STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175410	A. BUILDING _____ B. WING _____	12/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC CARE CENTER, INC	6700 E 45TH STREET NORTH BEL AIRE, KS 67226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS F000: A COVID-19 Focused Infection Control Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 12/22/20. The facility was found not to be in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total residents: 110	F 000		
F 880 SS=E	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 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		

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.

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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.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.

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This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure staff wore personal protective equipment (PPE) in a manner to prevent possible transmission of COVID-19 while performing a blood glucose check on one resident (R6). The facility failed to ensure staff disinfected the blood glucose meter with the appropriate disinfectant to prevent transmission of blood-borne pathogens, and failed to sanitize hands prior to donning and after doffing PPE. The facility identified a census of 110 residents.

Findings include:

On 12/15/20 at 10:57am, during an observation Medication Aide (MA1) wore a surgical mask underneath her N95 mask but did not have goggles or a face shield on. MA1 entered R6's room without goggles or a face shield, leaned over the over bed table in front of R6 who sat in a chair and performed a blood glucose procedure on the resident. MA1 left the room and cleansed the blood glucose meter with an alcohol wipe. When asked, MA1 indicated she cleansed the glucometer with an alcohol wipe prior to performing the procedure on R6. MA1 indicated that the blood glucose meter was shared by multiple residents on the unit and she performed the glucose checks on each resident using the same glucometer. MA1 verified that four residents on the unit received blood glucose monitoring. MA1 then asked Licensed Practical Nurse (LPN1) if she should have used something different to clean the blood glucose meter. LPN1 instructed MA1 to use bleach wipes to cleanse the meter instead of alchol wipes. The bleach wipes were not available on MA1's medication

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cart or on the nurses' medication cart.

On 12/15/20 at 11:27am during an observation, a clipboard was laying on the floor in the doorway of a resident who was on isolation precautions. The Speech Therapist (ST) picked the clipboard up from the floor and positioned it between her legs without sanitizing it. Without sanitizing her hands, she put on PPE which consisted of a gown and gloves. The PPE was in a container that hung on the resident's door. The facemasks fell out onto the floor. The ST picked up the bag of face masks and placed it back into the sleeve in the container. Several masks had fallen out of the bag. She picked them up off the floor, entered the resident's room and threw them in the trash. The ST removed her gloves and gown, left the room and returned with another gown. Without sanitizing her hands or the clipboard, the ST placed the gown and gloves on, held the clipboard against her body and entered the resident's room.

During an interview on 12/15/20 at 2:58pm the Director of Nursing (DON) expected all staff working on each neighborhood were to wear either goggles or a face shield and an N95 face mask. The DON indicated the blood glucose meters were to be cleaned with bleach wipes not alcohol wipes. The DON indicated the clipboard should not have been placed on the floor and the ST should have sanitized her hands prior to putting on and taking off the PPE.

The undated "Personal Protective Equipment" Policy and Procedure recorded that in all neighborhoods during COVID outbreak, all workers were to always wear an N95 mask and goggles or face shield at all times. Face shields

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were preferred.

During an observation and interview on 12/15/20 at 10:58am, Housekeeper (H1) cleaned R6's room, touching surfaces in the room with her gloves while cleaning. H1 exited the room into the hallway, removed her gloves and then her isolation gown and placed them in the trash container on the housekeeping cart, pushing the trash down with her bare hands. H1 did not sanitize or wash her hands before she swept the floor in the hall, touched R6's door knob with her hand to close the door, pushed the cart down the hall and then put on new gloves and isolation gown. H1 indicated that she had cleaned R6's bathroom and then wiped down all of the high touch surfaces in the room. She further indicated she put on new gloves and a gown because she was going to enter the next resident's room to clean. She said she forgot to clean her hands after cleaning R6's bathroom and other high touch surfaces.

During an interview on 12/15/20 at 3:10pm, the DON indicated H1 should have sanitized her hands after removing her PPE and before putting on new PPE.

The October 2018 "Standard Precautions" Policy and Procedure recorded "Standard Precautions are used in the care of all residents regardless of thier diagnoses, or suspected or confirmed infection status. Standard Precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and musous membranes may contain transmissible infectious agents." The policy recorded the following:

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F 880	Continued From page 5 "1. Hand hygiene a. Hand hygiene refers to handwashing with soap (anti-microbial or non-antimicrobial) or the use of alcohol-based hand rub (ABHR), which does not require access to water. b. Hand hygiene is performed with ABHR or soap and water: (1) before and after contact with the resident; (2) before performing an aseptic task; (3) after contact with items in the resident's room; and (4) after removing PPE. c. Hands are washed with soap and water whenever: (1) visibly soiled with dirt, blood, or body fluids; (2) after direct or indirect contact with dirt, blood or body fluids; (3) after removing gloves; and (before eating and after using the restroom. 5. Resident-Care Equipemnt a. Resident-care equipment soiled with blood, body fluids, secretions, and excretions are handled ina manner that prevents skin and mucous membrane exposure, contamination of clothing, and tranfer of microorganisms to other residents and enviornments. b. Reusable equipment is not used for the care of more than one resident until it has been appropriately cleaned and reprocessed."	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization,	F 883		

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each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the

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following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to ensure two residents (R1, R5) of five were provided an opportunity to recieve either a pneumococcal polysaccharide vaccine (PPSV23) or a pneumococcal conjugate vaccine (PVC13) vaccine. The facility identified a census of 110 residents.

Findings include:

1. R5's electronic medical record (eMar) recorded the resident received an influenza vaccine on 10/16/20. The record lacked evidence the resident received or was offered either a PPSV23 or a PVC13 vaccine.
2. During review on 12/17/20 at 10:00am, R1's electronic record lacked evidence that the facility offered either a PPSV23 or a PVC13 vaccine and/or refusal for the vaccinations.

During an interview on 12/18/20 at 12:30pm, the Infection Control Nurse (ICN) reported the facility Medical Records staff during the month of September send the vaccination consent forms out to the resident's Durable Power Of Attorney (DPOA) with the expectation that the DPOA will return the consent forms to the facility before October 16, 2020. When the facility received the

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signed consent form then a line list of residents who were to receive vaccinations was made and the vaccinations are then ordered from the pharmacy and administered to those residents for whom they have a signed consent form. The ICN further indicated R1 and R5 did not have a consent form or a refusal form returned by October 16, 2020, therefore the facility did not offer those residents the Pneumonia or Prevnar13 vaccinations. The facility did not have a tracking system or system to follow up to ensure residents who did not have a signed consent form would again be offered the opportunity to consent to receive the vaccines. When the facility received a request for R5's and R1's vaccination documentation from this writer, the ICN indicated the facility identified that R5's and R1's records lacked consent forms for the vaccines. At that time, the facility obtained consent from R5's and R1's DPOA and administered the vaccines.

The October 2019 "Vaccination of Residents" Policy and Procedure recorded "All residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated or the resident has already been vaccinated."