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

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

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #155336 and a Targeted Infection Control Survey/COVID-19 Focused Survey was conducted by the Kansas Department on Aging and Disability (KDADS) on August 25-27/202. The facility was found to be in compliance with Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID 19. This 2567 was electronically sent to the facility on 9/2/2020.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		

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

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F 880	Continued From page 1 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 2	F 880		

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
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,

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F 880	Continued From page 3	F 880		

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

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F 880	Continued From page 4	F 880		

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

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F 880	Continued From page 5 towel. The facility failed to ensure staff cleaned these three residents' nebulizer components in a sanitary manner prevent the spread of infection.	F 880		