STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E577	A. BUILDING _____ B. WING _____	**06/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ANDERSON COUNTY HOSPITAL LTCU	**421 S MAPLE STREET PO BOX 309 GARNETT, KS 66032**

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 -** Immediate jeopardy **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** The facility reported a census of 25 residents. Based on observation, 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 that entered the facility had a mask in place. Furthermore, the facility failed to ensure that all staff performed a self-screening prior to entry into the facility. Record review revealed lack of self-screening on three occasions that occurred from 03/14/20 to 05/19/20. The failure to have a mask in place and complete self-screening increased the risk of transmission of the pandemic COVID-19 virus to the vulnerable residents of the facility, placing them in immediate jeopardy. Findings included: - On 06/16/20 at 01:34 PM, Certified Nurse Aide (CNA) M revealed that after she takes her temperature and logs it, she enters the doors to the facility and goes to the nurse's station to get the masks that she needs. Most of the time they are out of masks at the screening station, and she did that today when she arrived at the facility. On 06/16/20 at 01:55 PM, CNA N revealed that when coming in at 06:30 AM for her shift, she checks her temperature, logs in on the self-screening sheet, goes to the breakroom to put away her purse and get protective safety eye glasses, and then she gets her masks behind the nurse's station. Furthermore, she reported usually they are out of masks on the screening table. On 06/16/20 at 01:59 PM, observation of the employee screening station did not reveal masks on the table, but a box of masks was in a holder attached to the hand sanitizer stand next to the table. On 06/16/20 at 06:34 PM, CNA O arrived at the employee screening station and checked her temperature, then entered the facility without a mask in place and went thru the door that leads to the breakroom area. The resident dining room was across the corridor form the door she entered that leads to the breakroom. On 06/16/20 at 06:43 PM, Administrative Nurse D confirmed that staff should have a mask on before coming through the doors to enter the facility from the employee screening station. On 06/16/20 at 07:10 PM, CNA O confirmed that she took her mask off when arriving to the screening station, she forgot to put it back on before entering the doors to the facility, and that a mask should have been in place. On 06/17/20 at 10:34 AM, Administrative Nurse E, responsible for Infection Control, revealed that the expectation of staff was to don masks before entering the facility, which was available before entering. On 06/17/20 at 01:22 PM, CNA M confirmed she enters the facility past the employee screening station and goes to the nurse's station without a mask in place. Furthermore, she reported that it was probably not okay to enter the facility through the doors without a mask in place, but the nursing staff does in the morning when they get there. On 06/17/20 at 01:44 PM, CNA N, confirmed that she enters the facility at the screening station, goes to the nurse's station without a mask in place sometimes, and pretty much everybody has no mask on when they go to the nurse's station. Furthermore, no mask is in place because there is no screener or masks at the entry way of the adjoining facility, and that the entrance to the facility at the employee screening station lacked masks. Per observation, the employee screening station was at a corridor on the other side of a set of double doors that adjoined the facility to another level of the care facility. Once staff passed through the double doors, there was a kitchen on the left, then a dining room that extended to the length of that corridor. To the right of that corridor included a door that entered another area that had the breakroom, staff bathroom, and two administrative nurse offices. Past that area to the right were medication carts located along the wall of that corridor, then there was an entry way to the right into the quiet living room. At the end of the corridor, straight ahead was the lobby area and adjoining it to the right is the nurse's station area, which is on the opposite side of the hallway of another entry into the quiet living room. Review of a staff email, sent out on 04/17/20 at 05:19 PM, included information that all staff that enter the facility should follow the Post-Acute Guidelines for Yellow level PPE (personal protective equipment). The yellow level required a level three mask, level one mask over, gloves, and eye protection. The yellow level PPE must be followed in any patient care areas. Areas to be considered patient care areas included any location where any staff may come within six feet of a resident who is not wearing a level one mask. A resident may be encountered in the dining room, walking down a hallway, or at the nurse's station. Masks and face shields are located at the nurse's station. In addition, on 06/16/20 at 08:57 AM Licensed Nurse (LN) G reported that the employee screening station was on the other side of hall doors near the dining room and that employees do their own screening. On 06/16/20 at 06:43 PM Administrative Nurse D confirmed that employees are to verify they do not have any of the CDC recommended symptoms, take their temperature, and fill out their screening form before entering the facility. If they have traveled or been exposed to someone that was positive for COVID-19 they shouldn't even show up for work. Review of Voalte message (a communication method seen by the staff when they login at the beginning of their shift) sent to staff, dated 03/13/20 at 11:53 PM, directed the employees to clock in and proceed to the (Facility name/Facility Name) door where there are logs where staff will record their temperature prior to entering. If temperature is greater than 100 degrees Fahrenheit (F), if you have traveled or been exposed to COVID-19, haven't been cleared by employee health, then you may not enter. Review of the nursing schedules and the employee temperature/screening logs, dated 03/14/20 to 06/15/20, revealed three CNA's failed to complete self-screening when arriving to the facility. On 03/14/20 CNA Q lacked a self-screening log, on 04/10/20 CNA P lacked a self-screening log, and on 05/19/20 CNA O lacked a self-screening log. On 06/17/20 at 02:15 PM, Administrative Nurse D confirmed that CNA Q, CNA P, and CNA O, failed to perform their screening. The facility policy COVID-19 Senior Living, dated 03/01/20, instructed to prevent the spread of respiratory germs in your facility that employees at least prior to starting their shift will be monitored for fever or respiratory symptoms. Staff are required to take their temperature at the start of each shift. An update to the policy on 04/20/20 contained the same instructions. The facility failed to ensure that all staff that entered the facility had a mask in place. Furthermore, the facility failed to ensure that all staff performed a self-screening prior to entry into the facility. The failure for staff to have a mask in place and complete self-screening increased the risk of transmission of the pandemic COVID-19 virus to the vulnerable residents of the facility. On 06/17/20 at 05:10 PM, Administrative staff D and E were informed that they were in immediate jeopardy status and provided the Immediate Jeopardy Template for failure to ensure that all staff that entered the facility had a mask in place and completed the self-screening to decrease the risk of transmission of the pandemic COVID-19 virus to the vulnerable residents of the facility. The facility provided an acceptable plan of removal of the immediate jeopardy on 06.18.2020 at 4:30 PM which included: 1. Staff are not allowed to enter the LTC (long term care) without being screened. 2. Creation of a new screening log to track symptoms of COVID-19 on 06/18/20. 3. Staff are not allowed to enter the LTC without properly donning a mask and performing hand hygeine. 4. The majority of staff were inserviced on 06/18/2020 from 12:00 PM thru 8:05 PM and all other staff will be inserviced on 06/19/20. 5. Update of the Daily Huddle form to include any PPE concerns and who to contact for additional PPE on 06/18/20 at 9:45 AM. 6. QAPI (Quality Assurance and Performance Improvement meeting held on 06/18/2020 at 4:30 pm with medical director. The survey team validated the immediate jeopardy removal on 06/22/2020 at 1:05 pm following the facility's implementation of the plan for removal of the immediate jeopardy. The deficient practice remained at the scope and severity of an F.

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