STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175520	A. BUILDING _____ B. WING _____	**06/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VICTORIA FALLS	**224 E CENTRAL ANDOVER, KS 67002**

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 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 72 residents with three residents selected for review. Based on observation, record review, and interview, the facility failed to provide the appropriate delivery of oxygen to one of the three residents reviewed. Findings included: - The Medication Review Report, dated 06/03/20, included Resident (R)2 had [DIAGNOSES REDACTED]. The report lacked orders for oxygen use. Review of the orders tab, in the electronic medical record system, on 05/29/20 included an order for [REDACTED]. He was totally dependent on staff for personal hygiene and received oxygen therapy. The Care Area Assessments (CAA), dated 05/01/20 lacked documentation related to oxygen use. The care plan, dated 04/20/20, lacked documentation related to oxygen use. The electronic medical record indicated that the resident discharged with return anticipated on 05/18/20 and returned to the facility on [DATE]. On 06/22/20 at 02:44 PM, R2 was resting in bed with oxygen in place per nasal cannula. The concentrator delivering the oxygen was set on four and a half liters. On 06/22/20 at 02:45 PM, R2 reported that he used to be on oxygen at two liters only at night, then his lung collapsed and he on oxygen all the time. On 06/22/20 at 02:54 PM, Certified Nurse Aide (CNA) N, reported she did not know when R2 was supposed to have oxygen in place. On 06/22/20 at 03:02 PM, Licensed Nurse (LN) H, reported the R2's oxygen was at three liters per minute the last time she admitted him, it may be two liters now, it is continuous, but he always takes it off. Then she reported it might be PRN (as needed) now. After checking his orders in the electronic medical record, she revealed that the oxygen was for two liters per minute at night. LN H reported she did not know how often the setting on the concentrator was looked at unless the resident is complaining about their breathing or that there is no oxygen coming through. On 06/22/20 at 03:42 PM, Administrative Nurse D confirmed that the oxygen setting should be monitored every shift and there should be an order in place for the oxygen on the Medication Review Report. Staff should have clarified the oxygen orders when he came back from the hospital and should be current in the electronic record. The facility policy Quality of Care, undated, directed that the (facility name) shall ensure that oxygen therapy is administered to a resident in accordance with a physician's orders [REDACTED].
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 72 residents. Based on 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. The facility failed to ensure that all staff had a mask in place while in resident care areas. Additionally, per record review and interview the facility failed to place 23 out of 28 residents in quarantine for 14 days upon admission or readmission. Furthermore, per record review and interview, the facility failed to ensure that all screening items were answered on the visitor and staff daily screening log. Record review lacked five instances when visitor/staff did not have a temperature recorded but answered screening questions, and five instances when visitor/staff had a temperature recorded but did not answer the screening questions. The failure to have a mask in place, failure to place all new admissions and re-admissions in 14 day quarantine, and lack of completion of all screening questions, increased the risk of transmission of the pandemic COVID-19 virus to the vulnerable residents of the facility. Additionally, per observation, record review, and interview the facility failed to appropriately clean a shared glucometer (device used to check blood sugar level) after use to reduce transmission of blood borne pathogens. Findings included: - On 06/22/20 at 10:44 AM, Certified Nurse Aide (CNA) M, reported the process when coming in for work included getting her temperature and oxygen saturation checked, answering the symptom questions, and sanitizing hands. Then, she reported to the nurse's station and placed a mask on. CNA M would have to walk down a hallway and through the dining area to arrive at the nurse's station. On 06/22/20 at 10:51 AM, Licensed Nurse (LN) G, revealed that some staff wear their facemask when coming in the building, and some not until they get to the nurse's station, which passes thru the dining area. On 06/22/20 at 12:27 PM, Certified Medication Aide (CMA) R, revealed that when coming in to work in the morning she does the health screening, sanitizes her hands there, then come's to the nurse's station to get a mask. Furthermore, she reported that today she was told to wear a cloth mask in, then change the mask at the nurse's station, and that she had been going from screening station to the nurse's station without one. On 06/22/20 at 02:07 PM, CMA S revealed that her temperature and oxygen level iss checked at the screening station, she fills out the logs, sanitizes her hands, then goes to the nurse's station without a mask in place and puts one on there. On 06/22/20 at 03:44 PM, Administrative Nurse D confirmed that the process when staff come in for their shift is to check in at the front desk and do their screening. If they have any symptoms, then they have to leave the facility. The staff were always to wear a mask when they were in the building. Furthermore, she revealed that she had just heard today that the staff go from the screening station to a neighborhood nurse's station without a mask. I'm not sure if they thought they could go to the nurse's station without one, we have started education with the staff. The facility policy COVID-19, updated June 2020, directs that respiratory protection (mask) to be used before entry into the resident room or care area. The facility failed to ensure that all staff had a mask in place while in resident care areas. - Furthermore, per observation, record review, and interview, the facility failed to ensure appropriate procedure for disinfection of shared glucometer increasing the risk of transmission of blood borne pathogens. On 06/22/20 at 09:31 AM, LN H reported that at 10:00 AM there were eight blood sugars to check. On 06/22/20 at 09:44AM, LN H, after performing blood sugar check and returning to the nurse's station, wiped the glucometer with a Super Sani Cloth wipe for approximately 30 seconds and then placed in a plastic basket. When questioned what the wet time was of the product, she reported 30 seconds. LN H then checked the product label on the container and reported the wet time was two minutes, and that she was not aware it had a wet time of two minutes, as the prior product she had used had a 30 second wet time. LN H also confirmed that the glucometer was shared among residents. On 06/20 at 03:44 PM, Administrative Nurse D confirmed staff are to clean the glucometers using the Super Sani Cloth wipes before and after use and believed the wet time was two minutes, then the machine was allowed to air dry. The facility policy Glucometer Cleaning, undated, instructs the meter must be cleaned prior to disinfection. Use one disinfecting wipe to clean exposed surfaces of the meter thoroughly and remove any visible dirt, blood, or any other body fluid with the wipe. Use a second wipe to disinfect the meter by following the disinfecting procedure. The disinfecting procedure directs the staff to put on non-sterile gloves, take out one disinfecting wipe from the package and squeeze out any excess liquid in order to prevent damage to the meter. Then, staff were to wipe all of the meter's exterior surface display and buttons, hold the meter with the test strip slot pointing down, and wipe the area around the test slot but be careful not to allow excess liquid to get inside. The meter was to be kept wet with disinfection solution contained in the wipe for a minimum of two minutes. Then, staff were to remove the wipe and allow the meter surface to dry completely. Remove and discard gloves in appropriate receptacles and wash hands. The facility failed to ensure the appropriate procedure for disinfection of the shared glucometer increasing the risk of transmission of blood borne pathogens.

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) - On review of the Employee/Visitor Screening Logs, dated 03/30/2020 through 05/13/2020, documentation revealed five staff/visitors did not answer screening questions for symptoms, travel and contact. An additional five staff/visitors lacked screening for elevated temperatures. On 06/23/2020 at 02:59 PM, Administrative Nurse D, confirmed the facility failed to obtain completed screening information from staff/visitors as noted above. She reported that sometime in April the facility's noted the COVID-19 screening log lacked completion and educated staff about the importance of completion of the screening tool. In May, the facility initiated weekly random audits of the screening sheets to determine staff compliance with completion of Staff/Visitor screening logs. She reported the facility lacked any documentation of audits to ensure completion of the staff/visitor screening logs. Administrative Nurse D stated the facility discussed implementing a daily audit procedure on 06/19/2020 but had not initiated the procedure. The facility policy titled Novel Coronovirus (2019-nCOV) (COVID-19), dated 03/16/2020 and revised 06/15/2020, documentation included the facility will screen visitors for symptoms of acute respiratory illness (e.g., fever, cough, difficulty breathing) before entering the healthcare facility. The policy lacked address of completion of screenings by staff/visitors and/or auditing process for completion of screening questions or temperature. The facility failed to complete screening for staff/visitors related to temperatures and questionnaires to prevent the potential spread of COVID-19 infection to the residents of the facility. The facility failed to audit the staff/visitor screenings for completion as required to prevent the exposure of the residents of the facility from potential exposure to COVID-19. - Review of the facility's Admission/Discharge To/From Report, dated 03/16/2020 through 06/24/2020, documentation revealed 28 residents admitted /readmitted to the facility from another discharging facility. The facility failed to quarantine twenty three of the 28 residents identified as admitted or readmitted . On 6/24/2020 at 09:07 AM, Administrative Nurse D confirmed the facility failed to quarantine the residents newly admitted or readmitted for 14 days in keeping with standards of practice and facility policy. New admissions that had a negative COVID test prior to admission were not quarantined unless the hospital recommended it. She was not aware that page six of the COVID-19 policy documented that new admissions and readmits were to be quarantined for 14 days. She stated that residents that demonstrate symptoms are quarantined immediately for 14 days and that testing repeated till 2 negatives. The facility policy titled Novel Coronovirus (2019-nCOV) (COVID-19), dated 03/16/2020 and revised 06/15/2020, documentation included the any admits or re-admits will be put on 14-day quarantine. The facility failed to quarantine newly admitted or readmitted residents for 14 days to prevent the potential spread of COVID-19, as directed in the facility policy.