		& MEDICAID SERVICES			RM APPROVI NO. 0938-03
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION (X3)	DATE SURVEY
		185446	B. WING_	Roll of San Tal	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP, CODE	05/01/2020
BLUEGI	RASS CARE & REHAE	BILITATION CENTER		3576 PIMLICO PARKWAY LEXINGTON, KY 40517	12/2
(X4)ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETIO DATE
F 000	INITIAL COMMENT	s	F 000		
SS=D	was initiated on 04/3 05/01/2020. The factor compliance with 42 regulations and the Medicaid Services (Disease Control and recommended practions and deficient practic Scope and Severity Infection Prevention CFR(s): 483.80(a)(1) §483.80 Infection Confection prevention adesigned to provide a comfortable environmedevelopment and training diseases and infections.	ices to prepare for COVID-19 e was cited at the highest of a "D". & Control)(2)(4)(e)(f) Introl ablish and maintain an and control program a safe, sanitary and ment and to help prevent the asmission of communicable	F 880	On 5/1/2020, Licensed Practical Nurse Manager assessed resident #2 for any signs and symptoms of infection by obtaining his vital signs and completing a respiratory assessment. No adverse findings were identified. Will continue to maniton every shift ongoing by monitoring for change in condition; new/worsening cough, fever (100 degrees or greater), shortness of breath, sore throat, or O2 saturation.	
	program. The facility must esta and control program (a minimum, the follows) §483.80(a)(1) A syste reporting, investigating and communicable distaff, volunteers, visite providing services uncarrangement based uppenducted according saccepted national starting accepted national starting and conducted accepted starting saccepted national starting accepted saccepted s	blish an infection prevention (IPCP) that must include, at ving elements: Im for preventing, identifying, g, and controlling infections seases for all residents, prs, and other individuals der a contractual pon the facility assessment to \$483.70(e) and following		On 5/2/2020 all rooms designated for isolation rooms were audited by the Director of Nursing to ensure all appropriate/required isolation equipment was available in the rooms for use to include but not limited to isolation receptacles. No other rooms were found to not have isolation receptacles.	

Administrator 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

(X6) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/07/2020 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 185446 B. WING 05/01/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY **BLUEGRASS CARE & REHABILITATION CENTER** LEXINGTON, KY 40517 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID in PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 880 | Continued From page 1 F 880 On 5/2/2020 the Director of Nursing reviewed procedures for the program, which must include, the COVID-19, donning and doffing Personal but are not limited to: Protective Equipment and Droplet precautions (i) A system of surveillance designed to identify policies to include isolation receptacles with possible communicable diseases or SRNA #2 and SRNA #3 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

The Director of Nursing, LPN managers and Weekend supervisor will educate all staff on the donning and doffing of PPE and Droplet Precaution Policies by 5/18/20. Validation of understanding of education will be obtained through 100% of staff completing a post test with 100% of questions answered correctly.

An audit checklist was developed and implemented on 5/14/2020 to include the Isolation rooms being checked daily for appropriate Isolation receptacles and the PPE bins being checked for adequate stock of appropriate PPE. The Central Clerk will complete this Monday-Friday and the Weekend Supervisor will complete it on Saturday and Sunday.

resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism

(iv)When and how isolation should be used for a

to be followed to prevent spread of infections;

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

020 /ED 391

DEPAR CENTE	RTMENT OF HEALTH	AND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 05/07/2 RM APPRO\
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
		185446	B. WING			
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP COD	<u> </u>	5/01/2020
BLUEGI	RASS CARE & REHAB	RII ITATION CENTED	ĺ	3576 PIMLICO PARKWAY		
		- CHIER		LEXINGTON, KY 40517		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI	OULDRE	(X5) COMPLETION DATE
F 880	Continued From page	ge 2	F 88	20		
III.	IPCP and update their program, as necessary.			The Director of Nursing and Admini	istrator will	
	by: Based on interview, facility's policies, and Disease Control (CE determined the facility maintain an infection program designed to comfortable environs development and tradisease and infection contain COVID 19 for sampled residents (FOD 04/29/2020 at 3:0 admitted to the facility facility is policies.)	00 PM, Resident #2 was		validate the daily audit form for PPI and Isolation receptacles in the isol rooms by reviewing the audit form making observations in the isolation daily for two weeks, then three tim for four weeks, then two times weeks, then once weekly for two weeks, then once weekly for two weeks, then once weekly for two words and the staff Development Coordinator Managers and Weekend Supervisor observation audits to include donnit doffing PPE in the correct order, do before entering an isolation room a PPE into the appropriate receptacle exiting the room on five staff membors weekly for four weeks three staff members weekly for four	E supplies ation and n rooms es weekly ekly for four eeks. T, LPN will do nng and nning PPE nd doffing s before eers on t, then r weeks.	
	precautions. However 04/30/2020 at 3:15 P disposal receptacles	er, observations on M, revealed no isolation in the resident's room for ective Equipment (PRE)		then one staff member weekly for for All areas of concern will be addresse immediately with reeducation.	our weeks.	

Additionally, observations on 04/30/2020 at 3:30 PM, revealed State Registered Nurses Assistant (SRNA) #2 enter Resident #2's room to lay doffed PPE on the foot of the bed without donning PPE. Further, observations on 04/30/2020 at 3:40 PM revealed SRNA #3 enter Resident #2's room without donning PPE to place isolation receptacles in the resident's room and SRNA #2 enter Resident #2's room without donning PPE to dispose of previously doffed PPE in the isolation receptacles.

The findings include:

Review of the facility's "Novel Coronavirus (COVID-19)" policy, dated 03/04/2020, revealed Long Term Care facilities should ensure all staff

The findings of the audits and observations will be reviewed in a weekly ad hoc Quality Assurance meeting for the next 90 days with the Director of Nursing, Administrator, Licensed Nurse Managers, Social Services, Director of Dietary Services, Health Information Manager, Business Office Manager, Nurse Supervisors, Activities Director and Medical Director. Then monthly ongoing.

Substantial completion date; 5/20/2020

ΈC 391

		E & MEDICAID SERVICES			PRINTED: 05/07/2 FORM APPRO
STATEMENT (AND PLAN OF	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED
		185446	B. WING_		08/04/0000
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	05/01/2020
BLUEGRA	ASS CARE & REHAE	BILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D.BE CONGRET

F 880 | Continued From page 3

are using appropriate Personal Protective Equipment (PPE) when they are interacting with patients and residents, to the extent PPE is available and per CDC guidance on conservation of PPE. Additionally, full PPE should be worn per CDC guidelines for the care of any resident with known or suspected COVID-19. Further, all new residents admitted to the facility will be placed in droplet precautions for seven (7) to fourteen (14) days.

Review of the facility's "Coronavirus (COVID-19) Pandemic Plan Information", revised 03/06/2020, revealed the purpose of the policy was to provide a safe and healthy workplace for all employees. The pandemic policy for coronavirus outlines our overall response based on CDC guidelines. This will be part of our emergency preparedness plan. This plan will guide you through steps to take to safeguard employees, and residents while ensuring Principle Long Term Care's ability to maintain essential operations. Prevention steps for people confirmed to have, or being evaluated for coronavirus include placing the resident on contact isolation (Droplet Precautions).

Review of the facility's "Isolation-Categories of Transmission-Based Precautions (TBP)" policy, dated October 2018, revealed TBP were initiated when a resident was at risk for transmitting an infection. Additionally, TBP were additional measure to protect staff, visitors and other residents from becoming infected. Further, when entering a Droplet Precautions or TBPs resident room, a mask, gloves, gown and goggles should be worn.

Review of a laminated Center for Disease Control (CDC), "Use PPE When Caring for Patients with

F 880

CENTER	IMENT OF HEALTH	AND HUMAN SERVICES				PRINT	TED: 05/07/202 DRM APPROVE
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES			(¥	OMB	NO. 0938-039
AND PLAN C	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		E CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
ų.		185446	B. WING				0E/04/2020
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		05/01/2020
BLUEGR	ASS CARE & REHAE	BILITATION CENTER			76 PIMLICO PARKWAY EXINGTON, KY 40517		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	THE DEC	(X5) COMPLETION DATE
Ftl we BOP MMM TO Red th	sneet that was tape revealed the CDC s donned correctly be must remain in place the duration of work Additionally PPE she patient care; and PF and deliberately in a self-contamination. Step by step how to disposal of PPE after Review of the facility received ongoing trategarding the "Donni COVID-19 Infection Handwashing" to incompand the second of the facility admitted th	ected COVID-19", procedure d to a resident's doorframe heet stated PPE must be fore entering the patient area; e and be worn correctly for in the patient area. Duld not be adjusted during PE must be removed slowly sequence that prevents Further, the CDC sheet listed don and doff PPE: including or doffing in a receptacle. It's Education and Training 1/2020, revealed nursing staff ining and education ing and Doffing PPE"	F 84	80			

)20 ED 191

ERS EOR MEDICARI	HAND HUMAN SERVICES				RINTED: 05/ FORM ADD	
2K3 FUR WEDICAKE				O	MB NO. 092	7KUVI 38_03
NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	4			(X3) DATE SUF COMPLET	RVEY
	185446	B. WING_		7	05/04/0	
F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE 719 CODE	05/01/2	020
	<u> </u>		3576 PIMLICO PARKWA	AY		
(EACH DEFICIENCY	Y MUST BE PRECEDED BY CHILL	ID PREFIX TAG	PROVIDER'S F ((EACH CORREC' CROSS-REFERENCE	PLAN OF CORRECTION CTIVE ACTION SHOULD I ICED TO THE APPROPR	RE COM	(X5) APLETIO DATE
abnormalities.		F 88	30	9		
o4/29/2020 at 3:00 F admitted to facility at Acute Hypoxic Resp Pneumonia, Conges Bilateral Pleural Effu Thoracentesis on 04 Additionally, the resid intravenous and oral review revealed the p problem was weakned was alert, oriented, a questions asked.	PM, revealed the resident was after an acute hospital stay for piratory Failure, Right Sided stive Heart Failure, and usions, status post a 4/14/2020 and 04/22/2020. ident had received al antibiotics. Continued resident stated his/her only less. Further, the resident and able to elaborate on					
revealed Resident #2 resident was at the forwheelchair, with his/h and his/her head nod light was within reach mumbling incoherent room, there were two plastic cart, which con sanitizer, and shoes of metal cart that contain shields and cotton gor revealed a laminated (CDC), "Use PPE Wh Confirmed or Suspect sheet taped to the left CDC sheet stated PPI before entering the pa place and be worn con work in the patient are not be adjusted during	2's door was open and the foot of the bed sitting in a her feet resting on the floor dded down ward. The call h and the resident was at words. Outside of the co (2) PPE carts; one (1) contained gloves, hand coverings and the other, a fined designated staff, face cowns. Continued observation of Center for Disease Control hen Caring for Patients with coted COVID-19", procedure fit side of the doorframe. The PE must be donned correctly atient area; must remain in correctly for the duration of the care. Additionally PPE should gratient care; and PPE					
Cy F SI C C C C C C C C C C C C C C C C C C	PROVIDER OR SUPPLIER RASS CARE & REHAB SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From page abnormalities. Review of Resident 04/29/2020 at 3:00 for admitted to facility at Acute Hypoxic Respendent Pleural Effur Thoracentesis on 04/20120 at 3:00 for admitted to facility at Acute Hypoxic Respendent Pleural Effur Thoracentesis on 04/20120 at 3:00 for admitted to facility at Acute Hypoxic Respendent Pleural Effur Thoracentesis on 04/20120 at 3:00 for admitted to facility at Acute Hypoxic Respendent Pleural Effur Thoracentesis on 04/20120 at 3:00 for admitted to facility at Acute Hypoxic Respendent was weakned was alert, oriented, at a questions asked. Observations, on 04/20120 at 3:00 for admitted to facility at the formal problem was weakned was alert, oriented, at questions asked. Observations, on 04/20120 at 3:00 for admitted the formal problem was weakned at the formal problem was weakned at the formal problem was within reach mumbling incoherent room, there were two plastic cart, which constitute the problem was within reach mumbling incoherent room, there were two plastic cart, which constitute the formal problem was within reach mumbling incoherent room, there were two plastic cart, which constitute the formal problem was within reach mumbling incoherent room, there were two plastic cart, which constitute the formal problem was within reach mumbling incoherent room, there were two plastic cart, which constitute the formal problem was within reach mumbling incoherent room, there were two plastic cart, which constitute the formal problem was allowed to the formal problem was allowed to the formal problem was allowed to the left constitute the patient are not be adjusted during must be removed slowed slowed to the formal problem.	TRASS CARE & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 abnormalities. Review of Resident #2's Progress Note, dated 04/29/2020 at 3:00 PM, revealed the resident was admitted to facility after an acute hospital stay for Acute Hypoxic Respiratory Failure, Right Sided Pneumonia, Congestive Heart Failure, and Bilateral Pleural Effusions, status post a Thoracentesis on 04/14/2020 and 04/22/2020. Additionally, the resident had received intravenous and oral antibiotics. Continued review revealed the resident stated his/her only problem was weakness. Further, the resident was alert, oriented, and able to elaborate on	A BUILDI TO DEFICIENCIES OF CORRECTION (X1) PROVIDER SUPPLIER RASS CARE & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 abnormalities. Review of Resident #2's Progress Note, dated 04/29/2020 at 3:00 PM, revealed the resident was admitted to facility after an acute hospital stay for Acute Hypoxic Respiratory Failure, Right Sided Pneumonia, Congestive Heart Failure, and Bilateral Pleural Effusions, status post a Thoracentesis on 04/14/2020 and 04/22/2020. Additionally, the resident had received intravenous and oral antibiotics. Continued review revealed the resident stated his/her only problem was weakness. Further, the resident was alert, oriented, and able to elaborate on questions asked. Observations, on 04/30/2020 at 3:15 PM, revealed Resident #2's door was open and the resident was at the foot of the bed sitting in a wheelchair, with his/her feet resting on the floor and his/her head nodded down ward. The call light was within reach and the resident was mumbling incoherent words. Outside of the room, there were two (2) PPE carts; one (1) plastic cart, which contained gloves, hand sanitizer, and shoes coverings and the other, a metal cart that contained designated staff, face shields and cotton gowns. Continued observation revealed a laminated Center for Disease Control (CDC), "Use PPE When Caring for Patients with Confirmed or Suspected COVID-19", procedure sheet taped to the left side of the doorframe. The CDC sheet stated PPE must be donned correctly before entering the patient area; must remain in place and be worn correctly for the duration of work in the patient area. Additionally PPE should not be adjusted during patient care; and PPE must be removed slowly and deliberately in a	A STREET ADDRESS, CITY, 3576 PIMILIO PROVIDERS UPPLIER/CLIA IDENTIFICATION NUMBER: 185446 PROVIDER OR SUPPLIER RASS CARE & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY IN THE PROVIDER'S) AND THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 abnormalities. Review of Resident #2's Progress Note, dated 04/29/2020 at 3:00 PM, revealed the resident was admitted to facility after an acute hospital stay for Acute Hypoxic Respiratory Failure, Right Sided Pneumonia, Congestive Heart Failure, and Bilateral Pleural Effusions, status post a Thoracentesis on 04/14/2020 and 04/22/2020. Additionally, the resident had received intravenous and oral antibiotics. Continued review revealed the resident stated his/her only problem was weakness. Further, the resident was alert, oriented, and able to elaborate on questions asked. Observations, on 04/30/2020 at 3:15 PM, revealed Resident #2's door was open and the resident was at the foot of the bed sitting in a wheelchair, with his/her feet resting on the floor and his/her head nodded down ward. The call light was within reach and the resident was mumbling incoherent words. Outside of the room, there were two (2) PPE carts; one (1) plastic cart, which contained gloves, hand sanitizer, and shoes coverings and the other, a metal cart that contained designated staff, face shields and cotton gowns. Continued observation revealed a laminated Center for Disease Control (CDC), "Use PPE When Caring for Patients with Confirmed or Suspected COVID-19", procedure sheet taped to the left side of the doorframe. The CDC sheet stated PPE must be donned correctly before entering the patient area; must remain in place and be worn correctly for the duration of work in the patient area. Additionally PPE should not be adjusted during patient care, and PPE must be removed slowly and deliberately in a	A BUILDING PROVIDER OR SUPPLIER RASS CARE & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION) Continued From page 5 abnormalities. Review of Resident #2's Progress Note, dated 04/29/2020 at 3:00 PM, revealed the resident was admitted to facility after an acute hospital stay for Acute Hypoxic Respiratory Failure, and Bilateral Pleural Effusions, status post a Thoracentesis on 04/14/2020 and 04/22/2020. Additionally, the resident had received intravenous and oral antibiotics. Continued review revealed the resident they as alert, oriented, and able to elaborate on questions asked. Observations, on 04/30/2020 at 3:15 PM, revealed Resident was alert, oriented, and able to elaborate on questions asked. Observations, on 04/30/2020 at 3:15 PM, revealed Resident was the foot of the bed stiting in a wheelchair, with his/her feet resting on the floor and his/her head nodded down ward. The call light was within reach and the resident was mumbling incoherent words. Outside of the room, there were two (2) PDE carts; one (1) plastic cart, which contained designated staff, face shields and cotton gowns. Continued observation revealed a laminated Center for Disease Control (CDC), "Use PPE When Caring for Patients with Confirmed or Suspected COVID-19", procedure sheet taped to the left side of the doorframe. The CDC sheet stated PPE must be donned correctly before entering the patient area; must remain in place and be worn correctly for the duration of work in the patient area; and PPE must be demoned and PPE must be removed slowly and deliberately in a	OF CORRECTION (X1) PROVIDER SUPPLIER (X2) MULTIPLE CONSTRUCTION (X3) DATE SUPPLIER (X4) MULTIPLE CONSTRUCTION (X3) DATE SUPPLIER (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONS

sequence that prevents self-contamination.

2020 VED

	ERS FOR MEDICARI NT OF DEFICIENCIES	& MEDICAID SERVICES			FOR OMB N	RM APPRO 10. 0938-0
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) E	OATE SURVEY
	2	185446	B. WING	9		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE ZIP CODE	5/01/2020
BLUEG	RASS CARE & REHAR			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 PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLET DATE
F 880 Continued From page 6 Further, the CDC sheet listed step by step how to don and doff PPE: including disposal of PPE after doffing in a receptacle. Observations, on 04/30/2020 at 3:25 PM, revealed Resident #2's call light above the doorway was on. SRNA #2 stood at the resident's doorway and asked how she could assist the resident. The resident stated he/she need the wheelchair food rest. SRNA #2 stated she would be in to assist shortly. Continued observation revealed SRNA #2 donned PPE in the hallway outside of Resident #2's room; sanitized hands, donned a mask, sanitized hands, donned shoe coverings, sanitized hands, donned gloves, sanitized hands, donned gown, and donned face shield. SRNA #2 donned PPE out of sequence; she donned her gloves before gown. Additional observation revealed SRNA #2 enter Resident #2's room and assisted the resident with care. Continued observation revealed after assisting the resident with care,		F8	80			
	SRNA #2 walked to a removed her foot couthe soiled PPE on the doorway. She then seemoved her gown, labed and sanitized he stepped outside of R hallway and removed laid on top of the plas	the resident's doorway and verings and gloves and laid e foot of the bed by the sanitized her hands and aid the soiled gown on the r hands. SRNA #2 then esident #2's room, into the I her face shield, which she stic PPE cart in the hallway.				

her facemask, sanitized her hands again and donned another facemask. Further, at 3:30 PM, SRNA #2 stepped back into Resident #2's room to lay the used facemask on the end of the bed.

Continued observations on 04/30/2020 at 3:30 PM, revealed SRNA #2 ask SRNA #3, who was

DEDARTMENT OF HEALTH AND

D 11

		ARE & MEDICAID SERVICES			FORM	: 05/07/202 APPROVE
	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DAT	. 0938-039 E SURVEY IPLETED
		185446	B. WING_		05/	04/0000
В	IAME OF PROVIDER OR SUPPLIED	HABILITATION CENTER		STREET ADDRESS. CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517	1 03/	01/2020
	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	II D RE	(X5) COMPLETION DATE
	F 880 Continued From	page 7	F 004			

also standing in the hallway, to ask the nurse what to do since there was no designated isolation receptacle in Resident #2's room to place the doffed PPE. SRNA #2 sanitized the face-shield she previously laid on the plastic PPE cart and SRNA #3 went to the nurses' station. SRNA #3 returned and stated Licensed Practical Nurse (LPN) #1 directed her to sanitize and move the receptacles in the room across the hallway to Resident #2's room. Additional observations at 3:40 PM revealed SRNA #3 sanitized the receptacles and moved them out of the room across the hallway and into Resident #2's room; however, SRNA #3 did not don PPE when she entered Resident #2's room to place the receptacles. Further, SRNA #2 stepped back into Resident #2's room to place previously doffed PPE, which she had laid on the foot of the bed, into the receptacles without donning PPE.

Interview with SRNA #2, on 04/30/202 at 4:11 PM, revealed she had worked at the facility for five (5) years. Additionally, the facility had provided recent and ongoing training and education related to COVID-19, TBP, PPE and Infection Control procedures. Per interview, she was trained by the facility to don and doff PPE correctly by CDC guidelines; to don PPE in a specific sequence including shoe coverings, glove, gown, mask and face shield when providing care to residents in droplet precautions; to doff PPE and dispose of it in designated isolation receptacles in resident rooms. Per interview, she should have referred to the CDC sheet by the resident's door for correct PPE donning sequencing if she had any questions/concerns and there should have been a designated isolation receptacle in Resident #2's room for immediate disposal of doffed PPE. She stated she was nervous and today was her first

F 880

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/07/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

185446

B. WING

05/01/2020

BLUEGRASS CARE & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

3576 PIMLICO PARKWAY LEXINGTON, KY 40517

(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 880 Continued From page 8

day working with the residents in droplet isolation. SRNA #2 stated it was important to maintain CDC Guidelines related to donning and doffing PPE to ensure staff do not bring germs in the hallway and contaminate other residents or staff. Further, it was the Unit Coordinator/LPN#1's responsibility to ensure isolation rooms had designated receptacle for doffed PPE.

Interview with SRNA #3, on 04/30/2020 at 4:21 PM, revealed she had worked at the facility for nine (9) months. Additionally, the facility had provided training related to COVID-19, isolation precautions, PPE and infection control policy and procedures. Per interview, the Unit Coordinator/LPN #1 provided daily discussions about updates with infection control guidelines, policy and procedures. Per interview, she should have donned PPE before entering Resident #2's room to place the isolation receptacles; but working with these guidelines was new to her and she made a mistake and was not thinking when she entered Resident #2's room to place the receptacles. Further, when working in resident care areas for residents in isolation precautions for COVID-19, it was important to ensure we are wearing PPE per CDC Guidelines to decrease the risk of spreading it to other staff and residents.

Interview with LPN #1/ Unit Coordinator for the North hallway, on 04/30/2020 at 4:30 PM revealed he had worked at the facility for seven (7) months. Per interview, he had received training on COVID-19 by the Director of Nursing (DON) including isolation precautions, when to wear PPE, handwashing and sanitizing, respiratory hygiene and strategies for minimizing the spread of COVID-19. Continued interview

F 880

)20 ED 91

CENTI	RTMENT OF HEALTH	H AND HUMAN SERVICES E & MEDICAID SERVICES				PRINTE! FOR	D: 05/07/20 M APPROVE
STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT		CONSTRUCTION	OMB NO	O. 0938-039 ATE SURVEY OMPLETED
		185446	B. WING_				
1	F PROVIDER OR SUPPLIER BRASS CARE & REHAE	BILITATION CENTER		357	REET ADDRESS, CITY, STATE, ZIP CODE 76 PIMLICO PARKWAY EXINGTON, KY 40517	<u>l 05</u>	5/01/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT! (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	IDDE	(X5) COMPLETION DATE
	revealed he receive the DON on change Procedure and shar care staff. Per interprecaution rooms shareceptacles for doffe uncertain why Resid designated isolation at 3:40 PM, twenty-fadmission. Further, enters an isolation rolling the sexpectation of Si for PPE to be donneresident's room and before exiting a resident's room and before exiting a resident control increceptacles; not main infection control increcross contamination. Interview with the DOPM, revealed it was his should don and doff I CDC Guidelines each room. Additional interprooms should have disposal of PPE per found in the rooms with infeceptacles must not isolation rooms with the #1/Unit Coordinator's	ed daily morning updates from es to Guidelines, Policy and red those updates with direct rview, isolation/droplet hould have designated ed PPE; however, he was dent #2's room did not have a receptacles until 04/30/2020 four (24) hours after, anytime a staff member room, PPE should be donned. SRNA #2 and SRNA #3 was ed each time before entering a to be doffed each time dent's room in the designated intaining guidelines for reased the risk and source of a to other residents and staff. ON, on 04/30/2020 at 4:39 her expectation that staff PPE per facility policy and the time they enter an isolation designated receptacles for facility policy and CDC rview, the facility changed in the last week and the thave made it into the new the move; however, LPN should have noticed the present upon admitting	F 88	30			

Further, it was important to maintain Infection Control Policy and Procedure to prevent transmission of disease. Continued interview

revealed her surveillance and audit process did not identify problems/concern with staff donning and doffing PPE per CDC Guidelines; however,

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/07/2020 FORM APPROVED OMB NO. 0938-0391

		& MEDICAID SERVICES				OMB N	O. 0938-0391
	AND I DIN OF COUNTED TOTAL TOTAL TOTAL PROPERTY.		(X2) MU A. BUILI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185446	B. WING	s			
NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			,	S 3:	0	5/01/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTIN (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O RE	(X5) COMPLETION DATE
F 880	the audit did not inc for receptacles. Interview with the Ad 2:00 PM, revealed h for five (5) weeks. A to maintain facility prinfection control prad doffing PPE and the receptacles in isolati it was important to m	dministrator, on 05/01/2020 at the had worked at the facility additionally he expected staff olicy and regulation related to ctices specific to donning and use of designated on rooms. Further, he stated naintain infection control chances of spreading	F	380			
						•	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/07/2020 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING_ COMPLETED 185446 B. WING NAME OF PROVIDER OR SUPPLIER 05/01/2020 STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY **BLUEGRASS CARE & REHABILITATION CENTER** LEXINGTON, KY 40517 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (X5)REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETION TAG DATE DEFICIENCY) E 000 Initial Comments E 000 A COVID-19 Focused Emergency Preparedness Survey was initiated on 04/30/2020 and concluded on 05/01/2020. It was determined there were no concerns with 42 CFR §483.73 related to E-0024 (b)(6).

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		100400				WIPLE I ED
NAME OF	PROVIDER OR SUPPLIER	100492	B. WING	NATE 20000	05	/01/2020
BLUEGR	RASS CARE & REHAE	BILITATION CENTI 3576 PIN	ADDRESS, CITY, S MLICO PARKY TON, KY 4051	VAY		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLE DATE
N 000	Initial Comments		N 000			
	was initiated 04/30/ 05/01/2020. The fa	ed Infection Control Survey 2020 and concluded on cility was found to not be in nt to 42 CFR 483.80 and as cited.				
		8				
				PECETI		
				MAY 15 2020		
					J	
•	•	N E		×		
				it.		
ATORY DI	RECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNA	ATURE ALL	TITLE	_ \	(8) DATE
FORM		68	99 XB3	111	S (S OC) If continuation	