STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E445	A. BUILDING _____ B. WING _____	**07/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
STANTON COUNTY HEALTH CARE FACILITY LTCU	**404 N CHESTNUT PO BOX 779 JOHNSON, KS 67855**

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 census totaled 23 residents (R). Based on observation, interview, and record review the facility failed to screen employees regarding their travel history and exposure to individuals with known or suspected COVID19, which had the ability to affect all residents in the failty. The facility further failed to ensure a Certified Nurse Aide (CNA) appropriate use of gloves and hand hygiene during R1's care and failed to ensure Licensed Nurse (LN) staff offered R2 hand hygiene after toileting. Findings included: - Interview with Housekeeping Staff H on 07/07/20 at 08:50 AM revealed employees come in the back door, get a mask and go to nurses' station to obtain temperature, sign in, and screen about symptoms. Interview with Housekeeping Staff I on 07/07/20 at 09:16 AM revealed she entered through the back door and went to nurses' station to take her temperature and sign in. She only answered about the symptoms on the sheet. There form lacked questions regarding if the staff member had traveled to any states with outbreaks or if they had any contact with a known or suspected COVID19 positive individual. Interview with Dietary Staff G on 07/07/20 at 09:58 AM revealed that she entered the back door and went to the nurses' station to take her temperature and obtained a mask. Interview with Certified Nurse Aide (CNA) D on 07/07/20 at 09:23 AM revealed when she arrived at work, she came in the back door and went to the nurse's station to take her temperature and sign the COVID19 symptom sheet. Then she would use hand sanitizer and obtained a mask to put on for her shift. Interview with CNA F on 07/07/20 at 01:58 PM revealed the licensed nurse on duty completed the screening process for employees, but sometimes CNA F signed in with a co-worker because when she arrived, the nurse was not around to complete the screening. Interview with Licensed Nurse (LN) C on 07/07/20 at 11:24 AM revealed she would obtain a temperature and screen the employees about signs and symptoms. Employees would obtain their temperature and screen themselves for symptoms if LN staff were not around to do so. She did not ask employees about travel or exposure, and there were no questions related to that on the employee log if they complete it independently. If the employees screen themselves, she guessed the employee would notify the nurse of any signs or symptoms if the answer were yes. Interview with LN B on 07/07/20 at 11:50 AM revealed the facility's process for screening had been lacking, and we would have to implement different screening procedures. The employee screening of all staff were completed at the beginning of their shift for fever and signs/symptoms of illness but they were not screened for travel and exposure to others. That needed to be added to the forms to update them. The screening log for employee's did not included questions about travel and exposure either. Interview with Administrative Nurse A on 07/07/20 at 09:00 AM revealed employees could enter through the back door of the building, but they must come around to the main door to be screened by the nurse at the nurse's station. There was a Screening Questionnaire that could be referenced on the very bottom of the pile, and the nurse on duty needed to acknowledge the questions on the screening form along with the symptoms that are on the employee screening log. The nurse was supposed to complete the employee screenings daily, but sometimes the employees screened themselves. Review of undated blank Stanton County Hospital Family Practice & LTCU COVID screening log for employees revealed the staff's temperature was obtained and they were asked about if they had experienced any signs and symptoms to include: fever, chills, rigor (sudden feeling of cold with shivering accompanied by a rise in temperature, often with copious sweating, especially at the onset or height of a fever), myalgia (muscle pain), malaise (fatigue), headache, sore throat, cough, shortness of breath, diarrhea, and new olfactory (sense of smell) or taste disorder. The form lacked screening for travel and exposure to others. Review of 04/15/20 Surviellance for Infection Control revealed the intent of surveillance was to identify possible communicable diseases or infections before the spread to other persons in the facility or those working in the facility. The facility failed to screen employees regarding their travel history and their exposure to individuals with known or suspected COVID19. - Observation of resident cares with CNA D for R1 on 07/07/20 at 02:38 PM revealed staff masked and assisted R1 to the restroom with a sit-to-stand lift, CNA D had washed her hands and applied gloves, then applied a sling to the resident, and lifted R1 to the toilet. CNA D, using the same gloves, moved the wheelchair next to recliner. Using the same gloves CNA D then assisted R1, obtained wipes, cleaned the resident, and pulled R1's brief up and secured without changing her gloves. Interview with CNA D on 07/07/20 at 02:45 PM revealed she usually changed her gloves after she got the resident on the toilet, and stated she did not this time. Interview with Administrative Nurse A on 07/07/20 at 03:00 PM revealed gloves should be used for cares and changed when going from dirty to clean. Staff should not touch equipment with gloves and then touch resident, gloves should have been changed before continuing care. Review of 07/20/19 Handwashing policy revealed all personnel shall follow our established handwashing procedures to prevent the spread of infection and disease to other personnel, patients, and visitors. Appropriate handwashing must be performed under the following conditions: after handling used dressings, contaminated equipment, etc. The facility failed to ensure employees implemented appropriate use of personal protective equipment (PPE) during resident care. - Observation of Licensed Nurse (LN) C on 07/07/20 at 01:01 PM revealed she answered the call light for R2 who was in the restroom on the toilet and was needing assistance with finishing up. LN C assisted the resident but did not offer or encourage the resident to wash or sanitize her hands after completing toileting. Interview with LN C on 07/07/20 at 01:01 PM revealed she should have offered the resident hand hygiene after toileting. Interview with LN B on 07/07/20 at 11:50 AM revealed the facility probably had not offered enough hand hygiene for residents; just being honest. The CNA's needed to do more encouraging to have the residents wash their hands. Interview with Administrative Nurse A on 07/07/20 at 03:00 PM revealed the residents were to be encouraged and provided hand hygiene after toileting. Review of 07/20/19 Handwashing policy revealed all personnel shall follow our established handwashing procedures to prevent the spread of infection and disease to other personnel, patients, and visitors. Residents are encouraged to perform hand hygiene before eating and after using the restroom. The facility failed to residents were not offered or educated on the need for hand hygiene after toileting.

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.