STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175180	A. BUILDING _____ B. WING _____	**09/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OVERLAND PARK CENTER FOR REHABILITATION AND HEALTH	**5211 W 103RD STREET OVERLAND PARK, KS 66207**

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 119 residents. The sample included six residents. Based on observations, interviews, and record reviews the facility failed to ensure the use of standard infection control precautions (infection prevention practices which include but are not limited to hand hygiene and use of gloves) as the staff performed their daily tasks This deficient practice placed residents at risk for transmission of communicable diseases including COVID-19 (potentially life-threatening respiratory virus). Findings include: - On 09/21/20 at 08:30 AM Licensed Nurse (LN) G placed a glucometer (reusable instrument used to measure blood sugar levels) on top of a medicine cart. LN G sanitized her hands, donned gloves, and proceeded to Resident (R)1's room and placed the glucometer on the bedside table, without a protective barrier underneath. LN finished procedure, doffed gloves, walked up the hall, and placed the glucometer on the medication cart. LN G did not sanitize the glucometer or her hands after the procedure. On 09/21/20 at 08:48 AM Certified Nurse Aide (CNA) M distributed breakfast trays to rooms [ROOM NUMBER] and did not sanitize hands until he came out of room [ROOM NUMBER]. CNA M walked to the nurse's desk, poured milk and juice into paper cups, and placed them on breakfast trays. CNA M placed the palm of his right hand on top of the lids of nine cups and pushed down to seal the cups, he then walked to room [ROOM NUMBER] and set up a breakfast tray on the resident's bedside table and proceeded to room [ROOM NUMBER] and set up the breakfast tray, and did not sanitize hands. CNA M opened a door behind the nurse's station and came out with a plastic trash bag. CNA M picked up breakfast trays from rooms 212 through 208 without hand sanitization. On 09/21/20 at 09::50 AM LN H stood by a medication cart, located in the 200 hall, and talked on the phone with the mask pulled down under her chin. LN H finished the call and placed the phone back on the charger. LN H did not sanitize the phone or her hands. At 10:50 LN H stated she had attended in-services on the computer and with administrative staff for the proper procedures for donning/doffing Personal Protective Equipment (PPE) and proper hand hygiene. In the last couple of months, she had attended two or three in-services. At 10:50 AM LN H stated she had training on donning/doffing personal protective equipment (PPE) and hand sanitization. Improper sanitation of hands could lead to spread of infections to the residents. The staff's number one priority was the residents' safety. On 09/21/20 at 10:05 AM a female staff member took a blood pressure reading and placed soft boots on a resident in room [ROOM NUMBER]. The staff did not sanitize her hands or wipe down the blood pressure cuff after the procedure and placed the cuff on a medication cart. On 09/21/20 at 12:17 PM CNA M placed cups on two lunch trays. CNA M placed his index finger in the glass approximately inside the cup and delivered meal trays to rooms [ROOM NUMBERS] then sanitized his hands. At 12:20 PM CNA M stated he had attended in-services on how to don/doff PPE and proper hand hygiene. On 09/21/20 at 10:54 AM CNA N walked thru the Heritage hall, entered the secured resident unit, talked to a staff member and returned to the Heritage hall. CNA N's mask did not cover her nose with either observation. CNA N stated she had attended in-services on proper PPE donning/doffing but, did not realize her mask was not placed properly. On 09/21/20 at 12:24 PM a male staff member delivered a lunch tray to room [ROOM NUMBER] then delivered a meal to room [ROOM NUMBER], talked to the resident and brought the tray back out of room and placed it on the nurse's station. He did not sanitize hands. On 09/21/20 at 12:26 PM a female staff member wore gloves and set up lunch trays on bedside tables in rooms [ROOM NUMBERS]. She did not doff gloves or sanitize hands. On 09/22/2020 at 1:15 PM Administrative Nurse D stated that glucometers should be sanitized with a bleach wipe and let it sit for 5 minutes for wet to dry time. She also stated that staff should sanitize hands after every resident interaction and in between passing trays. Administrative Nurse D revealed that if it was done improperly it could spread infections and germs. She further stated that the blood pressure cuffs were to be wiped down after use with the purple sanitizing wipes, and she had performed spot checks with no concerns noted. The facility's Cleaning and Disinfection of Resident-Care Items and Equipment policy dated 07/2020 documented that handheld instruments such as blood glucose meters were cleaned after each use for manufacturer guidelines, and in absence of a manufacturer's cleaning instruction the surfaces would be cleaned with a detergent/disinfectant. It further documented reusable resident care equipment would be decontaminated and/or sterilized between residents. The facility's Handwashing/Hand Hygiene policy revised 03/2020 documented that employees must wash their hands before and after direct contact with residents, before and after performing any invasive procedure, before and after entering isolation precaution settings, before and after assisting a resident with meals, and after handling soiled equipment or utensils. The facility failed to ensure nursing staff used of standard infection control precautions while performing their daily tasks. These deficient practices had the potential for transmission and/or development of infections among the residents and staff.

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.