DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		185446	B. WING _			01/	06/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				35	76 PIMLICO PARKWAY		
BLUEGRA	SS CARE & REHABILIT	ATION CENTER		LE	EXINGTON, KY 40517		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX			PREFIX	<	(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG	REGULATORT OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		
F 000							
F 000	INITIAL COMMENTS		FC				
		d Infection Control Survey					
		5/2021 and concluded on					
	01/06/2021. The faci						
		CFR 483.80 Infection nd had not implemented the					
		& Medicaid Services (CMS)					
	and the Centers for D	. ,					
		commended practices to					
		9. Total census was 98. A					
		with the highest scope and					
	severity (S/S) of an "E	Ξ".					
F 880	Infection Prevention &	& Control	F 8	380			
SS=E	CFR(s): 483.80(a)(1)	(2)(4)(e)(f)					
	§483.80 Infection Cor						
	The facility must esta						
	infection prevention a designed to provide a						
		nent and to help prevent the					
		ismission of communicable					
	diseases and infection						
	§483.80(a) Infection p	prevention and control					
	program.						
		blish an infection prevention					
		(IPCP) that must include, at					
	a minimum, the follow	ving elements:					
	\$182 80(a)(1) A avet	m for proventing identifying					
		em for preventing, identifying, g, and controlling infections					
		seases for all residents,					
		ors, and other individuals					
	providing services un						
		pon the facility assessment					
		to §483.70(e) and following					
	accepted national sta						
		SUPPLIER REPRESENTATIVE'S SIGNATUR			TITLE		(X6) DATE
ADURATORY					1111 E		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

PRINTED: 04/19/2021

(X3) DATE SURVEY COMPLETED 01/06/2021		
01/06/2021		
(X5) E COMPLETIC DATE DATE		

Facility ID: 100492

If continuation sheet Page 2 of 12

		MEDICAID SERVICES				IO. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION		TE SURVEY MPLETED	
		185446	B. WING		0	1/06/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
BLUEGRA	ASS CARE & REHABILIT	ATION CENTER		3576 PIMLICO PARKWAY LEXINGTON, KY 40517			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 880	Continued From page	e 2	F 88	0			
		ict an annual review of its ir program, as necessary.					
	by: Based on observation and review of the fac determined the facilit maintain an infection program designed to comfortable environm control the developm communicable diseas and/or contain COVII interventions per the Medicaid Services (C Control and Prevention Department for Public Department) State gu	y failed to establish and prevention and control provide a safe, sanitary, and nent and to help prevent and ent and transmission of ses, to properly prevent D-19, and to implement Centers for Medicare and CMS), the Center for Disease on (CDC), and the Kentucky c Health (Health uidelines for COVID-19.					
	sampled residents we Resident #1 was obs multiple residents' roo who was in Droplet Is observed sitting withi	I two (2) of eleven (11) ere not social distancing. erved entering and exiting oms for visits. Resident #10, solation Precautions, was n two (2) feet of the open nts and staff passed by in					
	residents were in the wore masks inapprop	d (5) of eleven (11) sampled hallway without masks or priately with no staff dent #1 was wearing the					

Facility ID: 100492

If continuation sheet Page 3 of 12

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/19/2021 APPROVED D: 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	
		185446	B. WING			01/	06/2021
NAME OF PF	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BLUEGRA	SS CARE & REHABILIT	ATION CENTER			576 PIMLICO PARKWAY		
		-		L	EXINGTON, KY 40517		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Isolation Precautions without a mask. Resi Isolation Precautions (2) feet of the doorwa #6 and Resident #11 a mask. Observation revealed inappropriately wearin respirator/mask and r performing hand hygi masks and eye protect The findings include: 1. Review of the facil Coronavirus (COVID- revealed the purpose provide clarification for take regarding the No (COVID-19) and ensu the facility's residents required to help each his/her highest level of	Resident #2 was in Droplet and was in the hallway ident #10 was in Droplet and was sitting within two by without a mask. Resident were in the hallway without I two (2) staff members ing a fit tested N95 multiple staff members not ene after touching their face ction (goggles).	F	880			
	2015, revealed reside practice hand hygiene Observation of meal p 11:44 AM, revealed n	Hygiene," dated August ents would be encouraged to e frequently. pass, on 01/06/2021 at					
	Interview with Hospita	ality Aid (HA) #1, on					

Facility ID: 100492

If continuation sheet Page 4 of 12

PRINTED: 04/19/2021

		()(0) 10 10			D. 0938-039	
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY	
	185446	B. WING		01	/06/2021	
OVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
SS CARE & REHABILIT	ATION CENTER		3576 PIMLICO PARKWAY LEXINGTON, KY 40517			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETIO DATE	
01/06/2021 at 2:40 Pl was to be performed Interview with License on 01/06/2021 at 4:02 process involved assi hygiene prior to the m revealed proper resid necessary for infectio Interviews, on 01/06/2 Nurse Aide (SRNA) # 2:04 PM, SRNA #3 at PM, and LPN #2 at 3 control interventions f hygiene before meals and when visibly soile Interview with the Infe Registered Nurse (IPI PM, revealed residen hygiene prior to meals revealed all staff had hygiene and had beet this area and were ex residents with hand h Interview with the Dire 01/06/2021 at 6:22 Pl was expected to be p residents per policy. 2. Review of the facil Coronavirus (COVID-	M, revealed hand hygiene on residents prior to meals. ed Practical Nurse (LPN) #3, 2 PM, revealed the meal isting residents with hand heal. Further interview lent hand hygiene was in control practices. 2021, with State Registered f1 at 1:39 PM, SRNA #2 at t 2:16 PM, LPN #1 at 3:15 :41 PM, revealed infection for residents included hand a, after using the bathroom, ed. ection Preventionist RN), on 01/06/2021 at 4:28 ts were to receive hand s. Further interview received education on hand in tested for competency in spected to assist the ygiene frequently per policy. ector of Nursing (DON), on M, revealed hand hygiene ierformed frequently on all lity's policy, "Novel -19)," dated 08/18/2020,	F 88	0			
	F DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER SS CARE & REHABILIT SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page 01/06/2021 at 2:40 P was to be performed Interview with License on 01/06/2021 at 4:02 process involved ass hygiene prior to the n revealed proper resid necessary for infectio Interviews, on 01/06/2 Nurse Aide (SRNA) # 2:04 PM, SRNA #3 at PM, and LPN #2 at 3 control interventions to hygiene before meals and when visibly soils Interview with the Infe Registered Nurse (IP PM, revealed residen hygiene prior to meal revealed all staff had hygiene and had bee this area and were ex residents with hand h Interview with the Dir 01/06/2021 at 6:22 P was expected to be p residents per policy. 2. Review of the faci Coronavirus (COVID-	F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: SS CARE & REHABILITATION CENTER SS CARE & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 01/06/2021 at 2:40 PM, revealed hand hygiene was to be performed on residents prior to meals. Interview with Licensed Practical Nurse (LPN) #3, on 01/06/2021 at 4:02 PM, revealed the meal process involved assisting residents with hand hygiene prior to the meal. Further interview revealed proper resident hand hygiene was necessary for infection control practices. Interviews, on 01/06/2021, with State Registered Nurse Aide (SRNA) #1 at 1:39 PM, SRNA #2 at 2:04 PM, SRNA #3 at 2:16 PM, LPN #1 at 3:15 PM, and LPN #2 at 3:41 PM, revealed infection control interventions for residents included hand hygiene before meals, after using the bathroom, and when visibly soiled. Interview with the Infection Preventionist Registered Nurse (IPRN), on 01/06/2021 at 4:28 PM, revealed residents were to receive hand hygiene prior to meals. Further interview revealed all staff had received education on hand hygiene and had been tested for competency in this area and were expected to assist the residents with hand hygiene frequently per policy. Interview with the Director of Nursing (DON), on 01/06/2021 at 6:22 PM, revealed hand hygiene was expected to be performed frequently on all residents per policy. 2. Review of the facility's policy, "Novel Coronavirus (COVID-19)," dated 08/18/2020,	F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIP A. BUILDING 185446 B. WING ROVIDER OR SUPPLIER SS CARE & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 4 F 88 01/06/2021 at 2:40 PM, revealed hand hygiene was to be performed on residents prior to meals. Interview with Licensed Practical Nurse (LPN) #3, on 01/06/2021 at 4:02 PM, revealed the meal process involved assisting residents with hand hygiene prior to the meal. Further interview revealed proper resident hand hygiene was necessary for infection control practices. 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Review of the facility's policy, "Novel Coronavirus (COVID-19)," dated 08/1	F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIERCLIA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING INFORMATION SS CARE & REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMILICO PARKWAY LEXINGTON, KY 40517 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERCENCE ON TO THE CONDERCY AND THE PRECEDED BY FULL (EACH CORRECT MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERCENCE ON TO THE CORRECT MUST BE PRECEDED BY FULL (EACH CORRECT MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERCENCE ON TO THE CORRECT MUST BE PRECEDED BY FULL (EACH CORRECT MUST BE PRECEDED TO THE LA CORRECT ON THE PRECEDED TO THE LA CORRECT ON THE PRECEDED THE PRECEDED TO THE LA CORRECT ON THE PRECEDED THE PRECEDED THE PRECEDED TO THE LA CORRECT ON THE PRECEDED THE PRECEDED THE PRECEDED TO THE LA CORRECT ON THE PRECEDED THE PRECEDED THE PRECEDED TO THE LA CORRECT ON THE PRECEDED THE PRE	FGEFORENCIES CORRECTION (X1) PROVIDERINGUPFUERCLA IDENTIFICATION NUMBER: 101 (X2) MULTIPIE CONSTRUCTION A BUILDING B. WING (X2) MULTIPIE CONSTRUCTION A BUILDING (X3) OF CONSTRUET ADDRESS, CITY, STATE, ZIP CODE (X4) OF CONSTRUET ADDRESS, CITY, STATE, ZIP CO	

If continuation sheet Page 5 of 12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SL COMPLE NAME OF PROVIDER OR SUPPLIER 185446 B. WING 01/06 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517 12 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION 12		-	ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 04/19 FORM APPR MB NO. 0938-	OVED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BLUEGRASS CARE & REHABILITATION CENTER 375 PIMLICO PARKWAY LEXINGTON, KY 40617 (Y4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DERICENCY MUST BE PRECEDED BY FULL MEDILATORY OR LSC LIBENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH OBRICENT ACTION SHOULD BE CROSS-HEFERINCET) TO REACTION SHOULD BE CROSS-HEFERINCET TO REACTION SHOULD BE CROSS-HEFERINCET TO REACTION SHOULD BE CROSS-HEFERINCET ON THE APPROPRIATE DEFICIENCY F 880 Continued From page 5 F 880 Review of the facility's policy, "Isolation-Initiating Transmission-Based Precautions," dated August 2019, revealed Transmission-Based Precautions. Droplet Precautions, or Airborne Precautions. Transmission-Based Precautions, Totaled August 2016, revealed for Droplet Isolation Precautions, to maintain a separation of roommates, visitors, and staff for at least three (3) feet. Review of Resident #1's medical record revealed the facility admitted the resident, on 08/19/2018, with diagnoses to include Vascular Dementia with Behavioral Disturbance and Unspecified Symptoms and Signs involving Cognitive Functions and Awareness. Review of Resident #10's medical record revealed a Physician's Order, dated 01/04/2021, which placed the resident on Droplet Isolation Precautions. Observation, on 01/06/2021 at 9:16 AM, revealed Resident #1 entered multiple resident's rooms on the South Hall. Further observation revealed Resident #1 entered multiple resident's rooms on the South Hall. Further observation revealed Resident #1 entered staff inquiring about the identity of Resident #1. Furthermore, Resident #1 was in Room #49 for five (5) minutes, less than three (3) feet apart from the resident that </td <td>STATEMENT O</td> <td>OF DEFICIENCIES</td> <td>(X1) PROVIDER/SUPPLIER/CLIA</td> <td>` ´</td> <td></td> <td>l</td> <td></td> <td>(3) DATE SURVEY COMPLETED</td> <td>0001</td>	STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` ´		l		(3) DATE SURVEY COMPLETED	0001
BLUEGRASS CARE & REHABILITATION CENTER 3378 PINILCO PARKWAY LEXINGTON, KY 40517 YM, ID PRE:RX TAG SUMMAY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST DE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PRE:RX PREVIEW CONTREST DENTIFYING INFORMATION) D PRE:RX TAG PROVIDERS FLW OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 880 Continued From page 5 F 880 Review of the facility's policy, "Isolation-Initiating Transmission-Based Precautions," dated August 2019, revealed Transmission-Based Precautions, could include Contact Precautions, Droplet Precautions, or Airborne Precautions, to maintain a separation of roommates, visitors, and staff for at least three (3) feet. F 880 Review of Resident #1's medical record revealed the facility admitted the resident, on 09/19/2018, with diagnoses to include Vascular Dementia with Behavioral Disturbance and Unspecified Symptoms and Signs involving Cognitive Functions and Awareness. Review of Resident #10's medical record revealed a Physician's Order, dated 01/04/2021, which placed the resident on Droplet Isolation Precautions. Notestient #10's medical record revealed Resident #10's medical record revealed a Physician's Order, dated 01/04/2021, which placed the resident on Droplet Isolation Precautions. Observation, on 01/06/2021 at 9:16 AM, revealed Resident #1 retrieve of New (16 staff numing about the identity of Resident #1. Furthermore, Resident #1 was in Room #49 for fibre (5) minutes, less than three (3) feet apart from the resident that			185446	B. WING				01/06/202 ²	1
BLUEGRASS CARE & REHABILITATION CENTER LEXINGTON, KY 40517 (PA) ID PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG PREFX PREFX CASS-REFERENCED TO THE APPROPRIATE DEFICIENCY ID PREFX TAG F 880 Continued From page 5 F 880 F 880 Review of the facility's policy, "Isolation-Initiating Transmission-Based Precautions," dated August 2019, revealed Transmission-Based Precautions, could include Contact Precautions, could include Contact Precautions, could include Contact Precautions, could include Contact Precautions, to maintain a separation of roommates, visitors, and staff for at least three (3) feet. F 880 Review of Resident #1's medical record revealed for Dropiet Isolation Precaulians, to maintain a separation of roommates, visitors, and staff for at least three (3) feet. F Review of Resident #10's medical record revealed a Physician's Order, dated 01/04/2021, which placed the resident on Dropiet Isolation Precautions. F Review of Resident #10's medical record revealed a Physician's Order, dated 01/04/2021, which placed the resident on Dropiet Isolation Precautions. F Review of Resident #10's medical record revealed a Physician's Order, dated 01/04/2021, which placed the resident on Dropiet Isolation Precautions. F Review of Resident #10's medical record revealed a Physician's Order, dated 01/04/2021, which placed the resident on Dropiet Isolation Precautions. F Review of Resident #10's medical record revealed a Physician's Order, dated 01/04/2021, which placed the resident's rooms on the South Hall. Further observation revea	NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS,	, CITY, STATE, ZIP CODE			
PREFIX TXG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TXG CACH DEFICIENCY WAST DEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 880 Continued From page 5 F 880 Review of the facility's policy, "Isolation-Initiating Transmission-Based Precautions," dated August 2019, revealed Transmission-Based Precautions could include Contact Precautions, Droplet Precautions, or Airborne Precautions, to maintain a separation of roommates, visitors, and staff for at least three (3) feet. F 880 Review of Resident #1's medical record revealed the facility admitted the resident, on 08/19/2018, with diagnoses to include Vascular Dementia with Behavioral Disturbance and Unspecified Symptoms and Signs involving Cognitive Functions, on 01/06/2021 at 9:16 AM, revealed Resident #1 enerated no Droplet Isolation Precautions. Observation, on 01/06/2021 at 9:16 AM, revealed Resident #1 enerated in Room #49, another resident's noom, until the State Survey Agency Surveyor contacted staff inquinging about the identity of Resident #1. Furthermore, Resident #1 was in Room #49 enother	BLUEGRA	SS CARE & REHABILIT	ATION CENTER						
Review of the facility's policy, "Isolation-Initiating Transmission-Based Precautions," dated August 2019, revealed Transmission-Based Precautions could include Contact Precautions, Droplet Precautions, or Airborne Precautions. Review of the facility's policy, "MED-PASS, Inc. Transmission-Based Precautions," dated August 2016, revealed for Droplet Isolation Precautions, to maintain a separation of roommates, visitors, and staff for at least three (3) feet. Review of Resident #1's medical record revealed the facility admitted the resident, on 08/19/2018, with diagnoses to include Vascular Dementia with Behavioral Disturbance and Unspecified Symptoms and Signs involving Cognitive Functions and Awareness. Review of Resident #10's medical record revealed a Physician's Order, dated 01/04/2021, which placed the resident on Droplet Isolation Precautions. Observation, on 01/06/2021 at 9:16 AM, revealed Resident #1 entered multiple residents' rooms on the South Hall. Further observation revealed Resident #1 remained in Room #49, another resident's room, until the State Survey Agency Surveyor contacted staff inquiring about the identity of Resident #1. Furthermore, Resident #1 was in Room #49 for five (5) minutes, less than three (3) feet apart from the resident that	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH	H CORRECTIVE ACTION S REFERENCED TO THE A	HOULD BE	(X5 COMPLE DAT	TION
Transmission-Based Precautions, " dated August 2019, revealed Transmission-Based Precautions could include Contact Precautions. Review of the facility's policy, "MED-PASS, Inc. Transmission-Based Precautions, " dated August 2016, revealed for Droplet Isolation Precautions, to maintain a separation of roommates, visitors, and staff for at least three (3) feet. Review of Resident #1's medical record revealed the facility admitted the resident, on 08/19/2018, with diagnoses to include Vascular Dementia with Behavioral Disturbance and Unspecified Symptoms and Signs involving Cognitive Functions and Awareness. Review of Resident #10's medical record revealed a Physician's Order, dated 01/04/2021, which placed the resident on Droplet Isolation Precautions, on 01/06/2021 at 9:16 AM, revealed Resident #1 entered multiple residents' rooms on the South Hall. Further observation revealed Resident #1 remained in Room #49, another resident #1. Furtherore, Resident Yureyor contacted staff inquiring about the identity of Resident #1. Furthermore, Resident #1 was in Room #49 for five (5) minutes, less than three (3) feet apart from the resident that <td>F 880</td> <td>Continued From page</td> <td>5</td> <td>F 88</td> <td>30</td> <td></td> <td></td> <td></td> <td></td>	F 880	Continued From page	5	F 88	30				
than three (3) feet apart from the resident that		Transmission-Based 2019, revealed Trans could include Contact Precautions, or Airbon Review of the facility's Transmission-Based 2016, revealed for Dra to maintain a separati and staff for at least th Review of Resident # the facility admitted th with diagnoses to incl Behavioral Disturband Symptoms and Signs Functions and Awared Review of Resident # revealed a Physician's which placed the reside Precautions. Observation, on 01/06 Resident #1 entered of the South Hall. Furth Resident #1 remained resident's room, until Surveyor contacted si identity of Resident #	Precautions," dated August mission-Based Precautions t Precautions, Droplet me Precautions. s policy, "MED-PASS, Inc. Precautions," dated August oplet Isolation Precautions, ion of roommates, visitors, hree (3) feet. 1's medical record revealed he resident, on 08/19/2018, ude Vascular Dementia with ce and Unspecified involving Cognitive ness. 10's medical record s Order, dated 01/04/2021, dent on Droplet Isolation 6/2021 at 9:16 AM, revealed multiple residents' rooms on er observation revealed d in Room #49, another the State Survey Agency taff inquiring about the 1. Furthermore, Resident						
policy. Observation, on 01/06/2021 at 11:37 AM, revealed Resident #10 was sitting less than two		than three (3) feet apa lived in Room #49, in policy. Observation, on 01/06	art from the resident that violation of the facility's 6/2021 at 11:37 AM,						

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CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES				FORM OMB NC): 04/19/2021 1 APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185446	B. WING		_	01/	06/2021
NAME OF PF	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
BLUEGRA	SS CARE & REHABILIT	ATION CENTER		ES76 PIMLICO PARKWAY			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	facility's policy. Interviews, on 01/06/2 PM, SRNA #2 at 2:04 PM, revealed infection residents included so Interview with LPN #2 revealed the door to a on Droplet Isolation P closed to prevent the Interview with the Dire 01/06/2021 at 6:22 PI location marks had be area, and staff was ex residents. Further int Isolation Precaution r be kept closed, and th if the door was open. 3. Review of the facil Protective Equipment revealed visitors and to comply with Transr were educated on the protective equipment equipment at no charge	a doorway, in violation of the 2021 with SRNA #1 at 1:39 PM, and LPN #1 at 3:15 in control interventions for cial distancing. 2, on 01/06/2021 at 3:41 PM, a resident's room, who was Precautions, was to be spread of infection. ector of Nursing (DON), on M, revealed social distance een placed in the common kpected to monitor erview revealed a Droplet esident's room door should ne curtains were to be pulled ity's policy, "Personal c," dated October 2018, residents who were asked nission-Based Precautions e proper use of personal (PPE) and provided with ge.	F 880				
	the facility admitted th with diagnoses which Disease with Late On with Personal Care, a with Behavioral Distur	set, Need for Assistance Ind Unspecified Dementia rbances.					
		Resident #2's medical record s Order, dated 12/29/2020,					

Facility ID: 100492

If continuation sheet Page 7 of 12

TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DAT	E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · ·	IPLETED
		185446	B. WING		0,	1/06/2021
NAME OF P	ROVIDER OR SUPPLIER	•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BLUEGR/	ASS CARE & REHABILIT	ATION CENTER		576 PIMLICO PARKWAY EXINGTON, KY 40517		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 880	 which placed the resident on Droplet Isolation Precautions because he/she had been the roommate of Resident #4, who tested positive for COVID-19 on 12/29/2020. Observation, on 01/06/2021 at 9:16 AM, revealed Resident #1 moving throughout the South Unit with his/her mask under his/her chin. Observation, on 01/06/2021 at 9:27 AM, revealed Resident #11 in the South Unit hallway not wearing a mask. Further observation revealed a staff member approached and spoke with Resident #11, but did not assist with applying a mask to the resident. Observation, on 01/06/2021 at 9:36 AM, revealed a Droplet Isolation Precaution sign on the doorway of Room #30, and no one inside the room. Interview with HA #1, on 01/06/2021 at 9:37 AM, revealed Resident #2 lived in Room #30 and was on Droplet Isolation Precautions because his/her roommate (Resident #4) recently tested COVID positive. Further observation revealed Resident #2 in the hallway not wearing a mask. 		F 880			
	Isolation Precautions (2) feet from the door staff and residents pa Observation, on 01/0 revealed Resident #6	0, who was on Droplet , was sitting less than two way with no mask on while assed by the doorway.				

Facility ID: 100492

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	-	D HUMAN SERVICES				FORM	: 04/19/2021 APPROVED
STATEMENT O	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	
		185446	B. WING		_	01/0	06/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
BLUEGRA	ASS CARE & REHABILITA	ATION CENTER	-	576 PIMLICO PARKWAY .EXINGTON, KY 40517			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	 #1, and SRNA #3 at 2 #2 frequently left his/r mask and often requir Interviews, on 01/06/2 PM, SRNA #2 at 2:04 LPN #1 at 3:15 PM, a revealed infection corresidents included rerwaring a mask. Interview with the DO PM, revealed residention Precautions were required a mask. Further interbeen trained on reappresident mask usage enforce proper mask of 4. Review of the facili Protective Equipment revealed training on the disposal of PPE was pand at regular interval visitors and residents with Transmission-Bae educated on the proposition of the facility's Policy and Procedure dated August 2007, respirators were to fit below the chin, and the to be secured at the mask of the facility is policy and procedure the full protection of the facility is policy and procedure to fit below the chin, and the to be secured at the mask of the facility is policy and procedure to fit below the chin, and the proposition of the facility is policy and procedure to fit below the chin, and the proposition of the facility is policy and procedure to fit below the chin, and the proposition of the facility is policy and procedure to fit below the chin, and the proposition of the facility is policy and procedure to fit below the chin, and the proposition of the facility is policy and procedure to fit below the chin, and the proposition of the facility is policy and procedure to fit below the chin, and the proposition of the facility is policy and procedure to fit below the chin, and the proposition of the facility is policy and procedure to fit below the chin, and the proposition of the facility is policy and procedure to fit below the chin, and the proposition of the facility is policy and procedure to fit below the chin, and the proposition of the facility is policy and procedure to fit below the chin and the proposition of the facility is policy and procedure to fit below the chin and the proposition of the facility is policy and procedure to fit below the chin	2021 at 1:39 PM with SRNA 2:16 PM, revealed Resident her room without wearing a red assistance. 2021 with SRNA #1 at 1:39 PM, SRNA #3 at 2:16 PM, and LPN #2 at 3:41 PM, and expected to wear view revealed staff had by and expected to wear view revealed staff had by and monitoring and were expected to wear view revealed staff had by and were expected to wear view revealed staff had by and were expected to wear view revealed to comply sed Precautions, use, and provided upon orientation Is. Further review revealed who were asked to comply sed Precautions were er use of PPE and provided charge. so policy, "Infection Control Manual for Donning PPE," evealed mask and snugly to the face and ne ties or elastic bands were niddle of the head and neck. stated the front of the mask	F 880				

Facility ID: 100492

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M						FORM): 04/19/2021 APPROVED). 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE	
	185446	B. WING _				01/	06/2021
NAME OF PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP COD)E	-	
BLUEGRASS CARE & REHABILITA	TION CENTER			576 PIMLICO PARKWAY EXINGTON, KY 40517			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BI		(X5) COMPLETION DATE
F 880 Continued From page	9	F	380				
 2015, revealed the fac hygiene the primary m of infections. Further r personnel would follow hygiene procedures to infections to other persovisitors. Review of the facility's (COVID-19)," dated 08 anytime stakeholders to their hands, they must hands. Observation, on 01/06 revealed a staff memb wearing a N95 mask w secured over the head 11:41 AM, revealed an North Unit wearing a N bottom strap secured of Interview with the Reg 01/06/2021 at 11:42 A should be worn with bo because if not worn pr provide protection. Interview with the Adm 01/06/2021 at 9:00 AW wear fit tested N95 or 1 protection when enteri Further interview with the 	Aygiene," dated August billity considered hand heans to prevent the spread review revealed all withe handwashing/hand billity considered hand review revealed all withe handwashing/hand billity considered all withe handwashing/hand billity considered all withe handwashing/hand billity considered all withe prevent the spread of sonnel, residents, and a policy, "Novel Coronavirus B/18/2020, revealed touched their masks with timmediately wash their billity considered all without the bottom strap billity constrated all without the bottom strap billity constrained all without						

Facility ID: 100492

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FO	RM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		185446	B. WING			o	1/06/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BLUEGRA	ASS CARE & REHABILIT	ATION CENTER			3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 880	the expectation for the that both straps were according to the guide Observation, on 01/06 tour, revealed multiple their masks and eye p performing hand hygi revealed SRNA #1 at PM, and HA #1 at 2:4 and eye protection wi hygiene afterwards. Interview with the Die at 3:07 PM, revealed when auditing them for control practices. In a provide on-the-spot, of improper PPE use or were observed during Interview with LPN #1 revealed N95 or KN99 protection were require entering the units. Fu hands were to be sam mask and eye protect Interview with LPN #2 revealed hand hygien touching your face. Interview with LPN #3 revealed hand hygien touching masks or go	e fit tested N95 masks was to be worn over the head elines. 5/2021, during the facility e staff members touching protection without ene. Further observations 1:39 PM, SRNA #3 at 2:16 0 PM, touched their masks thout performing hand tary Director, on 01/06/2021 he observed dietary staff or compliance with infection addition, he stated he would or immediate, education if hand hygiene practices these audits.	F	880			

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PRINTED: 04/19/2021

		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 04/19/2021 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE	
		185446	B. WING				01/	06/2021
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
BLUEGRA	ASS CARE & REHABILIT	ATION CENTER			576 PIMLICO PARKWAY EXINGTON, KY 40517			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORREC CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 880	hygiene after touching mask and eye protect Continued interview v at 6:22 PM, revealed requirements was pro one-on-one education offs. Further interview	g their face or adjusting their	F	880				

Facility ID: 100492

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CENTERS FOR MEDICARE TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
		185446	B. WING			01/06/2021	
NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY			
		·····		LEXINGTON, KY 40517			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE		
E 000	Initial Comments		ΕC	000			
	Survey was initiated concluded on 01/06	sed Emergency Preparedness d on 01/06/2021 and 5/2021. The facility was found with 42 CFR 483.73 related					
		20			5		
	18						
		3 Z					
					8		
				•			

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.

Event ID 8YJZ11

Facility ID: 100492

PRINTED: 04/16/2021

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED	
5	100492	B. WING			01/06/2021	
AME OF PROVIDER OR SUPPLI		DDRESS, CITY, STATE, ZIP CODE			2	
LUEGRASS CARE & REH		MLICO PARKW TON, KY 4051			×	
REFIX (EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE	
N 000 Initial Comments		N 000				
was initiated on (01/06/2021. The noncompliant wit Control regulation	used Infection Control Survey 01/06/2021 and concluded on facility was found to be h 42 CFR 483.80 Infection hs and had not implemented the care & Medicaid Services (CMS					
and the Centers Prevention (CDC	for Disease Control and) recommended practices to ID-19. Total census was 98.)				
					10*	
		4				
	э					
				5. <u>9</u> .7		

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