STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175335	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHERRYVALE NURSING AND REHABILITATION CENTER	1001 W MAIN STREET, PO BOX 366 CHERRYVALE, KS 67335

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement CMS and CDC recommended infection control practices in order to control and prevent the potential spread of COVID-19 amongst residents and staff. The facility failed to ensure that facility staff appropriately wore facial masks, including when entering the room of a resident under observation for COVID-19; failed to thoroughly screen staff for COVID-19 prior to caring for residents in the facility, and failed to ensure staff providing care to residents under observation for developing signs or symptoms of COVID-19 wore appropriate PPE. These same staff then provided care to other residents of the facility, who were not under observation for COVID-19. Additionally, the facility failed to ensure that the residents of the facility practiced social distancing during mealtimes. A determination was made that the facility's noncompliance with one or more requirements of participation placed all residents in the facility in immediate jeopardy, which began on 3/18/20. On 7/1/20 at 3:34pm, the Administrator was notified of the immediate jeopardy at F880, Infection Prevention and Control. The immediate jeopardy was removed on 7/1/20 after the surveyor verified implementation of the facility's removal plan. The scope and severity was lowered to an F. Findings include: - Review of CDC recommendations for the use of facemasks, located in guidance titled Preparing for COVID-19 in Nursing Homes, documented the following: Implement Source Control Measures. HCP (healthcare providers) should wear a facemask at all times while they are in the facility. When available, facemasks are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. Guidance on extended use and reuse of facemasks is available. Cloth face coverings should NOT be worn by HCP instead of a respirator or facemask if PPE (personal protective equipment) is required. Further review of CDC recommendations for new admissions and readmissions of residents documented the following: Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown. Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. Testing at the end of this period can be considered to increase certainty that the resident is not infected. On 7/1/20 at 9:35am, a sign on resident (R1)'s door documented: Isolation 6/19/20-7/3/20. No PPE supplies were available outside of R1's room. On 7/1/20 at 9:43am, Nurse Aide (NA1) indicated that R1 was on isolation following her admission to the facility. NA1 further indicated that R1's neighbor, R2, was not on isolation. NA1 indicated that when staff entered R1's room, they must wear a facemask and gloves, but no further PPE. NA1 indicated that facility staff were expected to only wear a facemask and gloves when entering isolation residents' rooms as regular practice. NA1 indicated that facility staff would only don further PPE if a resident tested positive for COVID-19. NA1 indicated that residents would sit across the table from each other at activities and at meals, but that facility staff would attempt to keep them six feet apart. On 7/1/20 at 10:07am, NA1, wearing only a cloth facemask, assisted R1 with her pillow. NA1 stood at R1's bedside, within three feet of R1. NA1 finished assisting R1, exited the room, used alcohol-based hand rub, and immediately entered R2's room. R2 indicated to NA1 that she would like to lay down in bed, and NA1 assisted R2 with transferring. On 7/1/20 at 11:25am, a facility staff person stood in R3's room, with a cloth facemask on. The mask failed to be applied correctly, and hung beneath the staff person's nose, exposing the nostrils. On 7/1/20 at 11:27am, dietary staff (D1) entered R1's room to deliver R1's noon meal. D1 wore only a cloth facemask, which was applied inappropriately, leaving D1's nose exposed. D1 stood within six feet of R1 while providing her with her noon meal. D1 then left R1's room, performed hand hygiene, picked up another meal tray, and entered R2's room to deliver her noon meal. R2 was not on isolation. D1's facemask continued to be worn inappropriately. After exiting R2's room, D1 performed hand hygiene, picked up another lunch tray, and entered the room of R4, another resident who was not on isolation. D1 continued to wear the facemask inappropriately. On 7/1/20 at 11:36am, D1 indicated that the cloth facemasks were ill-fitting, and often slipped down beneath the nose. D1 indicated that when facility staff entered R1's room, they were expected to wear only a facemask and gloves. Facility staff would only wear further PPE if a resident was positive for COVID-19. D1 then indicated that facility staff were provided with two cloth facemasks at the beginning of the COVID-19 pandemic. D1 then indicated that facility staff received a text message on Monday, which documented that if facility staff needed a mask for their shift, they must pay $1.00 to the facility to get one. On 7/1/20 at 11:55am, a facility staff person, wearing only a disposable surgical mask (no other PPE was utilized by this staff member), entered R1's room carrying a full-body mechanical lift sling. On 7/1/20 at 12:18pm, Registered Nurse (RN1) indicated that facility staff were expected to wear only a facemask and gloves when entering R1's room. RN1 indicated that this practice seemed wrong, as R1 was under observation for COVID-19 symptoms, and that some people could be sick with COVID-19 but yet be free of symptoms of the disease. RN1 indicated that the facility recently tested a different resident for COVID-19, and while the facility awaited test results, facility staff were instructed by administration to wear only a facemask and gloves. RN1 indicated this was done because facility administration didn't feel like the resident had COVID-19. RN1 indicated that staff would only wear full PPE if a resident tested positive for COVID-19. RN1 indicated that facility staff were unaware of where the PPE supplies were, thusly inaccessible, but that facemasks were available in the Director of Nursing's (DON's) office. RN1 indicated that facility staff were supplied with two cloth facemasks by the facility, but that administration had sent a text message indicating that if facility staff needed a different mask, they must pay $1.00 to receive one. RN1 indicated that the facility attempted to practice social distancing with the residents, and tried to keep them six feet apart. RN1 indicated that facility staff did not focus on that any longer, and that low staffing played a part. RN1 indicated that at times, other facility staff wore facemasks beneath their noses, or would pull them down after leaving a resident room. RN1 indicated that on-the-spot education would be provided to the staff. RN1 indicated that it would be a struggle to keep a case of COVID-19 contained in the facility. On 7/1/20 at 12:34pm, NA2 exited a resident room, with their facemask beneath their nose, leaving the nostrils exposed. On 7/1/20 at 12:36pm, NA2 indicated that R1 was on isolation because she recently admitted to the facility. NA2 indicated that when staff entered R1's room, they were expected to wear only a facemask and gloves. NA2 indicated that they would only wear additional PPE if a resident became symptomatic, or tested positive for COVID-19. NA2 indicated that at mealtimes, facility staff would seat residents two to a table, and would attempt to keep them socially distanced, but could not always do that. NA2 indicated that the facility was often short-staffed, and that this was why they could not ensure residents were kept socially distanced. NA2 indicated that facility staff were provided with two cloth facemasks by the facility, but that if they needed a new one, they would have to pay $1.00. NA2 further indicated that the facility had surgical masks available, but that staff were told they could not wear them. NA2 indicated that the cloth masks were ill-fitting, and often fell down. During a confidential interview, a staff person provided the Federal surveyor with the text message, which read:

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175335	A. BUILDING _____ B. WING _____	**07/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHERRYVALE NURSING AND REHABILITATION CENTER	**1001 W MAIN STREET, PO BOX 366 CHERRYVALE, KS 67335**

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	(continued... from page 1) Alert: MASK!! Nothing has changed, they are required and you MUST wear them correctly when out with residents! There has been a lot of staff forgetting their mask. If you have to get a another mask from facility, it will cost you $1.00 thanks! On 7/1/20 at 12:54pm, the DON indicated that the facility had a good supply of PPE, and was not short. The DON indicated that new admissions or readmissions were required to be on isolation for 14 days following entrance to the facility. The DON indicated that facility staff were expected to only wear a facemask and gloves to provide care for residents under observation for signs or symptoms of COVID-19. The DON indicated that facility staff attempted to enforce social distancing, but some residents preferred to sit next to each other. The DON indicated that she was not aware of any issues with social distancing during mealtimes on the secured memory care unit. The DON indicated that some facility staff were forgetting their cloth masks at home, and so the administration sent a mass text message stating that extra masks would cost $1.00. On 7/1/20 at 1:00pm, the Administrator indicated that the mass text message was sent as a joke, and was not meant to be taken seriously. On 7/1/20 at 3:28pm, the DON indicated that the facility practice for new admissions and PPE since the onset of the pandemic was for staff to wear only a facemask and gloves when entering their rooms. - Review of CMS guidance, titled Guidance for Limiting the Transmission of COVID-19 for Nursing Homes, dated 3/4/20, documented the following: How should facilities monitor or limit visitors? Facilities should screen visitors for the following: 1. International travel within the last 14 days to restricted countries. For updated information on restricted countries visit: https://www.cdc.gov/coronavirus/2019- ncov/[MEDICATION NAME]/index.html 2. Signs or symptoms of a respiratory infection, such as a fever, cough, and sore throat. 3. Has had contact with someone with or under investigation for COVID-19 . How should facilities monitor or restrict health care facility staff? The same screening performed for visitors should be performed for facility staff (numbers 1, 2, and 3 above). Review of the Staff Screening Form COVID-19 documented that facility staff were to write their names, then document answers to the following questions: temperature, if shortness of breath was present, if cough was present, if so, was the cough new or changed; if sore throat was present, if so, was the sore throat new or changed; if redness was present around the eyes, and if the staff was sent home. Staff were to document the date and time of the screening. Review of the Staff Screening Form COVID-19 logs revealed the following: On 3/18/20, 3/21/20, 3/29/20, 3/30/20, 3/31/20, 4/2/20, 4/11/20, 4/13/20, 4/15/20, 4/16/20, 4/26/20, 5/22/20, 5/30/20, 6/24/20, and 6/28/20, facility staff failed to answer all screening questions prior to facility entry. On 3/23/20, 3/29/20, 4/3/20, 4/8/20, 4/26/20, 4/29/20, 5/14/20, 5/19/20, 5/21/20, 5/30/20, 6/3/20, 6/19/20, and 6/29/20, facility staff failed to have their temperature taken prior to facility entry. None of the facility staff indicated on the forms that they were sent home, indicating that they were permitted to begin their shifts. Review of Medical Personnel Only screening logs documented that medical personnel visitors were expected to document the date, their name, a telephone number, and their temperature. The visitors were expected to answer the following questions: if they experienced shortness of breath, a cough, if so, was the cough new or changed; a sore throat, if they traveled outside of the United States, and if they had redness around the eyes. Review of the Medical Personnel Only logs revealed the following: On 3/18/20, a visitor failed to answer any of the screening questions. On 4/10/20, a visitor failed to answer all of the screening questions. On 4/20/20, two visitors failed to answer any of the screening questions. On 5/8/20, a visitor failed to document a temperature. On 5/19/20, two visitors failed to document temperatures, or answer any of the screening questions. On 5/27/20, a visitor failed to document a temperature, or answer any of the screening questions. On 6/9/20, two visitors failed to document temperatures or answer any of the screening questions. On 6/21/20, two visitors failed to answer any screening questions. On 6/22/20, a visitor failed to document a temperature or answer any of the screening questions. On 6/23/20, two visitors failed to document temperatures or answer any screening questions. On 6/24/20, two visitors failed to answer any screening questions. On 6/25/20, two visitors failed to answer any screening questions, and an additional visitor failed to document a temperature or answer any questions. Review of the Visitors Only screening logs documented that resident's visitors were expected to document the date, their name, a telephone number, and their temperature. The visitors were expected to answer the following questions: if they experienced shortness of breath, a cough, if so, was the cough new or changed; a sore throat, if they traveled outside of the United States, the name of the resident they were visiting, and the time of entry to the facility. Review of the Visitors Only screening logs revealed the following: On 6/24/20, a visitor failed to answer any of the screening questions, and documented a temperature of 99.3F (Fahrenheit). On 7/1/20 at 10:45am, the Administrator indicated that the screening logs got mixed up, and that staff and resident visitors sometimes signed in on the Medical Personnel Only forms. On 7/1/20 at 12:54pm, the DON indicated that the facility administration reviewed the logs regularly to check if there were any blanks on the logs. The DON indicated that facility staff screened themselves into the facility, and were expected to complete the screening log themselves.The DON indicated that she was not aware of any issues with facility staff, visiting medical personnel, or resident visitors failing to complete the screening logs. - Review of CDC recommendations, located in Preparing for COVID-19 in Nursing Homes, under the section Additional Strategies Depending on the Facility's Reopening Status, documented the following: Implement Social Distancing Measures Implement aggressive social distancing measures (remaining at least 6 feet apart from others): Cancel communal dining and group activities, such as internal and external activities. Remind residents to practice social distancing, wear a cloth face covering (if tolerated), and perform hand hygiene. Further review of CDC recommendations, located in Infection Prevention and Control (IPC) Guidance for Memory Care Units, documented the following: Continue to provide structured activities, which may need to occur in the resident's room or be scheduled at staggered times throughout the day to maintain social distancing . Limit the number of residents or space residents at least 6 feet apart as much as feasible when in a common area, and gently redirect residents who are ambulatory and are in close proximity to other residents or personnel. On 7/1/20 at 9:10am, two residents sat in their wheelchairs in the main dining room, at the same table. The residents were approximately three feet apart. Neither of the residents wore facemasks. At 9:41pm, the residents continued to sit in the same manner. Intermittent observations between 9:10am and 9:41am revealed that no staff attempted to educate the residents about social distancing, or made attempts to separate the two residents. On 7/1/20 at 11:56am, two residents sat in the main dining room for the noon meal. The residents sat within six feet of each other, and did not wear masks. On 7/1/20 at 11:58am, on the facility's secured memory care unit, an unsampled male resident and an unsampled female resident sat at the same table, eating their meals. The residents sat within six feet of each other. At 12:00pm, approximately two minutes after the Federal surveyor entered the unit, a staff person picked up the male resident's meal and placed it at a different table. The staff person then assisted the male resident to sit at the different table. On 7/1/20 at 12:54pm, the DON indicated that the facility attempted to enforce social distancing among the residents of the facility. The DON indicated that she was not aware of any issues regarding social distancing in the secured memory care unit.