STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175258	A. BUILDING _____ B. WING _____	04/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDICALODGES FORT SCOTT	915 S HORTON, PO BOX 510 FORT SCOTT, KS 66701

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.** Based on observation, interview, and record review, the facility failed to implement Centers for Medicare and Medicaid Services (CMS) infection control techniques in order to prevent the introduction and spread of diseases, including but not limited to COVID-19, to the residents of the facility. Facility staff failed to implement a screening method to ensure that visitors to the facility received prompt and thorough screening, including measuring of temperatures. On 4/14/20 at 8:10am, a Federal surveyor entered the facility through the front door into the common area, where approximately 15 residents sat eating breakfast. Five facility staff were in the immediate vicinity, and all failed to screen the Federal surveyor, who walked in the facility for approximately five minutes, before going to the nursing station to initiate the screening process. The facility failed to ensure that all staff wore facemasks, when the five staff in the facility at 8:15am on 4/14/20 failed to correctly apply or wear facemasks. Two of these staff passed breakfast trays to residents, two were seated at the nursing station, and one walked throughout the facility. Additionally, the facility failed to implement a method of surveillance to thoroughly identify, track, and trend infections in the facility, as required. A determination was made that the facility's noncompliance with one or more requirements of participation at F880 placed all residents in the facility in immediate jeopardy. On 4/14/20 at 11:00am, the Administrator was informed of the immediate jeopardy. Findings included: 1. Review of CMS guidance, titled COVID-19 Long-Term Care Facility Guidance, released on 4/2/20, documented that: 3. Long-term care facilities should immediately implement symptom screening for all. In accordance with previous CMS guidance, every individual regardless of reason entering a long-term care facility (including residents, staff, visitors, outside healthcare workers, vendors, etc.) should be asked about COVID-19 symptoms and they must also have their temperature checked. Facilities should limit access points and ensure that all accessible entrances have a screening station . For the duration of the state of emergency in their State, all long-term care facility personnel should wear a facemask while they are in the facility. On 4/14/20 at 8:10am, the Federal surveyor approached the locked front door of the facility, wearing a facemask. A sign at the door documented that visitors must ring the doorbell for entry. The surveyor rang the doorbell, and was allowed entry to the facility by the Maintenance Supervisor, who wore a mask. A sign-in sheet was on a small table next to the door. No further screening information or equipment was available. The common area that the entrance led into was occupied by approximately 15 residents, who were seated at individual tables. The surveyor walked in the common area, to the dining room, and up and down the beginning of two hallways for several minutes. Several facility staff made visual contact with the surveyor, but failed to ask for identification, failed to complete the screening process, and failed to intercept the surveyor from walking near the residents. Upon entry to the facility, five facility staff were observed without proper facemask application, and walked amongst the residents, in the commons area, and in the hallways of the building. Nurse Aide (NA1) delivered breakfast trays from the kitchen to residents, and had a disposable surgical mask that was pulled down beneath her chin, leaving her mouth and nose totally exposed. NA2, also delivering meal trays to residents, wore a mask briefly, but then removed it. Licensed Practical Nurse (LPN1), walking down the hallway, wore a mask inappropriately, were the mask failed to cover her nose. LPN 2, seated at the nursing station, also failed to appropriately wear her mask, and had her nose exposed. Maintenance staff (MS1) walked in the common area and hallway of the facility, and failed to wear a facemask. On 4/14/20 at approximately 8:15am, the surveyor approached the nursing station. LPN2, seated at the nursing station, and LPN1, standing next to the nursing station, continued to inappropriately wear their facemasks. The surveyor identified herself and the reason and purpose of the visit. After this, LPN1 and LPN2 corrected their masks. LPN2 looked underneath a stack of papers, retrieved a black binder that contained screening forms, and finally completed the screening process. The Federal surveyor had been in the building for several minutes, walking near residents and staff, by the time screening was completed. On 4/14/20 at 8:20am, LPN2 indicated that when staff and visitors enter the building, they sign in, then walk through the common area to the nursing station to be screened. On 4/14/20 at approximately 8:45am, NA2 loudly indicated to another facility staff member that she did not want to wear a facemask, because it was uncomfortable. On 4/14/20 at 8:55am, the Social Services Designee (SSD) entered the facility and signed in. The SSD failed to wear a facemask. The SSD walked over to the nursing station, completed a screening form, and then walked to her office. The SSD was in the immediate vicinity of residents while failing to wear a facemask. On 4/14/20 at 9:00am, the SSD indicated that her facemask was in her office, in a paper bag. The SSD indicated that she entered the facility in her normal routine, completing the sign-in at the door, filling out the form at the nursing station, and then going to her office to retrieve her facemask. On 4/14/20 at 9:35am, the Assistant Director of Nursing (ADON) indicated that she oversaw the infection control program. The ADON indicated that the facility recently experienced an increase in respiratory infections. None of the residents had COVID-19. The ADON indicated that facility staff did not always wear their facemasks appropriately, and that the screening process was supposed to happen at the front door, not the nursing station, because screening at the nursing station may potentially expose residents to illnesses or disease. On 4/14/20 at 10:06am, Medication Aide (MA1) indicated that when staff report for work, they were screened at the nursing station. MA1 indicated that on 4/13/20 at 4:00am, NA3 failed to wear a facemask. MA1 indicated that NA3 failing to wear a facemask could spread illness or disease to the residents that NA3 worked with. MA1 indicated that facility staff failed to appropriately wear facemasks on multiple occasions. On 4/14/20 at 10:40am, the Dietary Manager stated that screening took place at the nursing station, after staff entered the facility. Staff must walk from the door to the nursing station to be screened. On 4/14/20 at 2:20pm, LPN3 indicated that facility staff failed to correctly wear facemasks, and that she had witnessed the failure on more than one occasion. On 4/14/20 at 3:00pm, the Administrator and the Director of Nursing (DON) indicated that facility staff were supposed to be screened at the front door, not at the nursing station. Facility staff must wear masks at all times while in the facility. 2. Review of the facility's infection control logs, dated January, 2020, documented that the facility logged 14 infections for the month. Of the 14 infections, only two received a culture or sensitivity test, six lacked resolution dates, all lacked an admitted for the afflicted resident, ten lacked documentation of signs or symptoms of infection, five lacked a site of infection, and all lacked identification of the causative organism. The facility failed to track if the ordered antibiotic was effective in treating the infection. There were no respiratory infections in the month of January. Review of a urine culture and sensitivity test, dated 1/28/20, documented that one resident (R1), received the test due to symptoms of a urinary tract infection. The infection control log failed to include this resident as having an infection. The test results documented that R1's physician ordered antibiotics on 2/4/20. Review of the facility's infection control logs, dated February, 2020, documented the facility logged 12 infections for the month. Of the 12 infections, none had documented signs or symptoms of infection, none had an admitted for the afflicted resident, none had documented causative organism for the infection, three lacked initiation dates for antibiotics, eight lacked resolution dates, and infection received an x-ray for diagnostic reasons. There were three respiratory infections in the month of February. The facility documented that R1 developed his infection on 2/4/20, then his physician prescribed antibiotics, despite documentation that R1 was symptomatic on 1/28/20. Review of the facility's infection control logs,

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 -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) dated March, 2020, documented the facility logged 25 infections for the month. Of the 25 infections, three received an x-ray for diagnostic reasons, and none of the infections had a culture or sensitivity test completed. Eighteen of the infections lacked documentation of signs and symptoms of infection, two lacked a site of infection, all lacked identification of a causative organism, and all lacked resolution dates. There were six respiratory infections in the month of March. On 4/14/20 at 1:00pm, the ADON indicated that she was informed of new infections usually by nursing staff or by new antibiotic prescriptions. The ADON indicated that the nursing staff did not always tell her when a resident was developing signs or symptoms of a possible infection, and so she had to rely on tracking new antibiotic prescriptions at times. The ADON indicated that she trended infections in the building by color-coding infections on a floor map of the facility and received an antibiotic usage report from the pharmacies. The ADON indicated that she identified an increase in the number of respiratory infections, discussed the increase with the facility medical director and the individual resident's physician, and instituted a handwashing check-off in April, 2020. The ADON could not recall any further interventions implemented. The ADON indicated that she was aware that the infection control logs failed to document multiple areas of required information, and indicated that she could not spend an adequate amount of time tracking and trending infections in the facility, due to other responsibilities. Reveiw of the facility policy, dated 12/2019, titled Infection Management Process, documented: The infection Management Process will assist the facility with preventing and managing infection events. . Infection events will be placed on the Infection Control Surveillance Log to assist with monitoring types, locations, and resolution. The facility will review and evaluate infection events weekly during Risk Committee Meeting and monthly during QAPI meeting. The immediate jeopardy was removed on 4/14/20 after the Federal surveyor identified implementation of a removal plan. The scope and severity was lowered to an F.