STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	12/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

(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 The following citations represent the findings of a Targeted Infection Control Survey/COVID-19 Focused Survey. The 2567 was electronically sent to the facility on 12/03/20.	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, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/03/2020

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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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.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 39 residents. Based on observation, record review, and interview, the

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facility failed to follow Centers for Medicare and Medicaid Services (CMS) and Center for Disease Control and Prevention (CDC) guidance to prevent COVID-19 (highly contagious respiratory infection) when the facility failed to close the fire doors to the COVID-19 Unit, staff failed to don clean Personal Protective Equipment (PPE) after caring for resident's in the COVID-19 Unit, staff sat at the nurse's station wearing soiled PPE, and staff failed to remove soiled PPE prior to applying clean PPE to enter the facility's "Reverse Isolation Unit."

Findings included:

- On 11/30/20 at 09:15 AM, observation revealed the fire doors to the COVID-19 Unit open to the rest of the facility and lacked any signage on the doors identifying it was the facility's "COVID-19 Unit."

On 11/30/20 at 10:00 AM, observation revealed Certified Nurse Aide (CNA) N wore PPE consisting of a gown, goggles, and mask, and went in and out of COVID-19 positive resident rooms without changing gowns.

On 11/30/20 at 10:45 AM, observation revealed Certified Medication Aide (CMA) R in PPE sat at the nurse's station. Continued observation revealed CMA R stood up, applied clean gloves and went into a COVID-19 positive resident room. Continued observation revealed CMA R came out of the same room, removed the soiled gloves, sanitized her hands and sat down at the nurse's station wearing the soiled gown.

On 11/30/20 at 12:20 PM, observation revealed CMA R assisted a COVID-19 resident with their

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noon meal, came out of the room, sanitized her hands and continued to wear the soiled gown.

On 11/30/20 at 01:45 PM, observation revealed Certified Nurse Aide (CNA) M stood at the "Reverse Isolation Unit" door with PPE on and donned a blue plastic gown over her paper gown, a surgical mask over her KN95 mask, applied gloves and a face shield, and entered the COVID-19 unit.

On 11/30/20 at 02:05 PM, observation revealed CNA M came out of the "Reverse Isolation Unit," removed the blue plastic gown, surgical mask, and gloves, and placed them in the trash can by the "clean unit" double doors. CNA M did not remove or change the blue paper gown.

On 11/30/20 at 03:45 PM, observation revealed CNA N donned a blue plastic gown over her paper gown, a surgical mask over her KN95 mask, applied gloves and a face shield, and entered the COVID-19 unit.

On 11/30/20 at 10:45 AM, CMA R stated staff wore a gown, KN95 mask, gloves, and a face shield when they entered a COVID-19 positive resident's room. CMA M further stated staff only applied clean gloves and did not have to change gowns every time they went in and out of positive resident rooms.

On 11/30/20 at 11:30 AM, Administrative Nurse D verified staff wore the same paper gowns in and out of the COVID-19 positive resident rooms and only needed to change gloves between residents. Administrative Nurse D further verified staff applied a blue plastic gown over the paper gown when they assisted resident's in the "Reverse

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Isolation Unit."

On 11/30/20 at 01:45 PM, CNA M stated she donned a clean plastic gown over her paper gown, placed a blue mask over her KN95 mask, cleaned her face shield, applied gloves, and entered the "Reverse Isolation Unit" when she assisted the residents. CNA M further stated she threw away the blue mask, gloves, plastic gown and sanitized her hands when she was finished in the unit.

On 11/30/20 at 05:15 PM, Administrative Staff A stated she did not feel staff needed to change their gowns between residents on the COVID-19 Unit because the residents were all positive and the residents were all staying in their rooms, so they were not cross contaminating anything. Administrative Staff A stated staff off the unit were the only ones that sat at the nurse's station, so they were not contaminating anyone else. Administrative Staff A further verified the doors to the COVID -19 Unit should be kept shut and stated nursing staff did not go through those doors after their shift began, and at the end of their shift went out a door off of the COVID-19 Unit.

On 12/01/20 at 11:45 AM, Administrative Staff A stated she directed staff to wear the same PPE when they entered a COVID-19 positive resident room because when the COVID-19 virus started, there was a shortage of PPE, she was afraid that she may eventually run short, and because all of the residents on the COVID-19 unit were positive. Administrative Staff A further stated she directed staff to don a clean gown over the soiled gown because of the chance of a gown shortage and having two gowns on was an extra layer of

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F 880	Continued From page 5 protection. The facility's undated "Policy and Procedure for COVID-19," documented the policy was to minimize the exposure and infection of Corona Virus (COVID-19) within our residents and staff. The policy directed staff to keep isolation equipment and trash can for discarded gowns near the resident's door and directed staff to preserve the PPE supplies as much as possible as there was a shortage of supplies and reuse the face masks, eye shields, and gowns for the shift as long as not soiled. The facility failed to follow CMS and CDC guidance to prevent COVID-19, when the facility failed to ensure the fire doors to the COVID-19 Unit were closed and staff failed to change PPE appropriately, placing the residents and staff at risk for cross contamination and infection.	F 880		