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	B076002	A. BUILDING: _____ B. WING _____	C 11/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH WIND HOME	496 YUCCA LANE PRATT, KS 67124

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S 000	INITIAL COMMENTS The following citation represents the findings of an abbreviated survey for complaint investigation 157681 conducted at the above home plus facility on 11/12/2020, 11/16/2020, 11/17/2020.	S 000		
S5225 SS=K	26-42-207 (a) (b) (1)(2)(3)(4) Infection Control a) The administrator or operator of each home plus shall ensure the provision of a safe, sanitary, and comfortable environment for residents. (b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements: (1) Using universal precautions to prevent the spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards; (4) providing sanitary conditions for food service; This REQUIREMENT is not met as evidenced by: KAR 26-42-207(b) The facility reported a census of 12 residents. The sample included 3 residents and 7 focused record reviews. The facility identified 9 (#112, #113, #115, #116, #117, #118, #120, #121, and #122) of the 12 residents and 4 certified care staff tested positive for COVID-19 on 10-29-20. Based on observations, interview and record review the operator failed to follow the local health departments recommendations for crisis staffing, which allowed for COVID-19 positive staff to	S5225		

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

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provide care for only the residents who tested positive and not residents who tested negative. On 11-9-20, 11 days later, resident #114 tested positive for COVID-19 after receiving care from certified staff B and certified staff C who had previously tested positive for COVID-19. This failure placed the health and safety of the residents #114, #119 and #123 who initially tested negative on 10-29-20 in immediate jeopardy for risk of contracting COVID-19 a potentially fatal illness for this high-risk population.

Findings included:

- On 11-12-20 at 10:50 AM surveyor arrived at the facility and Operator A reported the facility had residents in the facility who had tested positive for COVID-19. Operator A identified on 10-29-20 9 of the 12 residents tested positive for COVID-19 and on 11-9-20 another resident tested positive for COVID-19.

Review of resident #114's medical record revealed she admitted to the facility on 5/20/19 with diagnoses of congestive heart failure, hypertension and dementia.

The resident's functional capacity screen dated 1-13-20 revealed the resident required physical assistance with dressing and toileting and could not perform bathing or management of medications/medical treatments.

The resident's negotiated service agreement dated 1-13-20 revealed staff assisted with bathing 2-3 times per week, performed assistance with dressing and toileting as needed.

The resident's health care service plan last

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reviewed on 2-13-20 staff administered medications daily, provided assistance with toileting and personal care, dressing, and bathing.

Review of the resident's nurses' notes revealed the resident had no symptoms of COVID-19 until 11-7-20 when the resident had a fever of 99.2 and staff treated with Tylenol. At 6:20 PM on 11-7-20 the notes revealed the licensed nurse assessed the resident and noted with diminished lung sounds and when asked to cough had good cough effort.

On 11-9-20 at 5:40 AM the resident had a temperature of 101 and staff administered Tylenol per orders.

The nurse's notes revealed staff tested the resident for COVID-19 on 10-29-20 and the results were negative. Staff tested the resident again on 11-9-20, after receiving care from certified staff B and C who had previously tested positive. The results of the resident's COVID-19 test were positive.

Observation on 11-12-20 at 11:25 AM revealed certified staff C came out of resident #122's room which had yellow sign on it to wear personal protective equipment. Staff C came out of the room without a gown on and said the resident was at the end of her isolation. At 11:30 AM on 11-12-20, operator A walked by surveyor and certified staff C and stated that residents with the yellow signs on the doors are the residents that had tested positive and anyone who entered the room needed to wear proper PPE.

Observation on 11-12-20 at 11:51 AM certified staff C took the plastic disposable gown and face

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shield off of the back of resident #114's door, put it on, put on gloves and went into room resident #115's room to provide repositioning. Certified staff G told certified staff C she would come help and then proceeded to get another plastic disposable gown from resident #114's room, put on the face shield and went into resident #115's room to assist certified staff C. Certified staff C and G wore gowns and masks that were used to provide care for resident #114 who tested positive for COVID-19 on 11-9-20 in resident #115's room to provide personal care. Resident #115 tested positive for COVID-19 on 10-29-20 and had completed his 10 days quarantine. This use of gowns for multiple residents had the potential to re-expose residents to COVID-19.

On 11-12-20 at 11:25 AM certified staff C reported all residents and staff were tested for COVID-19 because resident #115 had tested positive. Eight other residents and few staff tested positive. Certified staff C reported that she tested positive on 10-29-20 and she worked the rest of her shift that day, worked 10-30-20 and came in on 11-3-20 but could only work about 3 hours. Staff C could not remember exactly what the health department told her about working but was told by operator A that she needed to continue to work since she was an essential worker. Staff C stated that she provided care for all residents in the facility, including those who had not tested positive for COVID-19.

On 11-12-20 at 11:47 PM Certified staff C stated staff used the same face shield and gown to provide care for residents who had tested positive for COVID-19. Staff C stated the face shields are sprayed down with Sani-spay to sanitize them at the end of their shift and they get a new KN95 face mask every 5 days.

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S5225	Continued From page 4 On 11-16-2020 at 10:53 AM certified staff B reported on 10-29-20 he tested negative for COVID-19. Staff B stated he worked that weekend and on Monday, 11-2-20 he started to not feel very good. Staff B stated he had told operator A that he did not feel good and wanted to get tested again for COVID-19 but Operator A told him he needed to get tested on his own. Staff B went to personal doctor for COVID-19 testing and tested positive on 11-5-20. Staff B stated he called the operator to call in sick for the weekend since the doctor and Health Department told him to quarantine and not work. Staff B stated operator A told him he was considered an essential worker and needed to work. Staff B stated he worked that weekend and so did certified staff H who was vomiting during our shift. Review of Staff B's timecard revealed he worked on 11-6-20 for 12 hours and on 11-8-20 for 12 hours. Staff B stated the staff had 1 gown for all the residents who tested positive and different gowns for residents who tested negative. Staff B stated that he provided care for all residents in the facility after he tested positive for COVID-19, including the residents who tested negative. On 11-12-20 at 12:54 PM the local Health Department nurse I confirmed 9 residents tested positive on 10-29-20 and another resident tested positive on 11-9-20. Nurse I also confirmed there were staff who tested positive. Nurse I's recommendation for the facility was for all employees who tested positive for COVID-19 to quarantine for 10 days. If anyone, resident or employee continued to have symptoms they were to consider them to still be positive for COVID-19. For employees who were "first degree" employees, had exposure to COVID-19 staff/residents but did not test positive should only	S5225		

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be with positive residents so they are not possibly exposing residents who tested negative since the employee had been exposed. If the employee developed symptoms, then they shouldn't work. When staffing is a concern the recommendation changes. Ideally positive employees should not be working, but if they are, they should only care for positive residents, even though that is not ideal.

On 11-16-20 at 1:06 PM certified staff F reported she wasn't feeling good but continued to work. Staff F said she had a cold and cough and then the next day she had to leave work early because she was just so tired and couldn't do it. Thursday, 10-29-20 one of the resident's was not feeling well and he tested positive and then we all were tested, and I tested positive. Review of certified staff F's timecard revealed she worked 12 hours on the 27th, 9 hours on the 28th and 12 hours on the 29th.

Review of operator A's statement revealed 4 employees had tested positive for COVID-19. It failed include staff B had tested positive. Operator A noted the health department told her if possible, have employees who tested negative take care of residents who tested negative and the same for employees who tested positive to take care of positive residents. She also noted the health department told her to do the best she could. The operators statement noted resident care was provided by the staff that was available to work and she tried to get agency staff in but did not get a response.

Review of the facility's policy for COVID-19 included that if a resident showed signs or symptoms of COVID-19 only one staff member would be allowed to enter the room with the

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appropriate personal protective equipment on. The policy did not identify a plan for crisis staffing in order to help prevent the spread of COVID-19 to residents that tested negative.

The operator failed to follow the local health departments recommendations for crisis staffing, which allowed for COVID-19 positive staff to provide care for only the residents who tested positive and not residents who tested negative. This failure placed the health and safety of the residents #114, #119 and #123 who initially tested negative on 10-29-20 in immediate jeopardy for risk of contracting COVID-19 a potentially fatal illness for this high-risk population. On 11-9-20, 11 days after testing negative, resident #114 tested positive for COVID-19 after receiving care from certified staff B and certified staff C who had previously tested positive for COVID-19.

On 11-12-20 at 12:12 PM operator A received notification of residents being in immediate jeopardy for having certified staff who tested positive for COVID-19 provide care for all residents in the facility, including residents who tested negative for COVID-19.

On 11-12-20 at 3:12 PM operator A provided a plan to abate the immediate jeopardy which included the following:
- Staff who answer any of the screening questions will be sent home and a replacement found for them until it can be determined by the health department or their physician, they are not positive for COVID-19 ... If staffing goes into crisis situation, staff that hasn't had a fever for 72 hours may be required to return to work before the full quarantine is finished. Local health Department will be contacted for support on how to care for the residents safely during the

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S5225	Continued From page 7 COVID-19 outbreak. The jeopardy was removed on 11-12-20 at 3:46 PM when the above plan was approved by the department. The operator failed to follow the local Health Departments recommendations during crisis staffing to have employees who tested positive for COVID-19 provide care to only positive residents.	S5225		