STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175376	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APOSTOLIC CHRISTIAN HOME	511 PARAMOUNT STREET SABETHA, KS 66534

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 -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and policy review, the facility failed to assure staff followed infection control policies related to isolation and protective equipment for one of five residents (Resident (R) 1) reviewed for infection control practices. Staff failed to implement precautions, after R1 developed a high fever of 102 degrees Fahrenheit (F) and respiratory symptoms for two days until the resident tested positive for the [MEDICAL CONDITION] (pandemic infection). In addition, the facility failed to assure that everyone, including staff were consistently screened, according to their policy, for COVID signs and symptoms prior to entering the facility. The surveyor and three employees (CNA 2, CNA3, Physical Therapy Assistant (PTA1) were not fully screened prior to entering the facility. These deficient practices had the potential to allow the spread of infections to other residents and facility staff. Findings include: Review of the facility's policy titled, Novel Coronavirus (2019-nCov) (COVID-19), dated June 2020 indicated that .any resident with a temperature of 100.4 degrees, a cough, fever, or sore throat will be considered to by (sic) symptomatic and transmission base precautions will be implemented immediately. The policy directed that facility staff wear appropriate personal protective equipment (PPE) including, gloves, isolation gown, mask, and eye protection for transmission-based protocols. In addition, the policy directed that upon entry a visitor would complete the facility's health questionnaire and staff would monitor for a fever and symptoms of a lower respiratory illness (e.g cough or shortness of breath). All residents, staff, visitors, volunteers will perform hand hygiene upon entering the facility. 1. Review of the Admitting and Discharge/Transfer Record in the Electronic Medical Record (EMR) revealed R1 entered the facility on 09/16/19, with [DIAGNOSES REDACTED]. Review of a Nurses Note dated 05/20/20 at 2:21 PM , in the EMR under the Nurses Notes tab, documented at 8:02 AM the resident had a fever of 102 degrees Fahrenheit (F) (normal 97-99 degrees F). The resident's temperature lowered to 100.6 degrees F at 9:45 AM after Registered Nurse (RN)3 administered Tylenol. The resident had lung congestion and the oxygen saturation (amount of oxygen in the blood) (SPO2)) was 76% on room air (normal 95-100%). Additional temperature readings for R1, found in the Nurses Notes, in the EMR under the Nurses Notes tab, documented on 05/20/20 at 11 PM 98.5 F, 05/21/20 at 4:09 PM 100.1 F and 05/22/20 at 11:30 AM 100.9 F. Review of the Office Clinic Notes, dated 05/20/20 at 9:57 AM, retrieved by the Minimum Data Set (MDS) Nurse, from the medical records department, revealed the resident was evaluated by the residents primary physician, via telehealth. The documentation noted the resident had a previous temperature elevation of 102 F, abnormal lung sounds, and SPO2 of 87% on room air. The Assessment/Plan section of the Office Clinic Notes noted the physician's assessment of aspiration pneumonitis (lung inflammation) with plans for [MEDICATION NAME] (breathing treatment) and [MEDICATION NAME] (anti-nausea medication). Review of a Nurse Note, dated 05/22/20 at 5:49 PM, found in the EMR under the Nurse Note tab, documented the resident's physician was called to follow-up from the 05/20/20 doctor visit, for respiratory symptoms. New orders were received for coronavirus testing and Roxonal (pain medication). Review of a Nurses Note, dated 05/23/10 at 10:54 PM, under the Nurses Notes tab, revealed R1 was placed on isolation precautions with a positive COVID-19 result. During an interview on 07/01/20 at 4:45 PM, RN1, stated she was present with R1 in the resident's room during the telemedicine evaluation. RN 1 stated that the physician determined that the resident had aspiration pneumonia. She did not recall if they discussed the possibility of COVID. Review of a Laboratory Report-Final form, dated 05/22/20, retrieved from the MDS Nurse, documented the nasopharyngeal COVID sample was collected on 05/22/20 at 12:55 PM. The analysis result on 5/23/20 indicated [DIAGNOSES REDACTED]-CoV-2 (COVID-19 was detected. During an interview on 07/01/20 at 3:00 PM, the Director of Nursing (DON) stated that the resident was not placed on transmission-based precautions on 5/20/20. She said the transmission-based precautions were implemented on 05/22/20, when the COVID test was ordered. During an interview on 07/01/20 at 4:20 PM, the Medical Director stated that the resident should have been place on transmission-based precautions immediately on 05/20/20 when he experienced an elevated temperature and respiratory symptoms. The Medical Director stated that the protocols for COVID suspect residents were well established. 2. Review of the facility's undated job description for Front Door Screener, indicated the screener is responsible to screen all staff and essential visitors entering and leaving the facility according to CMS guidelines. Duties included, but were not limited to, taking the temperature of everyone entering the building and asking four relevant COVID screening questions of everyone entering the facility. The screener was responsible for recording staff and essential visitors' information in the logbook, confirming that all who entered the facility used alcohol hand sanitizer before proceeding into the facility and ensuring staff and essential visitors had face masks on. Upon entering the facility on 07/01/20 at 8:00 AM, Certified Nurse's Aide (CNA) 1 was in the foyer of the building and took the surveyor's temperature and wrote it down in a logbook. CNA1 did not ask any COVID screening questions nor request that the surveyor use hand sanitizer prior to entering the facility. Further observations at the above date and time revealed four staff members entering the building wearing face masks. CNA1 took their temperatures but did not instruct the staff to use hand sanitizer nor did she ask the COVID screening questions. Staff were allowed entrance into the facility. Review of the logbook with CNA 1, who verified it was the same book she wrote in during the surveyor's entry into the facility, revealed documentation of the surveyor's entry and indicated the answer to the four screening questions was no. The three staff members (CNA 2, CNA3, Physical Therapy Assistant (PTA1) had their temperatures recorded and the answer to the four screening questions was marked no for the surveyor and the four staff members. Listed on each page of the logbook, under the heading COVID-19 Staff Screening were the following questions: 1. Signs or symptoms of respiratory infection, such as fever, cough, shortness of breath of sore throat 2. In the last 14 days, have you been in contact with someone confirmed with a [DIAGNOSES REDACTED]. Have you had contact with anybody that has respiratory symptoms? . 3. Have you travelled internationally in the last 14 days to countries with sustained community transmission or been to one of the high-risk states in the United States? . 4. Are you residing in a community where community-based spread of COVID-19 is occurring? During an interview on 07/01/20 at 9:29 AM, the CNA1 stated she took the screening temperatures of the surveyor and the four facility staff earlier. She confirmed that did not ask the screening questions. CNA1 stated she had been instructed to ask screening questions. She did not respond when asked why she did not do it. During an interview on 07/01/20 at 1:30 PM with the Human Resources Assistant, she stated that all staff received education regarding the COVID screening process. She said the screening process included the use of a sanitizing mat for shoes, inquiry regarding COVID (by utilizing the four screening questions), taking of temperature, and the use of hand sanitizer. All prior to entering the facility. During an interview on 07/01/20 at 3:00 PM, the DON and the Infection Control RN stated that screeners were required to ask the four COVID screening questions and instruct the use of hand sanitizer for all visitors and staff, prior to entry into the facility. They revealed all staff received education regarding this procedure.

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