STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175467	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KANSAS CHRISTIAN HOME	1035 SE 3RD STREET NEWTON, KS 67114

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 59 residents. Based on observation, interview, and record review, the facility failed to ensure cleaning of isolation resident rooms in a sanitary manner and failed to ensure staff sanitized a blood glucose meter used for four unsampled residents, in an appropriate manner, to prevent the spread of infections to the residents of the facility. Findings included: - Observation, on 06/30/20 at 10:51 AM, revealed housekeeping staff U gathered supplies and donned PPE (personal protective equipment) to clean an isolation resident's room. Housekeeping staff U placed the plastic cleaning caddy containing cleaning products and a sponge into the resident's room and placed it on top of the isolation trash can lid. Housekeeping staff U used a sponge to scrub the sink and returned the sponge into the cleaning caddy, beside the bottles of cleaning products. Staff U cleaned the toilet and placed the rags used to wipe the toilet beside the sponge, (used to clean the sink) in the cleaning caddy. Without changing gloves, Housekeeping staff U used the spray cleaning product and sprayed the sink, then obtained a rag to wipe the sink with the same gloves. Interview, at that time with housekeeping staff U revealed she used the sponge for multiple resident sink cleanings and would discard it after 3-4 uses. Housekeeping staff U stated she should place the soiled rags used to clean the toilet in a bag for laundering and the sponge should not be placed in the cleaning caddy next to the contaminated bottles of cleaning products . Interview, on 06/30/20 at 11:00 AM, with housekeeping staff W, confirmed the staff used the sponge to clean build up on the sinks for multiple resident rooms. Housekeeping Staff W confirmed that staff should place cleaning items taken into the isolation room on a barrier to prevent cross contamination. Observation, on 06/30/20 at 01:45 PM, revealed housekeeping staff V prepared to clean a droplet isolation resident's room. Housekeeping staff V donned PPE which included gown, gloves, mask and shoe covers, and took the cleaning caddy containing cleaning products into the room and placed it directly on the resident's floor. Housekeeping staff V used a sponge to clean the resident's sink and placed it into the cleaning caddy next to the cleaning products used for cleaning the toilet. After cleaning the toilet, without changing gloves, housekeeping staff V picked up a spray bottle of a cleaning product and sprayed a rag for cleaning the toilet, then placed the rag in a bag which was on the floor onto the sponge used to clean the sink. Housekeeping staff V stated she also used the sponge to clean other resident sinks. The facility policy Cleaning Isolation Rooms or Cleaning Special Care Areas, dated 03/31/20, instructed staff to pay special attention to the cleaning of environmental surfaces in the isolation room as these surfaces are implicated in the person to person transmission of infection for cleaning isolation rooms. The facility Task Checklist, Bathroom instructed staff to remove contaminated gloves, wash hands, and don clean gloves. The facility failed to provide isolation room cleaning in a sanitary manner to prevent the spread of infection by reusing sponges and placing cleaning caddies directly on the isolation room floors. - Observation, on 06/30/20 at 11:30 AM, revealed Licensed Nurse (LN) G prepared to obtain a blood glucose sample for an unsampled resident. LN G cleaned the glucometer with an alcohol wipe and prepared to enter a resident's isolation room. This surveyor questioned LN G if this was the resident's personal glucometer. LN G stated she used this glucometer on four residents during the morning round of blood glucose sampling and used the alcohol wipe to sanitize the glucometer between residents. Interview, on 06/30/20 at 11:35 AM, with Administrative Nursing staff D revealed each resident had their own glucometer and confirmed staff should not use the same glucometer for more than one resident. Administrative Nursing staff D stated staff should sanitize the glucometer with the manufacturers recommended product and the facility did use 70% alcohol wipes for this purpose. Review of the manufacturer's glucometer instructions revealed instructions to the staff to disinfect the meter with one of the validated disinfecting wipes and other EPA (environmental protection agency) registered wipes may be used for disinfection, however this could affect the performance of the meter. The list did not include 70% alcohol wipes. Furthermore, from the CDC (center for disease control) website, an excerpt from this guidance reads: The disinfection solvent you choose should be effective [MEDICAL CONDITION].[MEDICAL CONDITION], and [MEDICAL CONDITION] virus. Outbreak episodes have been largely due to transmission of [MEDICAL CONDITION] and [MEDICAL CONDITION]. However, of the two, [MEDICAL CONDITION] virus is the most difficult to kill. Please note that 70% [MEDICATION NAME] solutions are not effective against [MEDICAL CONDITION] bloodborne pathogens and the use of 10% bleach solutions may lead to physical degradation of your device. The facility policy Cleaning and Infection Control of Non-Critical, Reusable Resident Care Equipment, dated 03/31/20, instructed staff the facility recommended single-use glucometer and instructed staff to clean before and after each use with a sanicloth or alcohol wipe per manufacturer recommendation. If used for multiple elders, nursing staff will clean the glucometer before and after each resident with a sanicloth or alcohol wipe per manufacturer recommendation contact wet time. The facility failed to ensure staff utilized the single resident use glucometers for the designated resident and failed to provide effective sanitation of the glucometers to prevent the spread of infection for these four unsampled residents.

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