STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E034	A. BUILDING _____ B. WING _____	**06/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PROTECTION VALLEY MANOR	**600 S BROADWAY, PO BOX 448 PROTECTION, KS 67127**

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.** The facility reported a census of 42 residents. Based on observation, interview, and record review the facility failed to promptly review screenings of staff and visitors for COVID-19 signs and symptoms before gaining full entrance into the facility and access to residents. The facility further failed to ensure staff wore protective face coverings inside the facility and around residents. These failures placed all 42 residents in the facility in immediate jeopardy. Findings included: - Observation on 06/16/20 at 11:30 AM revealed Administrative Staff A in the foyer with the surveyors onsite and Administrative Staff A explained why the surveyors needed to screen themselves. Administrative Staff A did not wear a protective face mask. Observation on 06/16/20 at 11:35 AM revealed Administrative Staff A in the commons area of the facility and continued to not wear a protective face mask. Observation on 06/16/20 at 11:36 AM revealed three unidentified staff did not wear protective face masks while in the commons area of the facility. Observation on 06/16/20 at 12:00 PM revealed Certified Medication Aide (CMA) M and CMA N stood at a medication cart in the hallway of the facility, and neither wore a protective face mask while working. Observation on 06/16/20 at 01:00 PM revealed Certified Nurse Aide (CNA) O propelled an unidentified resident in her wheelchair. CNA O did not wear a mask in the presence of the resident, and he bent over and talked to the resident. During an interview on 06/16/20 at 12:05 PM, CMA M stated she sanitized her hands with gel, filled out the screening form, and took her temperature first thing when she arrived at work. CNA M reported she then put the form in a box by the time clock and went to work. CNA M reported the staff were not required to wear protective face masks. During an interview on 06/16/20 at 12:08 PM CMA N reported no staff wore protective face masks when they worked, as they were not required. CNA N also reported she did her own screening in the morning when she came in to work and put the form in that box (pointing to the box by the Director of Nursing (DON) office). During an interview on 06/16/20 at 01:00 PM CNA O reported he had his own protective face mask he carried in his pocket, but he did not have to wear it at this facility. CNA O did not know for sure who reviewed the screening sheets staff put in the DON box every day. During an interview on 06/16/20 at 12:30 PM Administrative Nurse B reported she tried to check the screening forms every day that she worked. Administrative Nurse B said the facility always had a registered nurse working and she attempted to have the nurse look at the screening sheets on their shift and hoped it was getting done. During an interview on 06/16/20 at 11:35 AM Administrative Staff A and Administrative Nurse B reported the staff in the facility do not wear face masks as it caused behaviors and anxiety with the residents who had a mental illness diagnosis. Administrative Staff A and Administrative Nurse B reported a meeting with the medical director who agreed for staff to not wear masks. Administrative Staff A said employees were responsible to screen themselves prior to entering the facility, by sanitizing hands, taking their own temperatures, and stated the employees also had to answer questions on symptoms and travel. Administrative Staff A stated no one person was responsible to screen employees as they came in to work and said Administrative Nurse B or the nurse reviewed the screening sheets sometime during that day. During an interview on 06/16/20 at 03:23 PM Physician JJ reported he just went along with the facility suggestion not to wear masks when they approached him about it. Review of a Centers for Medicare and Medicaid Services (CMS) guidance, dated 04/02/20, entitled COVID-19 Long-Term Care Facility Guidance, revealed long term care facilities were to implement symptom screening on every individual entering a long-term care facility to mitigate the spread of COVID19. The guidance further noted 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. The facility failed to ensure prompt review of screening of staff and visitors for COVID-19 symptoms before entering the facility, which allowed full access to residents and their environment, and failed to ensure staff wore face protective masks while in the facility. These failures put all residents in immediate jeopardy. On 06/16/20 at 05:00 PM the surveyor provided Administrative Staff A and Administrative Nurse B with the IJ template and notified that the facility failure to ensure all staff and visitor screenings were promptly reviewed for COVID-19 symptoms and the failure of facility staff to wear protective masks while in the facility constituted immediate jeopardy at F880, with the potential to affect all residents in the facility. The facility presented an acceptable plan of removal of the immediate jeopardy on 06/16/20 at 06:41 PM, which included in-servicing of staff regarding COVID-19 screenings for all visitors and staff and included all staff to wear protective face masks while in the facility. The survey team validated the immediate jeopardy removal on 06/17/20 at 07:55 AM following the facility's implementation of the plan for removal of the immediate jeopardy. The deficient practice remained at a scope and severity of an F.

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.