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S 000	INITIAL COMMENTS The following citations represent the findings of an Abbreviated Survey with complaint investigations 152197, 152131, 152090, 152255, 152492 at the above named assisted living facility conducted on 5/6/2020, 5/7/2020, 5/11/2020, 5/12/2020, 5/13/2020.	S 000		
S3305 SS=J	26-41-207 (a) (b) Infection Control (a) The administrator or operator of each assisted living facility or residential health care facility 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; (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (7) transferring a resident with an infectious disease to an appropriate health care facility if the administrator or operator is unable to provide the	S3305		

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

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isolation precautions necessary to protect the health of other residents.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-207(a)(b)(1)

The facility reported a census of 87 residents with 16 residents who tested positive for COVID-19 as of 5-6-2020. Based on observation, interview and record review, the administrator failed to ensure the provision of a safe, sanitary environment for residents by the failure to properly implement procedures to control the spread of COVID-19 based on staff screening processes. The facility failed to identify and take appropriate actions of sending staff home when staff, who had symptoms of COVID-19, as well as staff who identified they had not practiced infection control measures outside of work (social distancing, masks, etc.). The facility's failure to take appropriate action and send employees home based on the staff screening form, placed all residents who lived in the assisted living and memory care area in Immediate Jeopardy related to the spread of COVID-19, a potentially fatal respiratory illness. The administrator further failed to ensure staff followed procedures for appropriate use and reuse of personal protective equipment (PPE) in order to prevent the spread of COVID-19 throughout the assisted living and memory care areas of the facility.

Findings included:

- Review of resident line list for assisted living

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residents provided by the administrator revealed the following number of cases that tested positive for COVID-19 on the following dates:
4-11-20: 1 positive case.
4-21-20: 1 additional positive case
4-23-20: 3 additional positive cases
4-24-20: 3 additional positive cases
4-26-20: 2 additional positive cases
4-27-20: 1 additional positive case
4-30-20: 2 additional positive cases
5-1-20: 1 additional positive case
5-2-20: 1 additional positive case
5-4-20: 2 additional positive cases
5-7-20: 3 additional positive cases
The record also revealed that 4 other assisted living residents who tested positive for COVID-19 were transferred to the skilled unit. Of these that tested positive, the record revealed 5 residents from the assisted living have died as of -11-2020.

On 5-6-2020 administrative staff provided 35 pages of employee screening tool sheets from 4-29-2020 to 5-5-2020. Review of the screening tools revealed the following:
1. Review of the log revealed 8 pages without a date of the screening on it.
2. Review of the temperature section of the log revealed 5 times staff failed to record a temperature. It also included 5 employees with a temperature of 99.5 and 2 with a temperature of 99.6 but did not identify if the temperature was taken temporal or orally.
3. Review of the log included 5 direct care staff who answered yes to having the presence of potential COVID-19 symptoms.
4. Review of the log included 94 times staff marked they did not follow infection control outside of work.
5. The log also included 121 entries where staff

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failed to answer at least 1 of the 3 screening questions, which included did staff follow infection control outside of work, symptoms of COVID-19, and if staff traveled outside of the state.

The bottom of the screening tool included a key which stated:
If a staff member identified they had not practiced infection control measures outside of work: "If (checked) No - team member should NOT work".
List of symptoms for staff to use to answer the question if they had potential symptoms of COVID-19: cough, shortness of breath, muscle aches/pain, nausea, vomiting, diarrhea, sore throat, runny nose or congestion, new rash, pink or red eyes, drowsiness or confusion.

Review of employee time punch detail record revealed the following employees continued to work despite answering yes to having symptoms of COVID-19:

Housekeeping staff P marked yes for having COID-19 symptoms on the screening form dated 5-4-2020 and 5-5-2020 on it. Staff P worked her full shift on 5-5-2020. Per interview on 5-12-2020 at 10:30 AM administrative nursing staff S reported housekeeping staff P worked in the assisted living areas and would occasionally work on the memory care 2nd floor.

Direct care staff K marked yes for having COVID-19 symptoms on the screening form 3 days, 4-29-2020, 5-4-2020, and on another page which did not include a date. Staff K proceeded to work her full shifts on 4-29-2020 and on 5-4-2020. Per interview on 5-12-2020 at 10:30 AM administrative nursing staff S reported direct

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care staff K worked throughout the assisted living/memory care areas.

Direct care staff N marked yes for having COVID-19 symptoms on the screening forms dated 4-29-2020, 5-3-2020, and 5-4-2020. Staff N proceeded to work 4-29-2020, 5-3-2020, 5-4-2020, and also worked a full shift on 5-5-2020. Per interview on 5-12-2020 at 10:30 AM administrative nursing staff S reported direct care staff N primarily worked on the 1st floor memory care.

Direct care staff Q marked yes for having COVID-19 symptoms on the screening form dated 4-29-2020 and 5-4-2020. Staff Q worked her full shift on 4-29-2020 and worked a partial shift on 5-4-2020 (not her usual shift). Per interview on 5-12-2020 at 10:30 AM administrative nursing staff S reported direct care staff Q worked throughout the assisted living, including the memory care areas.

Direct care staff R marked yes for having COVID-19 symptoms on the screening form dated 4-29-2020 and she worked her full shift on that day. Per interview on 5-12-2020 at 11:34 AM administrative nursing staff S reported direct care staff R only worked in assisted ling and not in the memory care areas.

When the facility allowed staff P, K, N, Q, and R to continue to work even though they indicated they had potential signs and symptoms of the COVID-19 virus put all residents in the assisted living at risk for spread of COVID-19, a potentially life threatening illness.

During an interview on 5-11-2020 at 5:35 PM direct care staff K confirmed she answered the

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questions yes on the screening log because she had a cough during this time. Staff K stated the person at the desk taking temperatures took staff temperature and then had staff mark the answers to the questions and sign it. Staff K stated neither the person completing the screening or administrative staff said anything to her about having symptoms or telling her she had to go home and contact her doctor.

During an interview on 5-11-2020 at 7:23 PM direct care staff T confirmed she filled out the screening form before she started each shift. She stated sometimes the person who took the temperature did not wipe off the temporal thermometer before taking the next persons. Review of the employee COVID-19 positive testing revealed staff T tested positive for COVID-19.

During an interview on 5-11-20 at 10:18 AM administrative nursing staff B reported she expected the staff to fill out the screening tool completely and answer questions correctly.

During an interview on 5-11-2020 at 10:24 AM administrative staff A reported in order to identify if a staff member should have been sent home based on the recorded temperature on the log there was no way to check what type of thermometer was used at the time of screening.

Administrative staff A reported via email on 5-11-2020 at 11:01 AM that either she or administrative staff C reviewed the employee screening logs each day before they left work for the day.

During an interview on 5-12-2020 at 8:38 AM direct care staff N confirmed she had marked yes

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to having potential symptoms of COVID-19. Staff N stated neither the person completing the screen or administrative staff said anything to her about her symptoms or that she needed to go home

Administrative staff A reported in an email on 5-12-2020 at 10:11 AM the facility received a team member screening tool from the cooperate office which the staff who completed the screening process were provided and were to follow.

Review of the team member screening tool directed the person who supervised the screening process to do the following - 1. If a staff member had any of the following symptoms: elevated temperature, cough, shortness of breath, sore throat, runny nose, other respiratory symptoms, new onset of upset stomach, diarrhea, loss of appetite, malaise, nausea, vomiting, rash, recently diagnosed with urinary tract infection, upper respiratory symptoms, pneumonia or other infectious process in the last 14 days, or any muscle aches, pain, reddened eyes, drowsiness or confusion and the inability taste or smell, they were to be given a mask, asked to go home and follow up with their health care provider. 2. If a team member did not have any symptoms but answered "no" to the question that they had maintained safe social distancing while away from the facility they were to be given a mask and asked to go home and follow up with their health care provider. 3. If they identified they had close contact with anyone who had a confirmed case of COVID-19 they were to be advised to go home if they did not feel well.

Review of the facility's COVID-19 Mitigation and Response Plan dated 3-18-2020 and revised on

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S3305	Continued From page 7 5-4-2020 included the following bullet points related to team members screening process: team members must monitor themselves for fever and symptoms of COVID-19 and call their supervisor and not report to work if they are feeling sick; At the beginning of every shift team members will have their temperature taken to screen for fever and asked if they are experiencing symptoms of COVID-19. When a team member develops symptoms of COVID-19 at work they are to immediately have a mask put on and sent home to contact their medical provider. For all residents in the assisted living/memory care areas of the facility, the administrator failed to ensure the facility followed their COVID-19 Mitigation and Response plan related to team member screening. The facility failed to identify and act appropriately by sending staff home who answered screening questions which indicated potential symptoms of COVID-19 to minimize the spread of this potentially life-threatening illness. On 5-12-2020 at 2:14 PM administrative staff A received notification of immediate jeopardy for all residents in the assisted living/memory care areas of the facility. The administrator failed to ensure the facility followed their COVID-19 Mitigation and Response plan related to team member screening by failing to identify and act appropriately by sending staff home who answered screening questions that indicated potential symptoms of COVID-19 or who were not practicing infection control measures such as wearing a mask, social distancing and good hand hygiene outside of the facility, even if they did not have symptoms in order to minimize the potential spread of COVID-19, a potential life-threatening illness.	S3305		

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S3305	Continued From page 8 The immediate jeopardy was removed on 5-12-2020 at 4:24 PM when administrative staff A provided a plan to ensure the staff screening forms were filled out completely and correctly with appropriate actions taken if needed to ensure the minimization of the spread of COVID-19 illness. The plan included the following: 1. Facility will have a designated screener 24 hours per day, 7 days a week starting 5-12-2020. 2. The designated screeners will receive training regarding the screening process, how to handle and record team member responses to the questions and when to communicate concerns to a nurse leader. This training will be provided by the executive director, assistant executive director, or resident care director by 5-13-2020. 3. Assisted living staff will receive training prior to their next scheduled shift to ensure full understanding of symptoms, and other questions on the screening tool. This training will be provided by the executive director, assistant executive director, or resident care director. 4. On 5-11-2020 all assisted living staff are authorized to use one door for entrance and exit purposes. 5. Designated screeners will be authorized entrance during shift change and no team member will be able to begin their shift without being screened and meeting the screening requirements. Team members who do not meet the requirements will be provided a mask and sent home and advised to contact their health care professional. 6. The administrator or leader designee will review the screening forms at each shift to confirm screening process is functioning properly and that no team member is permitted to work who does not meet the work criteria. The screening form will be signed and dated with	S3305		

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each review.
7. The administrator or designee will report results weekly to quality assurance and performance meeting for the next 3 months.

- Review of resident #1's medical record revealed the resident admitted to the facility on 11-5-18 with diagnoses of heart failure, diabetes type 2, hypertension, and chronic kidney disease. The record also revealed the resident tested positive for COVID-19 on 5-1-2020.

At 9:46 on 5-6-2020 certified staff D prepared to go into residents' room. Staff D had on a mask, put on gloves, the blue gown that hung on the back of the resident's door, and then gathered supplies to take the residents temperature out of the isolation cart in the hall. Staff D came out of the room without gown or gloves on. Staff D used the hand sanitizer in her pocket on her hands properly before getting into the medication cart. Staff D took the residents medications and sat them on the shelf by the resident's room and proceeded to put on clean gloves and the same blue gown she had just removed and went into the resident's room. Staff D opened the door, removed the blue gown and put gloves in the biohazard trash, used her hand sanitizer and then continued passing medications. During the process of removing the blue gown certified staff D failed to spray down the gown with the spray bottle that was on the resident's isolation cart.

- Review of resident #6's medical record revealed the resident admitted to the facility on 4-27-2016 with diagnoses of hypertension, dementia and hypothyroidism. The resident's

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record also revealed the resident tested positive for COVID-19 on 4-24-2020.

At 10:05 AM on 5-6-2020 the resident sat in a wheelchair in her room with the door to the room fully open. There was an isolation cart on the outside of the resident's room which included a bottle of hand sanitizer in the drawer.

Observation on 5-6-2020 at 11:45 AM the isolation cart did not have a spray bottle of "sanitizer" or a container of Micro-Kill disinfectant wipes in it.

During an interview on 5-6-2020 at 11:45 AM certified staff L confirmed the resident did not have a spray bottle of sanitizer to use to spray the blue gowns after each use or the wipes to disinfect the face shield.

Observation on 5-6-2020 at 11:52 AM certified staff G put on gloves, got the blue gown that hung in the resident's room, put it on and then put on the face shield before entering the resident's room.

At 11:54 AM on 5-6-2020 certified staff L brought a container of Micro-Kill disinfectant wipes and put them in the bottom drawer of the isolation cart. Staff L started to walk away and then returned and opened the door and told certified staff G there were wipes in the bottom drawer.

At 11:58 AM on 5-6-20 certified staff G came out of the room and had already removed her gloves. Staff took off the blue gown before removing the face shield potentially contaminating the inside of the gown. She then hung the gown up on the hook in the resident's room without any type of disinfecting. Staff took off the face shield and put

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it in the middle drawer of the isolation cart with using the wipes to disinfect it.

- Observation on 5-6-2020 at 12:48 PM certified staff O went into resident #10's room who had an isolation cart outside of the room. Staff went into the room wearing a plastic gown, gloves and mask, came back out and the got a foam tray and took it to the resident. Staff O came out of the room without removing the plastic gown and getting new one.

At 12:49 PM certified staff O then proceeded to get ready to go into resident #3's room who tested positive for COVID-19. Certified staff G stood at the meal cart and as staff O started to put on the face shield staff G told him to put on the gown first, and it just pulled over his head. Staff O proceeded to put on the yellow disposable gown, face shield and gloves then took the food tray to the resident. At 12:53 PM certified staff O came out of the room, removed the shield and sprayed it with the solution in the spray bottle on the isolation cart and then took off the used gown, wadded it up and put it in the middle drawer of the isolation cart. Potentially contaminating everything in the second drawer of the cart. Staff O then removed his gloves and plastic apron and continued the process of passing out meal trays by putting on clean gloves and a clean plastic apron. Staff O did not use hand sanitizer between taking off gloves and putting on clean ones.

During an interview on 5-6-2020 at 10:09 AM certified staff G reported the personal, protective equipment (PPE, mask, gown, gloves, face shield) are available when we need to use them. She stated the supervisors had taught the staff

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how to do proper hand washing, put on and take off PPE properly in order to keep the illness (COVID-19) from spreading.

During an interview on 5-6-2020 at 10:15 AM certified staff H reported if a resident had a cart by their room it meant the resident was in some type of isolation. Staff would know what type of PPE to wear based on the posters on the outside of the resident's door.

During an interview on 5-6-2020 at 10:38 AM certified staff K reported the spray bottles on the cart are to disinfect the blue gowns when we take it off. The gown is to be hung up on the resident's door and then staff spray it down and spray the shield if they have one. She also stated for meals staff were to wear a plastic apron and gloves and change them between each resident.

During an interview on 5-6-2020 certified staff L reported the disinfectant in the spray bottles is to be sprayed on the blue gowns for residents who have the virus.

During an interview on 5-6-2020 licensed nursing staff M reported the blue gowns are to be used with any COVID positive rooms and are reusable. Staff are supposed to use the spray on the blue gowns or wipe it down with disinfectant wipes.

During an interview on 5-6-2020 at 11:12 AM certified staff F reported originally the facility only had the blue gowns but just got a shipment of yellow ones in. She stated the blue ones are to be used on residents who test positive and the yellow ones with residents who have symptoms but test negative. The yellow ones can be used by the same person for the whole shift for that particular resident and discard them at the end of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046049	A. BUILDING: _____ B. WING _____	C 05/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(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) COMPLETE DATE
S3305	Continued From page 13 their shift. During an interview on 5-11-2020 at 10:18 AM administrative nursing staff B stated if staff wore a yellow disposable gown into a resident's room who had symptoms/presumed positive the staff needed to throw it away after use and confirmed it should not have been put in the isolation cart. Review of the mitigation and response plan dated 3-18-2020 and revised on 4-14-2020 included the following regarding the use of PPE: Eye protection: Reusable eye protection must be cleaned and disinfected... prior to re-use. Gowns: put on a clean isolation gown upon entry into the resident room. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated trashcan before leaving the resident room. Disposable gowns should be discarded after use. It also indicated for PPE preservation strategies to consider shifting gown use towards cloth isolation gowns. The policy did not mention that staff could spray reusable gowns after use to disinfect or that staff could use one disposable gown per resident for the whole shift. For all residents, the administrator further failed to ensure staff followed appropriate use and reuse of PPE in order to prevent the spread of COVID-19 throughout the assisted living and memory care areas of the facility.	S3305		