STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175165	A. BUILDING _____ B. WING _____	**09/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROLLING HILLS HEALTH CENTER	**2400 SW URISH ROAD TOPEKA, KS 66614**

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 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 72 residents. Based on interviews and observations the facility failed to provide a clean, orderly, and comfortable living environment for the residents. Findings included: - Observation on 09/16/20 at 06:30 PM in the lobby of the facility there were three large cardboard boxes stacked on the table. There were approximately six clear, untied trash bags filled with unidentified linens and/or textiles sitting on floor. There was a feeding tube pump next to the bags of linens. On 09/16/20 at 06:35 PM, staff were observed and heard yelling communications to other staff on both units in the facility from the dining room. Observations on 09/16/20 at 06:48 PM revealed the following: room [ROOM NUMBER] had an untied plastic bag of trash placed on the floor and an untied plastic trash bag hung on the handle. room [ROOM NUMBER] had a trash in a bag on the floor. room [ROOM NUMBER] had un untied bag of soiled linen and one untied bag with trash on the floor. room [ROOM NUMBER] had a pair of pants and soiled wash cloth on the bathroom floor and there were not bags noted to place linens or trash in. On 09/16/20 at 06:55 PM an observation, in the back hallway on the North unit, revealed an incontinence brief on the floor. On 09/16/20 at 07:05 PM, the front hall on the North unit was observed with a trolley cart in the hall, stacked with multiple clear bags of linen, which staff identified as dirty laundry that needed to go go downstairs. The front hall also had a trash can in the hall with no lid, which was overflowing with used isolation gowns. There was a container of bleach wipes, a spray bottle of disinfectant and a spray bottle of toilet cleaner sitting on the handrail. On 09/16/20 at 07:08 PM observation of room [ROOM NUMBER] revealed a resident laying in bed, partially covered. There were several used blue plastic isolations gowns draped over furniture inside the room next to the door. There were three gloves on the floor of the room next to the bed. On 09/16/20 at 07:40 PM an observation of the shower room on the 200 halls revealed the privacy walls had one area 44 inches by 5 inches, one 14 inches by 12-inches area and one 43 inches by 5 inches area with scuffed paint and missing tiles. On 09/16/20 at 07:25 PM Certified Nurse Aide (CNA) M stated the isolation rooms (rooms designated for residents who had communicable diseases) were usually equipped with special bags designated for trash and soiled linen, which were placed in disposal boxes, in the resident rooms. There were no boxes or isolation bags available and regular plastic bags were used for both the trash and linen. CNA M had not taken trash or soiled linen out of the rooms and was not sure on which staff member had the responsibility to do so. On 09/16/20 at 08:00 PM Licensed Nurse (LN) G stated the signs posted on rooms 201, 202, 209, and 210 designated the residents had symptoms consistent with COVID-19 (infectious disease which has resulted in an ongoing pandemic) and were awaiting the tests results. There had been a lack of isolation bags and container boxes to dispose of contaminated trash and linen. The disposal of the linen and trash had been treated as uncontaminated items. The shower walls had been missing the tiles for a long time, probably due to repeated banging of equipment into them. In an interview on 09/22/20 at 12:18 PM Administrative Staff A stated he had come to the facility on evening of the 09/16/20. He said he had also noted the front lobby with the bags of linens but did not know where they came from or why they were there. He stated staff were expected to remove trash and laundry per the established process. He further said there were plenty of boxes and bags for staff to use to bag isolation trash and linen and did not know why staff did not use them. The facility failed to ensure a clean, orderly, and comfortable environment for residents. This deficient practice had the potential to decrease the presence of a homelike environment and increase the residents' susceptibility for infections.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 72 residents. Based on observation, interview and record reviews the facility failed to ensure staff used appropriate personal protective equipment (PPE-items used to prevent the spread of infectious disease such as gloves, gowns, face masks and face shields) to prevent the spread of COVID-19 (a potentially fatal respiratory virus) and failed to post signage at the entrance of the COVID isolation unit alerting staff to the presence of COVID and the PPE requirement. The facility failed to ensure staff used hand hygiene per standards of practice in order to prevent the spread of infection. The facility failed to ensure dirty laundry and linens from COVID isolation rooms were handled and cleaned per The Centers for Medicare and Medicaid Services (CMS) and The Center for Disease Control and Prevention (CDC) guidelines. Findings included: - On 09/16/20 at 06:48 PM, License Nurse (LN) J confirmed the front and back halls of the North unit was the COVID isolation halls, for COVID positive residents. Observation revealed closed doors at the entry to the halls. The doors lacked any signage alerting anyone entering the halls of the presence of COVID and the need for PPE. On 9/16/20 at 06:51 PM an observation of a PPE station set up outside the doors of the front COVID hall revealed the following: A large plastic bin, with no covering, labeled clean face shields sat on the top of a table. The bin was empty. Another large plastic bin, with no covering and labeled dirty face shields, was on the floor underneath the table. The bin contained many disposable plastic face shields which were visibly soiled at the foam band. The station also had a plastic bin with drawers set on top of the table. The drawers contained gloves, bleach wipes, and two cloth gait belts (belt used to help transfer a person from one place to another). On top of the bin, a plastic container, with no lid, contained many (greater than 10) brown paper bags with names written on the bag. Several of the paper bags were open and upon visual inspection, the bags contained N95 masks which appeared to be used. LN J confirmed the bags contained used N95 masks which belonged to staff members. On 09/16/20 at 06:55 PM an unidentified staff member entered room [ROOM NUMBER], which had a red Stop sign on the room door, with only a mask on. The staff member donned PPE inside the room, then exited the room, and walked through the closed doors and off the unit wearing the same PPE. She obtained clean linen and returned to room [ROOM NUMBER]. On 09/16/20 at 07:00 PM, Certified Medication Aid (CMA) R was observed on the front COVID hall. She wore an N95 face mask and a face shield. She wore a plastic, reusable gown although the gown was ripped at one of the front closures and did not close completely. On 09/16/20 at 07:09 PM Certified Nurse Aid (CNA) P stood outside the door to room [ROOM NUMBER], which was partially open. The door had a red Stop sign on it. CNA P started to don gloves but the gloves ripped. CNA P was unable to locate more gloves in the isolation bin outside room [ROOM NUMBER]. CNA P then walked to the nurse's station, obtained a box of gloves, brought back to the isolation bin outside room [ROOM NUMBER] and placed the gloves in a drawer. CNA P then donned gloves, without performing hand hygiene. CNA P put on a plastic gown and then put on a face shield and entered room [ROOM NUMBER] and closed the door. On 09/16/20 at 07:20 PM an unidentified staff member entered room [ROOM NUMBER], which had a red Stop sign on the door wearing only a N95 face mask. On 09/16/20 at 07:21 PM CNA P stood in the doorway to room [ROOM NUMBER]. The door had a red Stop sign on it. With the door open, CNA P removed her gown and placed inside the room. Still wearing the gloves she had used in the resident's room, she then removed her face shield, obtained a bleach wipe from on top of a plastic bin outside the door of 120 and cleaned the face shield, Still wearing the same gloves, she opened a drawer in the plastic bin and placed the face shield in the bin. She then removed her gloves,

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175165	A. BUILDING _____ B. WING _____	**09/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROLLING HILLS HEALTH CENTER	**2400 SW URISH ROAD TOPEKA, KS 66614**

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	(continued... from page 1) stepped into the room to throw the gloves in the trash and then walked away without performing hand hygiene. On 09/16/20 at 08:00 PM Administrative Nurse F stated the bins with the dirty, used PPE should be stored separately from the clean PPE. She also confirmed the brown paper bags contained used N95 masks and that the bags were not closed/stored properly. Administrative Nurse F did not close the bags or move the dirty PPE bin away from the clean PPE supplies. On 09/17/20 at 03:30 PM CNA O was observed entering a room on the COVID hall. She was not wearing a gown, only a face mask and eye protection. On 09/22/20 at 09:45 CNA Q doffed PPE at the exit doors and exited the COVID unit but did not perform hand hygiene. On 09/22/20 at 10:10 AM an unidentified staff member doffed her gown and gloves and exited the COVID unit. She not perform hand hygiene. She then walked approximately 15 feet down the main corridor, and then returned to the PPE station, removed her protective eye gear, and turned to go back down the main corridor. She walked through the dining room to the double doors leading to the administrative offices, used the keypad, opened the doors and exited into the office area without performing hand hygiene. On 09/22/20 at 11:23 AM Administrative Nurse F stated the employees had received PPE training and hand hygiene training prior at regular intervals. On 09/22/20 at 12:18 PM Administrative Staff A stated he thought training regarding donning, doffing and use of PPE as well as hand hygiene had been provided to all staff within the last two weeks. He was uncertain of the exact date. The facility policy Coronavirus COVID-19 revised 03/06/20 documented staff entering a room with suspected or confirmed COVID-19 must put on disposable gloves, a long sleeve gown, a medical mask that covers the mouth and nose and eye protection such as goggles. The CDC signage, Sequence for putting on PPE provided by the facility documented the following sequence: Gown, mask/respirator, goggles or face shield, and finally gloves. The CDC instruction, provided by the facility, for how to safely remove PPE recorded the outside of gloves, the goggles and face shields, gowns and mask are all considered contaminated. It further instructed to perform hand hygiene immediately after removing all PPE. The facility failed to ensure staff used appropriate PPE, per CDC guidelines. The facility further failed to ensure staff implemented hand sanitation. This deficient practice placed the residents at risk for transmission of infectious disease, including COVID. - On 09/16/20 at approximately 07:05 PM the front COVID hall was observed with bags of laundry, in clear trash bags, stacked in the hall on a cart. CMA R stated the laundry were dirty and ready to be taken downstairs. She said staff did not need to use yellow bio bags (bags designed for infectious laundry, typically yellow) for linen on the COVID unit if they double bagged with the clear bags. CMA R reported the facility had not had the yellow bags for a while. On 09/16/20 at approximately 07:50 PM, inspection of the laundry room in the basement revealed the following observations: The laundry room contained no marked receptacles or barrels for biohazard linens from the COVID unit. There were gray barrels labeled North and South and a two-tiered stainless steel table which indicated staff were to place bags on separate tiers depending on which unit the linens came from. Two of three washers contained wet laundry. One washer contained white washcloths which were still damp. The other washer contained blue mop pads which were still damp. The washers were not running and there was no laundry staff present. Review of the temperature log for the washing machine revealed the temperatures had not been checked and logged since 09/05/20, 11 days. On 09/16/20 at 07:25 PM Certified Nurse Aide (CNA) M stated the isolation rooms were usually equipped with special bags designated for trash and soiled linen, which were placed in disposal boxes, in the resident rooms. There were no boxes or isolation bags available and regular plastic bags were used for both the trash and linen. CNA M had not taken trash or soiled linen out of the COVID rooms and was not sure which staff member had the responsibility to do so. On 09/16/20 at 07:55 PM Administrative Nurse E stated she was uncertain what the process was for handling the dirty laundry from the COVID unit. She stated she thought it was taken out the side doors and around the building. Administrative Nurse E was unable to give a reason why the dirty linens and laundry on the COVID unit were not in biohazard bags. On 9/21/20 at 0710 AM Housekeeping Staff (HS) U was observed in the soiled side of the laundry room in the basement of the building. She had a face mask which was worn below her chin, with mouth and nose exposed. HS U stated she was uncertain of the laundry process or handling of laundry/linens from the COVID unit because many things had changed since she had been there last, or the end of the previous week. HS U stated she knew which laundry was considered infectious because it should in the yellow bags. On 9/21/20 at 07:10 AM observation of the laundry area revealed no infectious bins present, no marked biohazard trash or PPE supply, other than gloves, in the laundry area. On 09/22/20 at 11:06 Am Housekeeping Staff V stated all linens coming from isolation room and/or the COVID unit were to be placed in the yellow biohazard bags for delivery to the laundry area so the laundry staff would be aware of the potential for contamination. On 09/22/20 at 12:18 PM Administrative Staff A stated he was not sure what happened to the process for the laundry. He said the facility had the appropriate bags, for infectious laundry and trash and staff just needed to use them. The facility policy Infectious Linens revised 05/07/20 documented all possibly contaminated linen and clothing including resident's personal clothing, linens towels and washcloths should be enclosed in designated leak-resistant infectious bags then placed in a laundry barrel with a lid. The laundry personnel handing the contaminated linens and clothing will don the required PPE prior to handling the contaminated linens. This includes a gown gloves, fame mask and face shield. The policy further noted damp laundry should not be left in machines overnight. The facility failed to ensure contaminated laundry was handled per infection control guidelines to reduce the risk of transmission of COVID and other infectious disease to all residents.