STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175181	A. BUILDING _____ B. WING _____	06/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LARKSFIELD PLACE	2828 N. GOVERNEOUR WICHITA, KS 67226

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.** Based on observation, interview, and record review, the facility failed to ensure that Dietary staff (D1) sanitized her hands upon entering and exiting multiple resident rooms in one of three resident halls. The facility failed to ensure staff were thoroughly screened for COVID-19 prior to entering the facility to work. The facility reported no residents with COVID-19 currently or in the past. The facility census was 62. Findings include: 1. Observations on 6/4/20 revealed the following: At 10:10am, D1 exited R1's room without performing hand hygiene, held a cell phone to her right ear, then placed the phone in her pocket as she approached R2's room. At 10:11am, D1 held the meal tray ticket she had picked up in R1's room, entered R2's room, without performing hand hygiene, touched the door, then touched the resident's knee while getting the tray ticket, and then exited the room without performing hand hygiene. At 10:13am, D1 entered R3's room without performing hand hygiene, held the tray tickets from R1 and R2 in her hand, picked up the tray ticket for R3 from the over-bed table and exited the room without performing hand hygiene. At 10:16am, D1 entered R4's room without performing hand hygiene, immediately exited the room without performing hand hygiene, entered R2's room, without performing hand hygiene, spoke to a coworker then exited R2's room without performing hand hygiene, then re-entered R4's room without performing hand hygiene with the tray tickets from R1, R2, and R3 in her hand. At 10:20am, D1 exited R4's room, without performing hand hygiene and placed all four tray tickets on her cart and proceeded to the kitchen. On 6/4/20 at 10:25am, D1 indicated she received education on infection control practices and standard precautions that included when to perform hand hygiene and the dietary managers educated staff at least every week. D1 indicated that hand hygiene should have been performed upon entry and exit of each resident's room that included either washing her hands with soap and water, or use alcohol based foam rub to sanitize her hands or following contact with any resident. D1 indicated she did not know why she failed to perform hand hygiene but did not think it was that big a deal, including the use of her cell phone while working and she didn't think about it carrying germs. During an interview on 6/4/20 at 11:25am, the Assistant Dietary Manager (ADM) indicated that all dietary staff had been educated on infection control practices, standard precautions, and hand hygiene that included hand hygiene upon entry and exit of a resident room. The ADM expected that once a tray ticket was picked up from a resident's room it was to be placed on the cart and not carried into another room and all staff were expected to foam in and foam out every time they enter a resident room. During an interview on 6/4/20 at 11:50am, the Registered Dietician (RD) indicated that all dietary staff had been educated on appropriate infection control practices and appropriate hand hygiene, especially upon entering and exiting a resident's room. The RD expected all dietary staff to follow the policies put in place to decrease the risk of transmission of infections. The RD indicated it would not be appropriate for staff to enter and exit multiple resident rooms without performing hand hygiene upon entering and exiting. The RD indicated that by staff failing to perform hand hygiene when entering and exiting resident rooms, it could increase the risk of infection by cross contamination and carrying tray tickets from one resident's room to another resident's room could increase the risk of transmission of infection. The 4/2020 Covid Infection Control Policy recorded the following: Level One (Current)-CDC (Centers for Disease and Prevention) or other governing body has issued shelter-in-place orders, but no active cases of virus are present in the facility. Handwashing done after each potential cross-contamination exposure and handwashing log is in place. The COVID-19: Resources and Information for Food and Nutrition Services Webinar and corresponding power point presentation recorded the following: Wash your hands thoroughly with soap and water and use an alcohol based sanitizer if unable to hand wash. Follow handwashing guidelines. Use hand sanitizer between residents. Avoid touching your face to prevent the spread of viruses to your hands. Food handlers must wash their hands after touching anything else that may contaminate hands, such as un-sanitized equipment or work surfaces. 2. Record review of the facility's Primary Respiratory Illness Screening Tool revealed the following: On 4/2/20 five out of 35 employees did not have a temperature recorded upon entry to the facility and one out of 35 employees was identified on the screening tool by his/her first name only. On 4/4/20 two out of 18 employees did not have a temperature recorded upon entry to the facility and one out of 18 employees was identified by his/her first name only. On 4/5/20 one out of 18 employees did not have a temperature recorded upon entry to the facility and one unnamed employee was screened upon entry to the facility. On 4/6/20 six out of 34 employees did not have a temperature recorded upon entry to the facility and two out of 34 employees were identified by first name only. On 4/10/20 two out of 18 individuals signed in to the facility did not have any screening or temperature recorded upon entry to the facility. It is unknown if these individuals were visitors or facility employees due to the lack of identifying information. On 4/13/20 13 of 39 employees did not have a temperature recorded upon entry to the facility. A notation on screening form showed no one taking temp. Five of 39 employees were identified by first name only. On 5/10/20 one of 15 individuals, identified by first name only, did not have any screening or temperature recorded upon entry to the facility. On 5/25/20 16 of 18 employees did not have a temperature recorded upon entry to the facility. On 5/30/20 five of 18 employees did not have a temperature recorded upon entry to the facility and three of 18 employees had no screening conducted at all. One of 18 employees was listed by initials only and did not have any screening or temperature recorded upon entry to the facility. On 5/31/20 13 of 15 employees did not have a temperature recorded upon entry to the facility. On 6/04/20 one of five employees did not have any screening or temperature recorded upon entry to the facility. One undated page showed two individuals, identified by first name only, and one identified by first initial and last name only, with no screening if the individual had traveled in the past fourteen days, had been in contact with a confirmed Covid-19, having any signs or symptoms of illness, worked in another healthcare facility, or had completed the hand washing and infection control education. One undated page showed one individual who was identified by one name only, and one individual who was identified by first name and last initial only. During an interview on 6/4/20 at 12:29pm, the Infection Control Preventionist (ICP) nurse indicated that there were no known or suspected cases of COVID-19 in the facility and expected staff to perform hand hygiene upon entering and exiting a resident's room. The ICP indicated that all employees and visitors were screened upon entry to the facility before proceeding to a resident unit. The ICP indicated that Human Resources (HR) was responsible for looking at the COVID-19 screening logs to ensure they were complete. During an interview on 6/4/20 at 1:32pm, HR1 indicated that she was responsible for scheduling the staff responsible for completed screening of employees and visitors, to ensure there was a screener available at the staff screening table. She indicated that staff screeners were trained by either HR, ICP, or the Director of Nursing (DON) and the training included how to use the thermometer and understanding the importance of completing the screening form appropriately. HR1 indicated that the screeners know they are to text, call, or email her if they have any concerns, are going to send someone home, or if someone is reporting symptoms. She reviewed the screening logs every day and scans the temperatures to make sure if someone reported an elevated temperature that it was followed up on and she only reviewed the screening logs that are computerized. She indicated that the ICP nurse was responsible for reviewing the paper screening logs completed by the night shift. HR1 indicated that it was the responsibility of the night shift charge nurse to take the temperatures of night shift staff as they came on duty because screeners were scheduled for the day and evening shift but not for the night shift. She was

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** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) unaware of any missing temperatures on the paper screening logs as she only reviewed the computerized logs. During an interview on 6/4/20 at 1:57pm, the ICP nurse indicated that she monitored the daily symptom screening logs, expected the night shift staff to complete the screening log as they came to work prior to going to the unit. Staff were to find the night shift charge nurse to have their temperature taken and the charge nurse recorded the temperature on the screening log. The ICP nurse thought they forget to go back and write their temperature down because she verifies with the night shift charge nurse that everyone was screened and no one was displaying symptoms. The ICP indicated that sometimes it's several days before she obtains the paper screening logs to review and follow up on but that staff would call her right away if there were any issues. During an interview on 6/12/20 at 6:38am, Registered Nurse (RN1) worked on the night shift. He indicated the night shift staff were screened at the table before coming onto the unit then came directly to the nurses' station to have their temperatures checked. RN1 indicated it was the responsibility of the nursing staff to record the temperatures on the screening sheet. During an interview on 6/12/20 at 3:41pm, Licensed Practical Nurse (LPN1) indicated she worked the evening shift. LPN1 indicated the evening shift nurse screened the night shift staff at the screening table. LPN1 indicated that if a staff member came to work late and no one was at the table, then they were to report directly to the 300 hall nurses' station for their screening which included checking their temperatures and completing the screening questions prior to starting the shift. LPN1 indicated the 300 hall was a direct path to the nurses' station from the screening station. The undated COVID-19 Response Plan recorded under the title Occupational Health, 3. Employees are screened at the door for symptoms, and temperature is taken before they report to work. The following questions are asked of each employee: -Did you use proper hygiene when arriving? - Have you traveled in the last 14 days? -Have you been I contact with confirmed COVID-19? -Are you experiencing symptoms of illness-fever, cough, congestion, shortness of air, sore throat, nausea, vomiting, fatigue? -Do you work any other place?