STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175182	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DELMAR GARDENS OF OVERLAND PARK	12100 W 109TH STREET OVERLAND PARK, KS 66210

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 97 residents. Based on observation, interview and record review, the facility failed to follow the Center for Medicare and Medicaid Services (CMS) and Center for Disease Control and Prevention (CDC) recommended practices to prevent transmission of COVID-19. The facility failed to provide a face mask or a tissue to five residents to cover their mouth and nose, Resident (R)1, R2, R12, R13 and R14, prior to staff providing direct care, failed to properly clean equipment shared between R10 and R11, and failed to quarantine five residents, R2, R5, R6, R7 and R8 for 14 days after readmission and/or being newly admitted to the facility. Findings included: - On 07/06/2020 at 11:30 AM, Administrative Staff A reported they had one resident on quarantine, R1. Observation, on 07/06/2020 at 12:52 PM, revealed R2 lying in bed. He appeared to be sleeping. There was no signage indicting he was in quarantine, even though he just admitted to the facility on [DATE]. Observation, on 07/07/2020 at 8:00 AM, revealed five quarantine carts on the hall designated as the COVID hall in front of R2, R5, R6, R7 and R8's doors. The same five rooms had signs on the door designating the residents were in quarantine and they had cardboard hazardous material boxes with red trash bags inside the resident's rooms (These were not present on 07/06/2020). Observation, on 07/07/2020 at 8:47 AM, revealed Administrative Nurse D enter R2 room, after donning proper PPE outside of the resident's room and answered the resident's call light. The resident asked why he was placed in quarantine today, after being here for a week already. On 07/06/2020 at 10:50 AM, Administrative Nurse D reported, if a resident was a new admission or readmitted from the hospital they were to be placed in quarantine for 14 days. We only have one resident on quarantine awaiting COVID testing results. On 07/07/2020 at 8:53 AM, Administrative Nurse D reported the facility policy stated the facility was to put all readmitted /newly admitted residents on quarantine even if they had a negative COVID test. On 07/07/2020 at 8:55 AM, R7 reported he was a resident at the facility and went to the hospital earlier in June and came back, but then went back to the hospital for five more days. R7 reported his quarantine was not in effect then and not until late yesterday (07/06/2020). R7 further reported the sign on his door and the gowns just started today. On 07/07/2020 at 11:02 AM, CNA N reported C hall was designated for residents with COVID, or for those coming back from the hospital. They are on quarantine for 14 days. When they are on quarantine they stay in their room and we provide everything in the room for them. We have to wear more PPE when we go into their room. I don't know why staff did not use the PPE yesterday, maybe they were out of it and no one asked for more. They usually have the gowns, red bags and a sign on the door when on quarantine. We know who is on quarantine with the signs on their doors. I do not know why there were no signs yesterday. On 07/07/2020 at 2:14 PM, LN H reported residents who are new admissions or return from the hospital are on quarantine for 14 days on C hall. LN H reported she did not work on 07/06/2020, but worked the weekend and could not say if they were on quarantine or not for sure. There are now several carts with people on quarantine on C hall. On 07/07/2020 at 3:06 PM, Administrative Nurse D reported there were five people on C hall that were not on quarantine on 07/06/2020. These residents had been after going to the hospital for various reasons and one was a new admission, but the hospital advised the residents were tested for COVID in the hospital, and were all negative. We were thinking the COVID test was negative, so we did not have to quarantine the residents any longer . Administrative Nurse D did not know the exact dates testing was done during the hospital stay. Furthermore, observation, on 07/06/2020 at 4:00 PM, revealed License nurse I entered into R2's room (a quarantine room). She advised the resident that she was going to obtain his blood pressure and assessed him. The resident asked if he should put his mask on. LN I advised him it was alright he did not have to. LN I only had on a mask upon entrance and donned gloves. She did not use any other personal protective equipment (PPE) such as a gown prior to entrance. The resident's room lacked signage indicating the resident was on quarantine precautions and lacked trash cans with red bags for disposal of contaminated items. Observation, on 07/06/2020 at 4:23 PM, revealed Certified Nurse Aid (CNA) O entered R2's room to take his dinner order and asked if he needed any assistance prior to CNA O leaving the room. CNA O had on a mask on, however, did not don any additional PPE available outside of the resident's room. Observation, on 07/07/2020 at 8:39 AM, revealed LN J physically assess R1 and did not offer R1 a face mask or tissue. Observation, on 07/07/2020 at 9:30 AM, and at 2:14 PM, revealed CNA Q assisted R1 with toileting and did not offer R1 a face mask or tissue to cover her mouth and nose. Observation, on 07/07/2020 at 11:41 AM and at 12:50 PM, revealed CNA V assisted R12 with toileting and did not offer him a face mask or tissue to cover his face. Observation, on 07/07/2020 at 12:34 PM, CNA M and CNA N entered into R2's room to help transfer him from the wheelchair to the bed. The resident had his mask on,but had pulled it under his nose. The staff assisted resident to transfer from the wheelchair to sit on the bed, and removed the mask prior to assisting the resident to lay down and be pulled up in the bed. On 07/06/2020 at 10:50 AM, Administrative Nurse D reported, residents do not have to wear a mask unless they are out of their rooms. On 07/06/2020 at 1:49 PM, R2 reported he had not been a resident for very long. He does therapy in his room and goes to the gym at times to work with therapy there. R2 further advised he does not have to wear a mask while in his room, but does when he goes out of his room. On 07/06/2020 at 3:28 PM, CNA O reported, the residents have to wear a mask when they come out of their rooms. The residents do not wear a mask while in the room, or not while we are doing cares. On 07/07/2020 at 9:40 AM, CNA Q reported the residents only have to wear a face mask when they are out of their rooms. On 07/07/2020 at 11:02 AM, CNA N reported the residents wear their mask when out of their rooms. The residents do not have to wear masks in their rooms. The residents do not have to wear a mask while staff are in the rooms providing direct cares. On 07/07/2020 11:25 AM, R9 reported residents have to wear a mask when out of their rooms, but don't have to wear while in the rooms, even when staff are assisting with cares. On 07/07/2020 at 12:50 PM, CNA V reported residents are encouraged to wear masks when they come out of their rooms. On 07/07/2020 at 2:14 PM, LN H reported the residents only have to wear a mask when out of their rooms and when in hallways working with therapy. They do not have to wear masks while in their room receiving direct cares. On 07/07/2020 at 3:06 PM, Administrative Nurse D reported, the residents must wear a mask when they come out of their rooms. We have a lot of residents who can not put on or take masks off without help from staff. The residents with dementia can not take the masks off, so we do not expect them to wear them at all. In addition, observation, on 07/07/2020 at 11:15 AM, revealed Housekeeping Staff Y cleaning a quarantine room. Staff Y exited the quarantine room while wearing PPE used to clean the room. He stepped out into the hallway to retrieve new gloves and re-entered the room. Observation, on 07/07/2020 at 12:04 PM, revealed Housekeeping Staff X putting on her PPE in the hallway. She cleaned the room and the bathroom. She took the vacuum into the room and vacuumed the floor. She finished using and placed the equipment back into the hallway prior to cleaning or sanitizing. She stepped out into the hallway to obtain a mop handle off of the cart with her PPE on. After using the mop, she walked out into the hallway with the same PPE on to place the unsanitized mop handle on the cart. She returned into the room and wiped down all areas sprayed earlier and disposed of the disposable cleaning cloths in her cart in the hallway instead of the red bags available in the resident's room. Observation, on 07/07/2020 at 8:45 AM, revealed CNA T entered R10's room, placing a temperature monitoring system on the resident's bed without a barrier. CNA T obtained a temperature on R10, left the resident's room, and proceeded to place the contaminated temperature monitoring system on the medication cart. CNA T then

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) reentered the room to obtain a temperature on R11 prior to cleaning the temperature monitoring system. CNA T placed the monitor on R11's bed without a barrier. When questioned regarding this practice, CNA T stated she should have cleaned the machine between uses. On 07/07/2020 at 3:06 PM, Administrative Nurse D reported, during cleaning of equipment, such as thermometers, staff should use the saniwipes or oxivar (types of sanitation wipes). We did an inservice on cleaning of equipment. The staff are expected to wipe the thermometers between residents and it has a one minute wet time. He further stated when cleaning the room housekeeping staff should clean the vacuum and the handle of the mop when they complete the room clean and prior to returning to the cart or hallway. It would not be acceptable for the staff to come out of the room with the PPE on, get more supplies and return to the room. They would be considered contaminated. The Centers for Medicare and Medicaid Services, titled COVID-19 Long-term Care Facility Guidance, dated 04/02/2020, documented .When possible, all long-term care facility residents, whether they have COVID-19 symptoms or not, should cover their noses and mouth when staff are in the room. Residents can use tissues for this. They could also use cloth, non-medical masks when those are available. Residents should not use medical face masks unless they are COVID-19 positive or assumed to be COVID-19 positive . The policy titled, Environmental Cleaning and Infection Control, dated April, 2020, directed the staff to clean all equipment, example given, mop handle prior to leaving the room/apartment. When cleaning an quarantine room take in all cleaning supplies and shut the door while cleaning. Place soiled cloths in designated container for laundering and place any waste in receptacles. Do not leave the room wearing gloves. The policy titled, Cleaning Guidelines for Resident Care Equipment, undated, standard precautions should be used for all resident equipment. The resident equipment which is shared between residents must be cleaned after each use with a Super Sani Cloth wipe. The facility failed to provide a face mask or tissue to cover the nose/mouth of five sampled residents observed, prior to provision of cares, to prevent the spread of respiratory infections, failed to sanitize a temperature monitoring device between use for two residents, and failed to quarantine five residents after they admitted /readmitted to facility from a hospital stay. These failures increased the risk of transmission of the pandemic COVID-19 virus to the vulnerable residents of the facility.