STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175340	A. BUILDING _____ B. WING _____	**08/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALDERSGATE VILLAGE	**3220 SW ALBRIGHT DRIVE 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 -** Some	**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 142. Based on observations, interviews, and record reviews the facility failed to follow standards of practice for personal protective equipment (PPE-protective clothing, helmets, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection) which included failure to change gowns between resident rooms on the isolation unit (unit where residents on 14 day quarantine due to unknown COVID status upon admission were located), wearing required PPE inside the COVID (highly infectious potentially life-threatening respiratory disease) unit (unit used to house residents with a positive COVID status), and removing PPE before leaving COVID unit. The facility failed to follow the manufacturer's directions for the cleaning solution used in the facility for disinfecting surfaces. This deficient practice had the potential for transmission and/or development of COVID-19 and other communicable disease among residents. Findings included: - An observation on 08/13/20 at 02:52 PM revealed an unidentified housekeeper wiped down handrails on the 500 hall on the dementia (progressive mental disorder characterized by failing memory, confusion) unit. The housekeeper removed a blue rag from a pail on the housekeeping cart and wiped the handrails with the rag. At 02:53 PM, the handrail was noted to be dry to touch. The housekeeper approached the surveyor to talk and accompanied surveyor off the unit without having checked that the handrail was still wet for appropriate wet time for the cleaning solution being used. The housekeeper told surveyor the disinfectant she used was called Oxivir and stated she would get the bottle of Oxivir for surveyor to review. In an interview on 08/13/20 at 02:55 PM, Housekeeper U stated the Oxivir solution usually dries within the five-minute directed wet time (the time that the disinfectant needs to stay wet on a surface in order to ensure efficacy) for Oxivir. An observation on 08/13/20 at 03:00 PM revealed label of Oxivir directed a wet time of five minutes was required to effectively disinfect surfaces. An observation on 08/13/20 at 11:05 AM revealed another unidentified housekeeper on the isolation unit exited a resident room with trash while wearing PPE of gown, gloves, eye protection, and mask. She returned to the resident's room to sanitize her hands and change her gloves. She did not remove the isolation gown she was wearing and proceeded to enter another resident room on the isolation unit. In an interview on 08/13/20 at 01:15 AM, Housekeeping Supervisor V stated he expected housekeeping staff to take off PPE and perform hand hygiene between resident rooms on the isolation unit. An observation on 08/13/20 at 05:01 PM revealed an unidentified dietary staff entered the COVID unit through the double doors that had a barrier in front of them. He wore a cloth mask without gown, gloves, or face shield. He walked to the kitchen door on the COVID unit then turned around and left via the same double doors to reenter the facility. In an interview on 08/17/20 at 09:31 AM, Dietary Supervisor BB stated if dietary staff are entering the COVID unit to go to the kitchen for a few minutes, they are expected to wear a KN95 mask. He stated dietary staff do not wear full PPE on the COVID unit since they are not in direct contact with the residents. An observation on 08/13/20 at 05:02 PM revealed an unidentified therapy staff, on the COVID unit, wore PPE which included gown, gloves, face shield, shoe covers, mask, and hair cap. She exited the COVID unit through the double doors with the barrier in front of them, into the facility, while wearing the same PPE worn on the COVID unit. She entered a room past the double doors off the unit. In an interview on 08/13/20 at 05:02 PM, Anonymous S stated therapy donned (put on) PPE in the therapy gym before entering the COVID unit through the double doors with the barrier in front. He/she stated it was expected that those doors are one way and therapy staff should not exit through there while wearing the same PPE as worn on the COVID unit. He/she stated they exited through the outside door after doffing (taking off) PPE when leaving the unit. The Teachable Moment last dated 04/21/20, directed staff that PPE does not have to be changed between patients with the same isolation precautions and that the same gown can be worn when caring for patients with the same isolation precautions in the same room or on an entire COVID unit. In an interview on 08/13/20 at 05:00 PM, Administrative Staff A stated if the cleaning solution was required to have a five-minute wet time then she expected staff to make sure that there was a five-minute wet time when using it. In an interview on 08/13/20 at 05:20 PM, Administrative Nurse D stated there are Oxivir wipes that have a one-minute wet time. An observation of the Oxivir wipes revealed white wipes in a pull top container. In an interview on 08/17/20 at 10:28 AM, Administrative Staff A stated staff do not have to change isolation gowns between resident rooms on the isolation unit and can go from room to room in the same isolation gown, but have to remove gown before leaving the isolation unit per the Centers for Disease Control and Prevention (CDC) guidelines. Administrative Staff A stated if anybody goes onto the COVID unit, they were expected to wear full PPE which is gown, mask, gloves, and face shield. She stated therapy staff should not leave the COVID unit in the PPE worn on the unit. The Novel Coronavirus Prevention and Response Policy, not dated, directed to educate staff on proper use of personal protective equipment and application of standard, contact, droplet, and airborne precaution including eye protection. The government website https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html documents the following guidance as a crisis contingency strategy for isolation gowns; extend the use of isolation gowns (disposable or cloth) such that the same gown is worn by the same HCP (health care provider) when interacting with more than one patient known to be infected with the same infectious disease when these patients housed in the same location (i.e., COVID-19 patients residing in an isolation cohort). This can be considered only if there are no additional co-infectious [DIAGNOSES REDACTED]. If the gown becomes visibly soiled, it must be removed and discarded as per usual practices. The same website defines crisis contingency strategies as strategies that are not commensurate with standard U.S. standards of care but may need to be considered during periods of known gown shortages. Crisis capacity strategies should only be implemented after considering and implementing conventional and contingency capacity strategies. Facilities can consider crisis capacity strategies when the supply is not able to meet the facility ' s current or anticipated utilization rate. The facility failed follow standards of practice for PPE which included failure to change gowns between resident rooms and donning/doffing appropriate PPE inside the COVID unit to avoid cross contamination from the COVID unit to other areas in the facility. The facility failed to follow the directions for wet time of five minutes for cleaning solution used in facility for disinfecting surfaces. The deficient practice placed the residents at risk for transmission and/or development of COVID-19 and other communicable disease.

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