose, to this resident quarantined in an isolation room before staff provided direct care.

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