| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **175287** | A. BUILDING _____ B. WING _____ | **06/15/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **EUREKA NURSING CENTER** | **1020 N SCHOOL STREET EUREKA, KS 67045** |

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<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | **Provide and implement an infection prevention and control program.**<br><br>The facility reported a census of 46 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 perform appropriate visitor screening that included screening questions and assessment of illness for two out of 58 visitors from dates 03/13/20 thru 06/09/20. Furthermore, the facility reported ten residents that received blood sugar checks from a shared glucometer. Based on observation, interview, and record review the facility failed to appropriately clean the glucometer for two of the two residents observed after use. Failure to appropriately clean the glucometer can lead to transmission of disease-causing pathogens or other harmful microorganisms. Findings included: - On 06/09/20 at 08:00 AM, two visitors rang the facility doorbell and entered the first set of doors. The second set of doors remained locked. Licensed Nurse (LN) G came thru the second set of doors after alerted by another staff member, checked the visitor's temperatures, and had them date and sign the Visitor Sign-In Log sheet. Then, LN G entered the visitor's temperature on the Visitor Sign-In Log sheet under the column designated for Visitor Expectations Read. The form included a column for Wellness Check Complete. There were no further screening questions asked or information provided. LN G reported she did not know where there were any more of the wellness screening logs as the next log in the book had no empty columns, and then allowed the two visitors with personal surgical type mask in place to enter the facility without answering the screening questions. Review of the Visitor Sign-In Log, dated with entries from 05/20/20 thru 06/09/20 directed that all non-employee visitors entering the building must sign-in on the visitor log and acknowledge the review of the expectations. Additionally, anyone entering the building must complete a Self-Wellness Check. If the visitor did not pass the Self-Wellness Check, they do not enter the Healthcare setting. The log had a column for the date, name, wellness check complete, and visitor expectations read. The front of the binder where the log sheets were kept included an information sheet titled COVID-19 Visitor Expectations and included that all non-employee visitors entering the building must sign-in on the visitor log and acknowledge the review of this expectation. Furthermore, the document included that anyone entering the building must complete a Self-Wellness Check at the visitor check-in point. In the binder behind the Visitor Sign-In Log was a Visitor Screening Log with the last date of 05/21/20 and behind that sheet was another Visitor Screening Log with the last date recorded of 06/05/20with 14 blank rows on the log. The Visitor Screening Log included a column for date, name, temperature, and O2 (oxygen) saturation. It also included a column for cough, shortness of breath, fever, or sore throat, and if answered yes, then the visitor was not allowed to enter the facility. Another column on the log was for reason for visit-limited to medically necessary, necessary to maintain facility function, end of life services, and if not related to this do not allow to enter. Other columns included the question of travel to a region of COVID-19 outbreak, contact with anyone who is COVID-19 positive, and to observe application of hand sanitizer. The last column on the log was to remind the visitor to wash their hands, maintain at least six feet of social distancing, wear appropriate PPE (personal protective equipment), and do not shake hands. The facility failed to compete the Visitor Screening Log questions before allowing the two visitors, with the exception of the temperature that was recorded on the Visitor Sign-In Log under the visitor expectations read column. Further review of the Visitor Sign-In Log from dates 03/13/20 thru 06/09/20, revealed two of the 58 entries lacked completion of the Visitor Screening Log. The facility policy (Facility Name) Nursing Center Coronavirus (COVID-19) Preparedness and Response Guidelines, updated 06/03/20, directed that all non-employee visitors entering the building must sign-in on the visitor log with visitation acknowledgements, and self-wellness checks are required for anyone entering the healthcare setting. On 06/10/20 at 04:42 PM, Administrative Nurse D confirmed the facility completed an in-service and all the staff received training on 03/13/20 and 03/26/20 to complete the visitor screening. 06/10/20 at 04:59 PM, Administrative Staff A confirmed that the wellness checks were in place for a reason and she expected them to be completed. All the staff received training on completing the visitor screening and wellness checks. On 06/11/20 at 08:27 AM, Administrative Nurse E confirmed facility staff failed to complete the screening on 06/09/20 for two visitors. The facility failed to perform appropriate visitor screening that included screening questions and assessment of illness for two out of 58 visitors from dates 03/13/20 thru 06/09/20. The failure to perform appropriate visitor screening increased the risk of transmission of the pandemic COVID-19 virus to the residents of the facility. - Observation, on 06/09/2020 at 10:35 AM, revealed Licensed Nurse (LN) G obtained a blood sugar level on Resident (R) 7 and then cleansed the glucometer with an alcohol prep. LN G failed to properly clean the glucometer after use. Observation, on 06/09/2020 at 11:03 AM, LN G obtained a blood sugar level on R8 and then pumped hand sanitizer into her hand and cleansed the glucometer with hand sanitizer and returned it to the basket. Per interview, on 06/10/2020 at 2:18 PM, with Administrative Nurse D, confirmed staff should clean the glucometer after each use, with a wet time of two minutes then allowed to air dry. Administrative Nurse D stated the glucometer was used to obtain blood sugars for ten residents. The facility's policy, Obtaining a Fingerstick Glucose Level, revised April 2001, documented to follow the manufacturer's instructions, clean and disinfect reusable equipment, parts/or devices (e.g., glucose monitoring system, Penlet, etc.) after each use. Clean and disinfect reusable equipment before storing with other clean equipment. The manufacturer's instructions, Evencare G3 Blood Glucose Monitoring System User's Guide, revealed, the Evencare G3 Meter should be cleaned and disinfected between each patient. The manufacturer listed approved products for cleaning and disinfecting the glucometer. An alcohol prep pad and hand sanitizer were not on the list. The facility failed to ensure and maintain an infection control program to reduce transmission of infections for these 10 residents when facility staff failed to properly disinfect the glucometer after each use. |

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.