STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175124	A. BUILDING _____ B. WING _____	**08/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKEPOINT EL DORADO, LLC	**1313 S HIGH STREET EL DORADO, KS 67042**

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.** The facility reported a census of 53 residents. Based on observation, interview and record review, the facility failed to maintain an effective infection control program including failure to sanitize a cart with glucose monitoring equipment, and failure to wash hands following delivery of linens into Resident (R) 8's quarantine room, also failure to properly sanitize nebulizer components for three R10, R11, R12 of four residents, when the components lay on paper towels, under the soap dispenser where staff washed their hands and dripped water onto the components and paper towels, to prevent the spread of infections to the residents of the facility. Findings included: - Observation, on 08/25/20 at 02:12 PM revealed signage on Resident (R)8's door indicating quarantine status. Licensed Nurse (LN) G, took a cart containing glucometer and vital sign supplies into (R) 8's room. Observation, on 08/26/20 at 10:45 AM, revealed LN G obtained a cart containing blood glucose collection supplies, from the medication room, wheeled the entire cart into R8's room, and proceeded to obtain the resident's blood glucose. LN G placed the glucometer directly on the resident's bed side table, and once LN G obtained the blood sugar, placed the glucometer back directly on the top shelf area of the cart. LN G removed the cart from the resident's room, used a sanitizing wipe to clean the glucometer, obtained another wipe to wrap around the glucometer and LC G did not sanitize the top shelf area of the cart. LN G confirmed R8 was in quarantine as he came from acute care following surgery. LN G stated the facility quarantined all residents admitted to the facility for 14 days. LN G stated the glucometer was for multiple residents, but only one resident required glucose monitoring at that time. Observation, on 08/26/20 at 12:53 PM, revealed Laundry Staff U, delivered clothing into R8's room, and did not sanitize her hands after exiting. Interview, at that time with Laundry Staff U, revealed she did not realize she should sanitize her hands after contact with R8's room (doorknobs.) Interview, on 08/26/20 at 04:00 PM, with Administrative Staff D, confirmed R8 was on quarantine but displayed no symptoms of COVID-19. Administrative Staff D stated nursing staff should wear a mask and wash their hands after contact with the resident/resident's room. Administrative Staff D stated staff should not take the entire cart containing glucose collection supplies into the quarantined resident's room. The undated facility policy Definitions: Quarantine instructed staff that residents who may have been exposed to a pathogen but not showing signs of illness are restricted to their room and all staff will wear a face mask when entering the room and caring for the resident. The undated facility policy Cleaning and Infection Control of Non-Critical, Reusable Resident Care Equipment for glucometers, instructed staff to place all equipment on a clean barrier to protect all areas of the equipment. The facility failed to ensure that staff properly obtained blood glucose in a manner to prevent possible contamination of the supply cart (containing blood glucose monitoring equipment) to prevent the spread of infection. Furthermore, Laundry staff failed to sanitize their hands, following delivering linens to the quarantined resident's room, to prevent the spread of potential infections to the other residents of the facility. - Observation, on 08/26/20 at 08:02 AM, revealed the common living area handwashing sink counter, positioned under the soap dispenser, contained three resident's R10, R11, and R12 nebulizer components on paper towels, in various states of drying. The paper towels were not separated and all three overlapped each other. Observation revealed multiple Certified Nurse Aides washed their hands at this sink and at times new water spots appeared on the paper towels, which held the nebulizer components. Interview, on 08/26/20 at 08:30 AM, with Administrative Nurse E, confirmed the nebulizer equipment components should be separated from each other. Administrative Nurse E confirmed this location (under the soap dispenser next to the common use sink) did not provide an area to sanitize the nebulizer components in a manner to prevent the spread of infections for the three residents. The facility policy Nebulizer Treatment, dated 01/15/2020, instructed staff to air dry the nebulizer components on a clean cloth or paper towel. The facility failed to ensure staff cleaned these three residents' nebulizer components in a sanitary manner prevent the spread of infection.

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.