STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185462	A. BUILDING _____ B. WING _____	09/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK TERRACE HEALTH CAMPUS	9700 STONESTREET ROAD LOUISVILLE, KY 40272

(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
E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was initiated on 09/08/2020 and concluded on 09/08/2020. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6).	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted on 09/08/2020. The facility was found not in compliance with 42 CFR 483.80 infection control regulations and has not implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census was 60.	F 000		
F 880 SS=D	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	F 880		10/1/20

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

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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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F 880	Continued From page 1	F 880		

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 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.

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F 880	Continued From page 2 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: Based on observation and interview it was determined the facility failed to implement their ongoing infection prevention and control program. Observations during survey revealed State Registered Nurse Aide (SRNA) #1 removed meal trays from two (2) of thirteen (13) separate isolation rooms in the yellow zone without donning a gown or eye protection. The findings include: Review of the policy titled, "Infection Prevention and Control Program (IPCP)," dated 05/22/19, revealed the facility had policies to prevent, identify, report, investigate, and contain infections or communicable diseases. The policy revealed the facility monitored the residents for infections, antibiotic usage, monitoring and reporting test results, and utilization of an IPCP surveillance program. Review of the policy titled, "Enhanced Infection Prevention and Control Program for COVID-19," dated 06/01/2020, revealed the facility was responsible for procedures, audits, education, personal protective equipment (PPE) supply management, monitoring, reporting, and surveillance of COVID-19.	F 880	1. Corrective action for affected residents Corrective actions for the residents referenced with this deficiency include the provision of remedial education for the SRNA observed not following infection control protocols during the survey. This education was provided on September 9, 2020, by the campus clinical support nurse, and included specific instruction on use of PPE and transmission based precautions. Twice daily temperature and oxygen saturation checks, as well as daily monitoring by the licensed staff to identify changes in condition, especially those related to signs and symptoms of COVID-19, are being completed. Weekly COVID testing was underway at the time of this survey and has continued since. COVID test results have been reported to the residents physician and responsible parties if applicable. Changes to the plan of care have been made as needed. 2. Identifying other potentially affected residents All residents have the potential to be affected by the same deficient practice.	

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F 880	Continued From page 3 Review of SRNA #1's employee education record revealed on 08/11/2020 SRNA #1 received policy education for blood borne pathogens, hand washing/hygiene, standard precautions, airborne precautions, droplet precautions, and contact precautions. The education record revealed proper steps for donning and doffing personal protective equipment (PPE). Observation of the yellow sign posted on residents' doors on the quarantine unit, on 09/08/2020 at 1:20 PM, revealed a gown, gloves, mask, and face shield or goggles were required to enter the yellow zone rooms. Continued observations revealed PPE supply carts, with supplies, located in the hall between every other resident room. Interview with SRNA #1, on 09/08/2020 at 1:38 PM, revealed she was educated on the proper PPE for entry to the yellow zone rooms which included a gown, mask, gloves, and eye protection or face shield. She stated she should have worn the PPE to retrieve meal trays from the rooms. SRNA #1 stated wearing the proper PPE prevented the spread of infection. Interview with Licensed Practical Nurse (LPN) #2, on 09/08/2020 at 1:22 PM, revealed the facility required staff to wear PPE, including mask, gown, gloves, goggles or face shield, to enter a yellow zone room. She stated the PPE was required any time an individual passed across the doorway threshold and it included when staff retrieved meal trays.. Interview with Registered Nurse (RN) #2, on 09/08/2020 at 1:46 PM, revealed staff donned	F 880	To identify residents potentially exposed to COVID -19, Twice daily temperature and oxygen saturation checks, as well as daily monitoring by the licensed staff to identify changes in condition, especially those related to signs and symptoms of COVID-19, are being completed. Campus wide COVID testing is being conducted weekly. In addition, the campus infection preventionist has reviewed the EHR infection reports, lab reports, and antibiotic usage reports for past 3 weeks to identify occurrence of infection cluster or outbreak that could be attributed to this alleged deficient practice. No such occurrence was identified. 3. Measures taken to ensure there will not be a recurrence. The campus Executive Director, Assistant Director of Health Services, who serves as the infection preventionist, Medical Director, Home Office Clinical Support Nurse, and Divisional Vice President conducted a root cause analysis of this event. The findings determined that need for additional staff training was primary contributing factor. To ensure there will not be a recurrence, campus staff were assigned the Transmission Based Precautions module in the campus in-service portal. This training reviewed standard precautions, contact, airborne, and droplet isolation, use of PPE required for each type of isolation, as well as the common clinical conditions associated with each type of precaution. The module included a post training test used to demonstrate	

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F 880	Continued From page 4 gown, gloves, mask, and goggles or face shield to enter the yellow zone resident rooms. She stated failing to wear the designated PPE when entering rooms could cause COVID-19 to be transmitted to staff or other residents. Interview with the Assistant Director of Health Services (ADHS), on 09/08/2020 at 2:10 PM, revealed staff were required to wear a gown, gloves, goggles or face shield, and mask in the yellow zone rooms. She stated the ADHS and the Director of Health Services (DHS) educated the staff on PPE requirements for COVID-19 isolation. Interview with the Director of Health Services, on 09/08/2020 at 6:22 PM, revealed staff were educated on the proper PPE usage for residents in the yellow COVID-19 isolation rooms during their fourteen-day quarantine period and for residents positive for COVID-19. She stated staff were instructed on how to put on and remove the PPE. The DHS stated staff were required to wear gown, gloves, mask, and goggles or face shield to enter the yellow zone rooms. She stated PPE audits were performed weekly and any instances that required further education would be addressed immediately. Interview with the Executive Administrator (EA), on 09/08/2020, at 7:40 PM, revealed staff were required to wear a gown, gloves, mask, and goggles or face shield in the yellow zone rooms. He stated the goal of proper PPE was to protect the residents, staff, and slow the spread of COVID-19. The EA stated incorrect PPE usage was concerning and could be a contributing factor to an outbreak in the facility.	F 880	understanding of the training materials. This training was completed on September 26, 2020. Transmission based precautions training is conducted annually and is part of the new hire onboarding curriculum. On September 30, 2020, the campus infection preventionist completed inservice training for all staff using the courses, Keep COVID Out and Lessons in PPE, as required by the directed plan of correction. Staff signed an attestation of completion 4. Monitoring changes to ensure continued compliance To ensure the corrective actions in this plan are effective and sustained, the Executive Director, Director of Health Services, Assistant Director of Health Services, or any administrative team member serving as weekend Manager on Duty, will use the campus PPE checklist to audit PPE usage. The audits will determine if the correct PPE is used for the type of isolation and that the PPE-gowns, mask, gloves, faceshields/goggles- are being used correctly. Any issues identified during the audits will be immediately corrected. Re-education and disciplinary action will be provided as needed. The audits will start on October 1, 2020. Three audits will be completed weekly, to include night shift and weekends, for 4 weeks. Then one audit a week will be conducted for the next 4 weeks. Monthly audits will continue for the remainder of the quarter. The completed audits will be integrated	

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F 880	Continued From page 5	F 880	into the QAPI committee meetings which occur at least quarterly. At a minimum, the committee members will include the Executive Director, Director of Nursing, Medical Director, Infection Preventionist, and at least 2 other members of the campus□ administrative team.	

Office of Inspector General

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N 000	Initial Comments A COVID-19 Focused Infection Control Survey was conducted 09/08/2020 and found the facility not in compliance pursuant to 42 CFR 483.80 with deficiencies cited.	N 000		

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

Electronically Signed | 09/28/20