STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175100	A. BUILDING _____ B. WING _____	**05/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VIA CHRISTI VILLAGE MANHATTAN, INC	**2800 WILLOW GROVE ROAD MANHATTAN, KS 66502**

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** Based on observation, interview, and record review, the facility failed to ensure employees followed COVID-19 Centers for Disease Control and Prevention (CDC) guidelines when two Dietary (D1, D2) staff failed to wear their personal protective equipment (PPE) i.e. masks, in two of six dining areas while providing services to residents and failed to follow handwashing infection control practices during food distribution in one of six dining areas and in three resident rooms. The facility's infection control monitoring logs failed to identify if infections were healthcare or community acquired, failed to include dates tests were completed or resolution of the infections identified. The census included 79 residents. Findings include: 1. During observation on 5/7/20 at 12:13pm in the A hall kitchenette, D1 set up a food plate, placed it on a tray, took it to R4's room. D1 placed the tray on the over bed table to remove the items from the tray onto the over bed table. D1 returned to the kitchenette and placed the tray onto the counter. Without washing or sanitizing her hands, D1 scooped ice from the ice machine into a glass, placed the glass and a packet of salad dressing on the same tray and returned to R4's room again placing the tray on the over bed table while she opened the packet of salad dressing, poured it over R4's salad and poured a liquid substance in the glass of ice. D1 returned to the kitchenette placed the tray on the counter, removed an Ensure shake (nutritional drink) from the refrigerator, unwrapped a straw then swiped down the entire straw with her bare hands before placing it in the shake drink. D1 took the drink to R4, returned to the kitchenette and placed the empty packet of salad dressing in the trash can. Without washing or sanitizing the tray or her hands, D1 grabbed a clean plate, placed it on the same tray and scooped the food onto the plate. D1 continued to distribute food to R5 and R6 who remained in their rooms for dining. D1 did not wash her hands or sanitize the tray after placing it on the over bed table in each resident's room or when she returned to the kitchenette. R1 sat in a wheelchair in the dining room. Staff provided the resident a nutritional drink which spilled on the floor. D1 retrieved the mop from the kitchenette and gave it to a staff member to clean up the spill. Without washing or sanitizing her hands D1 placed a napkin on R1, patted R1 on her back then cuddled her closely. D1 then returned to the kitchenette, grabbed another plate, prepared it without washing her hands or sanitizing the tray and placed the plate in front of R2 who sat at a table in the dining area. During an observation on 5/7/20 at 12:40pm in the D hall dining area revealed D2 sat at a table with her mask pulled down exposing her nose and mouth while she sat next to R3. During observation on 5/7/20 at 12:52pm, D1 was in the A hall dining area where R1 and R2 remained. D1's mask was pulled down exposing her nose and mouth. At this time when asked why her mask was pulled down, D1 stated the mask gets hot. When asked when she should wash her hands, D1 indicated she should have washed her hands between each resident and cleaned the tray in between residents but she forgot. On 5/7/20 at 12:57pm the Director of Nutrition services indicated dietary staff were to wash their hands in-between each resident, were not to use the same tray without disinfecting it between residents, not touch the straw with their bare hands and were to wear their masks at all times due to COVID-19 precautions. During an interview on 5/7/20 at 1:57pm the Infection Control Nurse indicated the facility did not have any COVID-19 positive residents or staff and all staff were to wear masks at all times while in the facility. The 1/2020 Meal Delivery & Pickup for Tray Service Only Policy and Procedure under the title Food and Nutrition Department recorded the following: If Food and Nutrition Department delivers trays to resident rooms -Knocks lightly on the door, identifies self and department and waits for response before entering to deliver the tray. Greets resident by name. -Uses alcohol-based hand antiseptic immediately after delivering a tray and before delivering the next resident tray. However, if hands are visibly soiled with food or other material, washes hands with soap and water. -Adheres to the information posted at the rooms requiring isolation precautions. -Places the tray on the over bed table with the food in the ready-to-eat position. Adjust the table for resident convenience. If the table is not clear, the Food Service Associate is permitted to move non-medical items (newspaper, etc.) to make room for the tray. The Food Service Associate should request assistance from nursing in clearing table of medical items (urinal, etc.). The undated Recommendations for Standard & Transmission-Based Precautions In Healthcare Settings Policy and Procedure recorded under the title Hand Hygiene the following: Hand hygiene frequently is called the single most important measure to reduce the risks of transmitting organisms from one person to another or from one site to another on the same patient. In the Dining Services department soap and water is the only approved method for decontaminating hands during food preparation and service. Hand sanitizers are NOT approved for use in the kitchen or other food service areas (they can be used in the dining rooms in between serving different residents). 2. Record review of the January through April 2020 Infection Control Logs lacked pertinent information for the residents to include if infections were healthcare or community acquired, dates tests were completed, and if the infections were resolved. During an interview on 5/11/20 at 12:13pm, the Infection Control nurse indicated she did not include community acquired infections on the log, did not include dates the infections resolved or dates tests were completed for residents identified on the logs. The information to be documented on the facility's infection control log included: 1. Identifying information (i.e., resident's name, age, room number, unit, and Attending Physician); 2. Diagnoses; 3. admitted , date of onset of infection (may list onset of symptoms, if non, or date of positive diagnostic tests); 4. Infection site (be as specific as possible, e.g. , cutaneous infections should be listed as pressure ulcer, left foot, pneumonia as right upper lobe, etc.); 5. Pathogens; 6. Invasive procedures or risk factors (i.e., surgery, indwelling tubes, Foley, etc., [MEDICAL CONDITION], malnutrition, altered mental status, etc.); 7. Pertinent remarks (additional relevant information, i.e. temperatures, other symptoms of specific infection, white blood cell count, etc.). Also, record if the resident is admitted to the hospital, or expires; and 8. Treatment measures and precautions (interventions and steps taken that may reduce risk.). B. Using the current suggested criteria for Healthcare-Associated Infections, determine if the resident has a Healthcare-Associated Infection.

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