DIVISION OF HEALTH CARE
PACKET PROCESS LIST

FACILITY: Cambridge Place CITY: Lexington, KY

LEVEL OF CARE: Skilled Nursing Facility SURVEY DATE(S): 06/14/2021 to 06/17/2021

SURVEY TYPE: INITIAL RELIC RECERT ☐ REVISIT ☐ OTHER ☒ **FICS**

COMPLAINT #[redacted] PRIORITY: 1 ☒ 2 ☐ 3 ☐ 4 ☐

X*NURSE AIDE TRAINING PROGRAM: ☐ **YES** ☐ **NO**

TEAM: Deborah Perkins, BSN, RN, NCI, Tonya Mansfield, RN PDC: _____

ACTION		INITIALS	DATE
Packet Completed: Deficiency (ies)?	☒ **YES** ☐ **NO**	DP	6/28/2021
Life Safety Code Tags included	☐ **YES** ☐ **NO**	TV	7/7/21
RPM Review			
SoD to Facility	☐ ePOC		
PoC Received and Copy to Coordinator		JH	7/9/21
POC Acceptable:	☐ **YES** ☑ **NO**		7/15/21
Providers Notified by: phone on 7/15/21			7/15/21
POC Returned to Facility		JH	7/15/21
2nd PoC Received and Copy to Coordinator		JH	7/15/21
2nd POC Acceptable:	☑ **YES** ☐ **NO**		7/16/21
Providers Notified by: phone on 7/16/21			
Revisit Required:	☑ **YES** ☐ **NO**		
Revisit Completed: Deficiency (ies):	☑ **YES** ☐ **NO**		8/5/21
Revisit SoD to Facility			8/20/21, JH Reid 8/25/21
PoC Received and Copy to Coordinator		SM	8/25/21
POC Acceptable:	☑ **YES** ☐ **NO**		
Providers Notified by: _____ on _____			
2nd Revisit Required:	☑ **YES** ☐ **NO**	MA	9/9/21
2nd Revisit Completed: Deficiency (ies):	☐ **YES** ☐ **NO**		
Packet Completed		JB	9/17/21

Highest Scope / Severity _____ Opportunity to Correct or No Opportunity to Correct (OTC or NOTC) SQC _____ .13 _____ .15 _____ .25 (X areas of SQC) ------

RPM / C.O. notified of SQC _____ Doctors / Board Letters Mailed – Ann Notified of SQC

Citation Issued: TYPE A or TYPE B **(Type A stamped & faxed to Attorney General's Office** _____)

PoC Due: _____ Latest PoC Date: 09/01/2021 Date to be Corrected: _____

IDR Requested _____ IDR Scheduled _____ IDR Held _____

Changes to SoD? ☐ **YES** ☐ **NO**

IDR PoC Received _____ PoC Acceptable? ☐ **YES** ☐ **NO** Provider Notified by: _____ on _____

PACKET TO C.O. 9/17/21 PACKET TO R.O. _____

ADMIN NAME: Cara Clark **EMAIL:** cclark@cambridgepl.com

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

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No.	Medicare	Medicaid	Other	Total Residents
185414	3 F75	73+5 = 78 F76	4 F77	85 F78

ADL	Independent	Assist of One or Two Staff	Dependent
Bathing	F79 0	F80 75	F81 10
Dressing	F82 6	F83 69	F84 10
Transferring	F85 21	F86 54	F87 10
Toilet Use	F88 21	F89 54	F90 10
Eating	F91 8	F92 67	F93 10

A. Bowel/Bladder Status

F94 0 With indwelling or external catheter

F95 Of total number of residents with catheters, 0 were present on admission.

F96 73 Occasionally or frequently incontinent of bladder

F97 54 Occasionally or frequently incontinent of bowel

F98 7 On individually written bladder training program

F99 7 On individually written bowel training program

B. Mobility

F100 9 Bedfast all or most of time

F101 54 In chair all or most of time

F102 6 Independently ambulatory

F103 16 Ambulation with assistance or assistive device

F104 8 Physically restrained

F105 Of total number of residents restrained, 55 were admitted with orders for restraints.

F106 12 With contractures

F107 Of total number of residents with contractures, 12 had contractures on admission.

C. Mental Status

F108 4 With mental retardation

F109 71 With documented signs and symptoms of depression

F110 30 With documented psychiatric diagnosis (exclude dementias and depression)

F111 60 Dementia: multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type

F112 23 With behavioral symptoms

F113 Of the total number of residents with behavioral symptoms, the total number receiving a behavior management program 23.

F114 3 Receiving health rehabilitative services for MI/MR

D. Skin Integrity

F115 6 With pressure sores (exclude Stage I)

F116 Of the total number of residents with pressure sores excluding Stage I, how many residents had pressure sores on admission? 3.

F117 80 Receiving preventive skin care

F118 0 With rashes

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

E. Special Care

F119-132 – indicate the number of residents receiving:

F119 1 Hospice care

F120 0 Radiation therapy

F121 0 Chemotherapy

F122 2 Dialysis

F123 0 Intravenous therapy, IV nutrition, and/or blood transfusion

F124 17 Respiratory treatment

F125 0 Tracheostomy care

F126 2 Ostomy care

F127 2 Suctioning

F128 21 Injections (exclude vitamin B12 injections)

F129 4 Tube feedings

F130 29 Mechanically altered diets including pureed and all chopped food (not only meat)

F131 28 Rehabilitative services (Physical therapy, speech-language therapy, occupational therapy, etc.) Exclude health rehabilitation for MI and/or ID/DD

F132 9 Assistive devices with eating

F. Medications

F133-139 – indicate the number of residents receiving:

F133 74 Any psychoactive medication

F134 25 Antipsychotic medications

F135 17 Antianxiety medications

F136 65 Antidepressant medications

F137 0 Hypnotic medications

F138 2 Antibiotics

F139 30 On pain management program

G. Other

F140 5 With unplanned significant weight loss/gain

F141 0 Who do not communicate in the dominant language of the facility (include those who use American sign language)

F142 0 Who use non-oral communication devices

F143 77 With advance directives

F144 70 Received influenza immunization

F145 23 Received pneumococcal vaccine

I certify that this information is accurate to the best of my knowledge.

Signature of Person Completing the Form	Title	Date
[signature]	DON	9/8/21

TO BE COMPLETED BY SURVEY TEAM

F146 Was ombudsman office notified prior to survey? ___ Yes ✓ No

F147 Was ombudsman present during any portion of the survey? ___ Yes ✓ No

F148 Medication error rate 0 %

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0CC311

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 100461

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **185444**
2. STATE VENDOR OR MEDICAID NO.
(L2) **7100180620**

3. NAME AND ADDRESS OF FACILITY
(L3) **CAMBRIDGE PLACE GROUP, LLC**
(L4) **2020 CAMBRIDGE DRIVE**
(L5) **LEXINGTON, KY** (L6) **40504**

4. TYPE OF ACTION: **6** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE (L35)

11. LTC PERIOD OF CERTIFICATION
From (a)
To (b)

12. Total Facility Beds (L18)

13. Total Certified Beds (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1) (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE Date
Marlene Abner RN gr 09/09/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date
Andrea Wilhelm, RN gr 09/17/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
__ 1. Facility is Eligible to Participate
__ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above

22. ORIGINAL DATE OF PARTICIPATION (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions (L44)
B. Rescind Suspension Date (L45)

26. TERMINATION ACTION (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE (L28)

29. INTERMEDIARY/CARRIER NO.
00000 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Cara Clark - Administrator
email - cclark@cambridgepl.com
859-252-6747

The facility is not currently enrolled in ePOC.

Last Standard Survey 09/24/2020

An Abbreviated Survey investigating KY00034018, KY00034019, KY00033958 and a COVID-19 Focused Infection Control Survey was initiated on 06/14/2021 and concluded on 06/17/2021. Complaints KY00034018, KY00034019, and KY00033958 were unsubstantiated with no deficiencies cited. However, unrelated deficient practices were identified with the scope and severity of an "E." The facility was found to be noncompliant 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 80.

SA Imposed Remedies:
Directed Plan of Correction (DPOC) for F-880; and
Discretionary Denial of Payment for New Admissions (DDPNA) beginning 07/31/2021.

SA Recommended Remedies:
A Per Instance CMP of $15,000.00: and,
Termination of the Provider Agreement if substantial compliance is not achieved by 12/17/2021.

An amended letter was sent on 07/07/2021, to correct the DDPNA date.

An Abbreviated Survey investigating KY#00034225 was initiated on 08/03/2021 and concluded on 08/05/2021. KY#00034225 was unsubstantiated with no deficiencies related to the complaint cited.

An acceptable POC was received on 07/16/2021.

An On-site Revisit Survey was initiated on 08/03/2021 and concluded on 08/05/2021. The survey determined the facility had corrected the deficiencies cited at F-0564; however, continued non-compliance was identified at 42 CFR 483.80 Infection Control F-0880 at a Scope and Severity (S/S) of an "E". Additionally non compliance was identified at 42 CFR 483.75 Qaulity Assurance, F-0865 at S/S of an "E".

A letter and SOD was issued to the facility on 08/19/2021.

Amended letters for the 06/17/2021 Survey and the 08/05/2021 Revisit Survey were issued to the facility on 08/20/2021 with the corrected DDPNA date of 07/31/2021.

SA Imposed Remedies:
*Directed Plan of Correction (DPOC) for F-880; and
*Discretionary Denial of Payment for New Admissions (DDPNA) beginning 07/31/2021.

SA Recommended Remedies:
*A Per Instance CMP of $15,000.00; and
*Termination of the Provider Agreement if substantial compliance is not achieved by 12/17/2021.

An acceptble PoC was received on 08/27/2021.

A second onsite revisit was initiated on 09/08/2021 and concluded on 09/09/2021. Based on the acceptable Plan of Correction (POC) received on 08/27/2021 and the onsite revisit survey, it was determined the facility had achieved substantial compliance as alleged on 09/01/2021.

Imposed Remedies:
*Directed Plan of Correction (DPOC) for F-880; and
*Discretionary Denial of Payment for New Admissions (DDPNA) beginning 07/31/2021 through 08/31/2021; and
*A Per Instance CMP of $15,000.00 for F-880 and $7,100.00 for F-564; and
*Loss of the Nurse Aid Training Program; and
*Termination of the Provider Agreement did not go into effect as the facility had achieved substantial compliance prior to 12/17/2021.

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
185444 Y1	A. Building B. Wing Y2	9/9/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE GROUP, LLC	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0865 Reg. # 483.75(a)(2)(h)(i) LSC	Correction Completed 09/01/2021	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 09/01/2021	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
			Marlene Abner	9/9/21
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 6/17/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

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

PRINTED: 08/19/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	R-C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE GROUP, LLC	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An On-site Revisit Survey was initiated on 08/03/2021 and concluded on 08/05/2021. The survey determined the facility had corrected the deficiencies cited at 42 CFR 483.10, Resident Rights, F-564, as alleged on 07/19/2021. However, continued non-compliance was identified at 42 CFR 483.80, Infection Control, F-880 at a Scope and Severity (S/S) of an "E". Additional, non-compliance was identified at 42 CFR 483.75 Quality Assurance and Performance Improvement, F-865 at a S/S of an "E".	{F 000}	**Plan of Correction** **Cambridge Place** **Abbreviated Survey 8/5/2021** **Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.**	
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's policies, and review of the Plan of	F 865		

AUG 2 7 2021

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

Administrator | 8/25/21

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	R-C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE GROUP, LLC	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

(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 865 Continued From page 1

Correction (POC) for the 06/17/2021 Abbreviated/Partial Extended Survey, and the Revisit Survey, with an exit date of 08/05/2021, it was determined the facility failed to maintain a Quality Assurance Performance Improvement (QAPI) Program that developed and implemented effective plans of action to correct quality deficiencies. This was evidenced by the repeat deficiency from the Abbreviated/Partial Extended Survey, with an exit date of 06/17/2021, at CFR 483.80 Infection Control, F-880.

The facility failed to implement procedures, as stated in the POC, to ensure staff was compliant with infection prevention and control (IPC) measures. During the survey, it was identified the facility failed to ensure staff followed the established procedures for disinfecting shared equipment to ensure full cleaning and disinfection per the user instructions in order to prevent the spread of potential infection to other residents. Furthermore, the facility failed to ensure staff followed the established procedures for hand hygiene and appropriate use of personal protective equipment (PPE).

The facility's leadership was in-serviced on the QAPI plan and the objectives of the plan: to provide a means to identify and resolve present and potential negative outcomes related to IPC; to establish and implement plans to correct deficiencies; and to monitor the effects of these action plans, and compliance of staff. However, the facility failed to ensure plans and actions implemented for the deficiencies cited, on 06/17/2021, were carried out to correct the identified deficiencies by the Acceptable Plan of Correction, dated 07/16/2021, with an allegation of compliance date of 07/19/2021.

F 865 **F 865 QAPI Program/Plan, Disclosure/Good Faith Attempt**

The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.

§483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and

§483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect.

Criteria 1: Facility management team members developed and implemented a Performance Improvement Project (PIP) on 8/16/21 as part of the facility QAPI program. This PIP outlines the following information: Infection Control areas identified for improvement; the Specific, Measurable, Attainable, Realistic, and Time-Bound (SMART) goals; the Root Cause Analysis of the infection control areas for improvement using the "5 Whys" completed with the assistance of the Infection Preventionist (IP), QAPI Committee, Governing Body; potential barriers; and the Plan for ongoing monitoring of the interventions implemented. Key implementation team members for the PIP include the Administrator, Director of Nursing (DON), Infection Preventionist (IP), ADON (Assistant DON), Housekeeping Supervisor, and contracted Inspectors/Consultants.

Criteria 2: The PIP developed by facility management team members (as stated above) was initiated on 8/16/21, with the planned intervention start dates of: 8/17/21 (training "Inspectors" on revised policies and scheduled audits), 8/19/21 (increased access to facility sanitation products), 8/20/21 (all staff education on CDC YouTube videos titled "Use PPE Correctly for COVID-19" and "Sparkling Surfaces"), 8/23/21 (created a communication binder with infection control specific education for contracted staff), and 8/23/21 (all staff education began on reviewed/revised policies).

Criteria 3: Facility management team members as outlined in Criteria 1 above have received inservice education on the PIP by the facility Administrator and Corporate Nurse on 8/16/21.

The Administrator, or designee, will present the PIP and QAPI audit results at the monthly QAPI Committee meeting. The QAPI team will then determine if any further interventions will need to be added to the PIP, and will decide

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	R-C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE GROUP, LLC	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

(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 865	Continued From page 2	F 865		

The findings include:

Review of the facility's policy titled, "Quality Assurance Committee Policy", not dated, revealed the facility shall establish a QAPI Committee for the purpose of maintaining programs for quality assessment and assurance. The committee's responsibilities included identifying and addressing quality issues. Furthermore, the QAPI Committee developed and implemented corrective action plans to correct any identified quality deficiencies. Review of the policy revealed the committee would monitor those areas which negatively affected quality of care provided to its residents.

Review of the facility's Plan of Correction (PoC), Criteria 4, with an allegation of compliance date of 07/19/2021, revealed the Director of Nursing (DON), the ADON (Assistant Director of Nursing) and Supervisors would utilize the QAPI audit tool to monitor ten (10) percent of the staff every week for four (4) weeks for compliance of infection control procedures. Monitoring included issues related to the proper procedure for handwashing and hand sanitization, and the cleaning and disinfection of shared medical equipment to prevent the spread of infection. Furthermore, nursing staff would receive random handwashing competency checkoffs for ten (10) percent of the staff weekly for four (4) weeks.

Review of the QAPI Infection Control audit tool, dated 07/09/2021, 07/16/2021, 07/23/2021, and 07/30/2021 revealed they all audited ten (10) staff members, except the audit, on 07/16/2021, which audited seven (7) staff members. All audits revealed staff members

the ongoing frequency of QAPI audit tool. A QAPI audit tool evaluating the effectiveness of the QAPI Program was developed by the Administrator on 8/15/21 and approved by the QAPI Committee on 8/16/21. The QAPI Committee, Infection Preventionist, Governing Body have reviewed the PIP for approval to implement on 8/16/21.

Criteria 4: 1) The PIP will be reviewed by the facility management team members weekly until completion on 8/31/21.

2) The completed PIP will be reviewed by the QAPI committee at the next monthly QAPI meeting on September 8th, 2021.

3) The QAPI tool for evaluation of the facility QAPI program will be utilized monthly X 2 months, quarterly x 6 months, and twice per year thereafter by the Administrator, with review by the facility Corporate Nurse. Findings of the tool will be presented at the monthly QAPI meeting.

4) The QAPI audit tool for the monitoring of staff compliance with infection control practices will be utilized by the DON/ADON/IP/Supervisors/Inspectors/Designees on varied shifts including 8 randomly selected staff five (5) days per week x 2 weeks, weekly x 4 weeks, monthly X 2 months, then quarterly thereafter as per the established QAPI calendar, under the supervision of the Director of Nursing or Administrator.

Criteria 5:

9/1/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	R-C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE GROUP, LLC	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

(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 865	Continued From page 3	F 865		

were observed for proper procedure for handwashing/hand sanitization and the cleaning and disinfection of shared medical equipment. All audits showed one hundred (100) percent compliance.

Interview with the Infection Preventionist (IP), on 08/04/2021 at 3:40 PM, revealed all facility staff received IPC training, which included proper hand hygiene techniques, appropriate use of PPE, and the correct way to clean and disinfect shared medical equipment. The IP stated leadership monitored staff for compliance. Per the interview, the IP stated nursing staff was educated to read the manufacturer's instructions if there was a question as to how to clean an item. She stated she expected that staff followed the facility's policy and the POC. The IP stated this was important for the health and safety of the residents.

Continued interview with the IP, on 08/05/2021 at 2:35 PM, revealed the IP stated that spraying shared equipment with Lysol did not follow the POC. Per the interview, the IP stated staff should have been corrected and educated to follow POC guidelines for the cleaning of shared equipment.

Interview with the ADON, on 08/04/2021 at 3:55 PM, revealed staff had completed the required education and training modules per the POC. She stated nursing leadership (DON, ADON, and IP) audited staff compliance per the POC and continued to observe all staff randomly to maintain compliance and as part of the facility's QAPI program. According to the ADON, the audit process had not identified deficient practice related to IPC practices. The ADON stated following IPC practices was important to prevent

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the spread of infection and disease.

Interview with the DON, on 08/04/2021 at 4:30 PM, revealed staff completed the required education and training modules per the POC. She stated nursing leadership audited staff compliance per the POC and continued to observe all staff randomly to maintain compliance. The DON stated it was her expectation that staff followed the facility's policies and the POC for cleaning shared equipment and other IPC practices. Continued interview revealed the DON stated nursing leadership and the Administrator did random "spot checks" to monitor compliance, and the ADON was responsible for performing formal audits of staff compliance as part of the QAPI program. According to the DON, the audit process had not identified deficient practice related to IPC practices. Additionally, it was the DON's expectation that the staff followed proper Centers for Disease Control and Prevention (CDC) guidelines for hand hygiene. She stated she expected the IPC policies to be maintained and the POC followed to prevent the spread of infection and for the safety of staff and residents.

Interview with the Administrator, on 08/05/2021 at 4:28 PM, revealed all but one (1) staff member, who was out on medical leave, had been in-serviced related to all deficiencies identified from the 06/17/2021 survey, by 07/18/2021. Per the interview, she had discussed her expectations of the POC process with staff. Additionally, she stated the ADON was responsible for performing the audits. Per the interview, the DON or Administrator was responsible for ensuring the overall execution of the POC and the implementation of staff compliance audits. At the

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QAPI Committee, the Administrator stated she presented the initial concerns related to findings from a survey, conducted by the State Survey Agency (SSA), with the exit date of 06/17/2021. She stated a POC was developed, which included monitoring staff compliance of IPC measures weekly for one (1) month, and once a month for two (2) months by auditing staff compliance for proper procedure for handwashing/hand sanitization and the cleaning and disinfection of shared medical equipment. She stated the QAPI Committee expected a compliance rate of at least ninety-five (95) percent.

Continued interview with the Administrator, on 08/05/2021 at 4:28 PM, revealed the facility held monthly QAPI meetings, which included the Administrator, Medical Director, DON, ADON, Infection Preventionist (IP), Social Services, Human Resources, and the Medical Records Coordinator in attendance. She stated, during the QAPI meetings, on 07/07/2021 and 07/26/2021, the results of the audit tool, addressing the compliance of IPC practices, and the POC for F-880 (the infection control deficiency) were reviewed thoroughly. Per the interview, the QAPI Committee identified no concerns related to IPC practices, nor did the committee recognize any areas for improvement.

Additional interview with the Administrator, on 08/05/2021 at 5:56 PM, revealed the Administrator expected that staff followed the POC and the facility's policies related to IPC practices. Furthermore, it was her expectation that the staff followed proper CDC guidelines for hand hygiene and the use of PPE. She stated she expected the IPC policies to be maintained and followed to ensure the highest health and

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F 865	Continued From page 6 safety of the residents. Continued interview with the Administrator, on 08/05/2021 at 5:56 PM, revealed the facility's leadership, through audits and QAPI Committee meetings, established to ensure staff was compliant with IPC practices per the facility's policies and CDC guidelines, did not identify the facility practices related to IPC that were deficient. Per the interview, these established processes did not identify that shared medical equipment was not cleaned and disinfected appropriately between residents' use and hand hygiene and appropriate use of PPE was not practiced per the POC.	F 865		
F 880} SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	{F 880}		

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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.
Personnel must handle, store, process, and transport linens so as to prevent the spread of

{F 880} F 880 Infection Prevention and 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 disease and infections.

Criteria 1: 1a) Facility lifts and weight chairs were deep cleaned by housekeeping staff on 8/6/21.

1b) SRNA #2 received one-on-one education on 8/23/21 by the DON on the proper procedure for disinfecting shared medical equipment, including but not limited to mechanical lifts and weight chairs, in accordance with the revised facility policy.

1c) SRNA #5 received one-on-one education on 8/23/21 by the DON on the proper procedure for disinfecting shared medical equipment, including but not limited to mechanical lifts and weight chairs, in accordance with the revised facility policy.

1d) SRNA #3 received one-on-one education on 8/23/21 by the DON on the proper procedure for disinfecting shared medical equipment, including but not limited to mechanical lifts and weight chairs, in accordance with the revised facility policy.

1e) Facility LPNs scheduled on 1st shift (7am-3pm) on 8/4/21 received one-on-one education on 8/23/21 by the DON on the proper procedure for disinfecting shared medical equipment, including but not limited to mechanical lifts and weight chairs, in accordance with the revised facility policy.

1f) The Infection Preventionist received one-on one education on 8/23/21 by the DON on the proper procedure for disinfecting shared medical equipment, including but not limited to mechanical lifts and weight chairs, in accordance with the revised facility policy.

2) Dietary Aide #1 is currently on medical leave and will not return to work until mid-September 2021. Dietary Aide #1 will receive one-on-one education by the Administrator prior to working his first scheduled shift back to work on the proper use of face masks, including but not limited to keeping the face mask covering the mouth and nose at all times, in accordance with the facility policy.

3) Dietary Aide #2 received one-on-one education on 8/27/21 by the Dietary Manager on correct hand sanitation including but not limited to hand sanitation from dirty to clean tasks, in accordance with the facility policy.

4) Dietary Aide #3 is no longer an employee of Cambridge Place.

5) Registered Nurse #2 received one-on one education on 8/23/21 by the DON on correct hand sanitation including but not limited to hand sanitation after

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{F 880}	Continued From page 8 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, interview, record review, and review of the facility's policies, it was determined the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent and control the development and transmission of communicable diseases, including COVID-19, and to implement interventions per the Centers for Medicare and Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC), and the Kentucky Department for Public Health (Health Department) State guidelines for COVID-19. Observations on the West Hall, revealed shared equipment, a weight chair in the shower room and two (2) "Hoyer" (mechanical lift) lifts were not appropriately cleaned and sanitized by staff between being used by residents. Observations in the kitchen and dining room revealed inappropriate use of personal protective equipment (PPE) and absence of hand hygiene by staff. The findings include: Review of the facility's policy titled, "Cleaning and Disinfection of Resident-Care Items and	{F 880}	touching any items between tasks and between residents, in accordance with the facility policy. **Criteria 2:** 1) An audit was conducted on 8/6/21 by the Housekeeping Supervisor determine that all facility mechanical lifts and weight chairs had been deep cleaned. 2) Scheduled infection control observations/audits are being performed by the PIP Team Members in accordance with the facility PIP to identify and immediately address any identified breaches in infection control practices, with the completion date of 8/31/21. **Criteria 3:** 1a) Facility staff will have completed review of the CDC YouTube videos "Use Personal Protective Equipment (PPE) Correctly for COVID-19" and "Sparkling Surfaces," as directed by the Administrator, Director of Nursing, and/or Infection Preventionist by 8/31/21. An attestation statement that staff completed both assigned CDC YouTube videos was written by the DON and Infection Preventionist on 8/31/21. 1b) The facility developed and implemented a Performance Improvement Project (PIP) as part of the facility QAPI program. This PIP outlines the following information: Infection Control areas identified for improvement; the Specific, Measurable, Attainable, Realistic, and Time-Bound (SMART) goals; the Root Cause Analysis of the infection control area for improvement using the "5 Whys" done with the assistance of the IP, QAPI Committee, Governing Body; potential barriers; and the Plan for ongoing monitoring of the interventions implemented. Key implementation team members for the PIP include the Administrator, Director of Nursing (DON), Infection Preventionist (IP), ADON (Assistant DON), Housekeeping Supervisor, and contracted Inspectors/Consultants. 1c) The Administrator, DON, ADON, and IP reviewed and/or revised the Cleaning and Disinfecting of Environmental Surfaces policy, Handwashing/Hand Hygiene policy, and Source Control—Pandemic Coronavirus policy on 8/16/21. Staff members in the departments of nursing, dietary, housekeeping, laundry, etc. will have received education by the Administrator/DON/ADON/Supervisors by 8/31/21 on the compliance of infection control guidelines, including topics such as: cleaning and disinfecting of environmental surfaces, handwashing/hand hygiene, and source control in order to prevent the spread of potential infection. **Criteria 4:** 1a) The facility Performance Improvement Project (PIP) will be completed by the assigned Team Members by 8/31/21. 1b) The QAPI audit tool addressing the compliance of infection control procedures including but not limited to the	

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Equipment," revised 07/2014, revealed reusable items (e.g., shared equipment) were to be cleaned and disinfected between residents and before reuse by another resident. Additionally, the policy stated reusable resident-care items and equipment would be decontaminated between residents according to the manufacturer's instructions. Per the policy, the following were intermediate and low-level disinfectants for non-critical items: 1) Ethyl or isopropyl alcohol; 2) Sodium hypochlorite; 3) Phenolic germicidal detergents; 4) Iodophor germicidal detergents; and, 5) Quaternary ammonium germicidal detergents.

Review of the CDC's "Cleaning and Disinfecting Your Facility", updated 06/15/2021, revealed cleaning agents reduced germs on surfaces by removing contaminants and decreased the risk of infection from surfaces. It stated, while disinfectant products might also contain cleaning agents, disinfectant products should not be used as cleaners unless the label indicated the product was suitable for such use. The CDC recommended following the manufacturer's recommendations for use.

Review of the Lysol® spray product page, retrieved from https://www.lysol.com/clean-and-protect/protect-against-germs/prevent-germs-from-spreading/difference-between-cleaning-sanitizing-disinfecting, revealed Lysol® spray was a disinfectant spray, not a cleaning agent. Per the Lysol® spray product usage instruction, hard, non-porous surfaces must be re-cleaned before use.

Review of the facility's policy titled, "Infection Control Guidelines for all Nursing Procedures",

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proper procedure for hand sanitizing, disinfecting of shared medical equipment, and correct wearing of face masks was developed by the Administrator on 8/15/21 and approved by the QAPI committee on 8/16/21. This QAPI audit tool will be utilized by the DON/ADON/IP/Supervisors/Inspectors/ Designees on varied shifts including 8 randomly selected staff five (5) days per week x 2 weeks, weekly x 4 weeks, monthly X 2 months, then quarterly thereafter as per the established QAPI calendar, under the supervision of the Director of Nursing or Administrator.

1c) The Administrator, or designee, will present the PIP and QAPI audit results at the monthly QAPI Committee meeting. The QAPI team will then determine if any further interventions will need to be added to the PIP, and will decide the ongoing frequency of QAPI audit tool.

Criteria 5:

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revised 09/2012, revealed, in addition to standard precautions, staff would use appropriate personal protective equipment (PPE) as necessary to prevent exposure to infectious materials.

Review of the facility's policy titled,"Handwashing/Hand Hygiene", revision date 08/2014, revealed all health care workers would follow the handwashing/hand hygiene procedures to help prevent the spread of infection. Alcohol-based hand rubs (ABHR) were to be used before and after direct contact with residents, after contact with objects in the immediate vicinity of the resident, and before and after assisting a resident.

1. Observation on the West Wing, on 08/03/2021 at approximately 11:50 AM, revealed State Registered Nurse Aide (SRNA) #2 left a resident's room with a Hoyer lift, after use on a resident, and took it into the residents' shower room for storage. SRNA #2 did not clean and disinfect the Hoyer lift. Further observation revealed SRNA #2 weighed Resident #15. After she weighed Resident #15, SRNA #2 sprayed the shared weight chair with a disinfectant spray. Interview with SRNA #2, during the observation, revealed she just sprayed the chair and other shared equipment to clean and disinfect them. When SRNA #2 was asked how she cleaned the Hoyer lift, she stated, "I just spray it with Lysol®." Continued observations of the Hoyer lift revealed the grab bar padding was visibly dirty; the padding was a brownish color with visible flecks of a dark, dirt-like substance. The entire lift apparatus was visibly soiled with a buildup of visible flecks of dark dirt and dust-like substances. Further observation revealed the base of the Hoyer lift was visibly soiled with a

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buildup of visible flecks of dark dirt and dust-like substances.

Interview with SRNA #2, 08/04/2021 at 11:00 AM, revealed she received one-on-one education provided by the DON and education and training through "YouTube" videos, education modules, and handouts on IPC (Infection Prevention and Control) practices, hand hygiene, and proper use of PPE. In addition, she stated she cleaned shared equipment with Lysol® spray because it cleaned and disinfected. Per the interview, SRNA #2 stated, "I brought in my own can of Lysol® spray because Housekeeping keeps it locked up." When asked by the State Survey Agency (SSA) Surveyor what was the process for cleaning shared equipment according to the facility's policy, SRNA #2 replied, "I think clean and disinfect."

Interview with SRNA #5, 08/04/2021 at 10:27 AM, revealed, she received education and training through training videos, education modules, and handouts on Infection Prevention and Control practices, hand hygiene, and proper use of PPE. She stated staff used ABHR before and after resident care. She stated further that all shared equipment, including the weight chair, was cleaned and disinfected with Sani-wipes (a quaternary ammonium germicidal compound approved per policy). Per the interview, SRNA #5 stated, "We don't use Lysol® spray. All shared equipment is cleaned with the purple topped Sani-wipes." SRNA #5 stated the parts of the mechanical lift (Hoyer lift) that a resident could potentially touch were wiped down with Sani-wipes. She stated residents did grab the padded bar when being lifted, and it was sanitized with Sani-wipes.

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Interview with SRNA #3, on 08/04/2021 at 10:45 AM, revealed she received education and training through "YouTube" training videos, education modules, and handouts on IPC practices, hand hygiene, and proper use of PPE. She stated staff used ABHR before and after resident care. SRNA #3 stated she did not use Lysol® spray on shared equipment, and she wiped down shared equipment and the entire Hoyer lift with the purple topped Sani-wipes after resident care, and allowed it to dry for four (4) minutes. She further stated that staff only cleaned the parts of the mechanical lift that could potentially touch the resident.

Interview with Licensed Practical Nurse (LPN) #7, on 08/04/2021 at 11:10 AM, revealed she had received multiple in-services and training on IPC practices, hand hygiene, cleaning and disinfecting shared equipment, COVID-19, and proper use of PPE through "YouTube" videos, education modules, and handouts. She stated that all shared equipment was cleaned and disinfected with a Sani-wipe before and after resident use, and allowed to air dry for two (2) minutes. Per the interview, LPN #7 stated shared equipment was cleaned with the purple topped Sani-wipes. LPN #7 stated the Hoyer lift should be wiped down with Sani-wipes after each use.

Interview with LPN #4, on 08/04/2021 at 11:34 AM, revealed shared equipment, including the weight chair and Hoyer lifts, was cleaned after each use with Sani-wipes and left to air dry before used again. LPN #4 stated, "I've seen them wiped down, the whole thing (Hoyer lift).", but staff paid more attention to the handles, remotes, and straps.

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Interview with the Infection Preventionist (IP), on 08/04/2021 at 3:40 PM, revealed all facility staff had received IPC training, including proper hand hygiene techniques, appropriate use of PPE, and the correct way to clean and disinfect shared medical equipment. Per the interview, the IP stated nursing staff was educated to read the manufacturer's instructions if there was a question as to how to clean an item. She stated staff used the purple topped Sani-cloths, which came in a container and were individually wrapped per the facility's policy. The IP stated this was the correct way to clean/disinfect shared equipment. She stated she was aware that SRNA #2 brought in a container of Lysol spray disinfectant, but she did not correct her, and she should have. She stated she expected staff to follow the facility's policy. The IP stated it was important for the health and safety of the residents.

Interview with the Director of Environmental Services, 08/05/2021 at 3:30 PM, revealed nursing staff was responsible for keeping shared medical equipment clean and disinfected between resident uses. He stated if housekeeping staff happened to see that shared equipment, such as the lift, needed to be cleaned, the housekeeping staff was instructed to clean the equipment. However, he stated there was no schedule for routine cleaning of shared equipment. He stated housekeeping relied on nursing staff to inform them to clean dirty equipment.

Interview with the Assistant Director of Nursing (ADON), on 08/04/2021 at 3:55 PM, revealed the staff was educated to use purple topped

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Sani-wipes on all shared medical equipment between resident uses. She stated it was her expectation that staff followed the facility's policy. The ADON stated following ICP practices was important to prevent the spread of infection and disease.

Interview with the Director of Nursing (DON), on 08/04/2021 at 4:30 PM, revealed she expected staff to follow facility policy for cleaning shared equipment. Additionally, the DON stated that housekeeping routinely cleaned the Hoyer lifts. Furthermore, the DON stated following IPC practices was important to prevent the spread of infection and disease.

Interview with the Administrator, on 08/05/2021 at 5:56 PM, revealed she was not aware that SRNA #2 brought a can of Lysol® spray from home to use on shared resident equipment. The Administrator stated she did not witness SRNA #2 use Lysol® spray, but SRNA #2 had been educated on the proper way to clean/disinfect shared equipment per facility policy. However, the Administrator stated staff could use Lysol® spray to clean and disinfect shared medical equipment. She stated, "We are allowed to use a disinfectant spray to disinfect a surface." During the interview regarding whether a disinfectant spray would be adequate to clean a soiled surface, the Administrator stated, it would not be adequate. Additionally, the Administrator stated nursing used purple topped Sani-wipes to clean and disinfect any area the residents could touch on the Hoyer lifts between resident use, but housekeeping was responsible to periodically look at them. She stated she was not aware of a schedule for cleaning shared medical equipment.

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	185444	A. BUILDING _____ B. WING _____	R-C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE GROUP, LLC	2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504

(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 15	{F 880}		

2. Observation of the Kitchen and Dining Room, on 08/03/2021 at 12:45 PM, revealed Dietary Aide (DA) #1 was wearing his mask below the nose while plating residents' food.

Interview with DA #1, on 08/04/2021 at 2:15 PM, revealed he received education related to IPC practices, hand hygiene, and the proper donning and doffing of PPE. He stated classes were done via tutorial modules and in classes. DA #1 stated that masks should be worn appropriately at all times. Continued interview revealed he was not aware his mask was below his nose. DA #1 stated to be worn properly, the mask should fit snuggly, covering the mouth and nose.

3. Observation of the Kitchen and Dining Room, on 08/03/2021 at 12:45 PM, revealed DA #2 reached inside her scrub pant pocket and removed a cellphone, scrolled on the screen with her fingers, and then placed it back inside her pocket. DA #2 did not use ABHR after handling her phone. Continued observation revealed DA #2 then proceeded to roll up utensils in napkins and arrange residents' meal trays, before placing the trays into the food cart.

4. Additional observation of the Kitchen, on 08/04/2021 at 1:05 PM, revealed DA #3 sorting individually wrapped food and snack items with her mask below her mouth and nose resting on her chin for approximately five (5) minutes. When DA #3 noticed the State Survey Agency (SSA) Surveyor, she placed her mask over her mouth and nose. Observation revealed DA #3 did not use hand sanitizer after touching her mask and before returning to sorting food items.

Interview with the Dietary Manager (DM), on

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{F 880}	Continued From page 16	{F 880}		

08/04/2021 at 2:46 PM, revealed all dietary staff completed IPC education training related to the appropriate use of PPE and hand hygiene, and should not break IPC protocols. Per the interview, staff must always wear a mask according to facility policy and CDC guidelines. Furthermore, the DM stated, if dietary staff "breaks flow" they must perform hand hygiene. She stated it was important to prevent the spread of infection and the safety of staff and residents.

5. Additional observations in the Dining Room, on 08/04/2021 at 6:20 PM, revealed Registered Nurse (RN) #2 touched a resident's back, shoulder, and then his/her wheelchair without performing hand hygiene. Observation revealed RN #2 assisted two (2) more residents, physically touching both. RN #2 went back to the first resident, and assisted the resident with removing a clothing protector and placed his/her mask back on after eating. Observation revealed RN #2 did not perform hand hygiene.

Interview with RN #2, on 08/04/2021 at 6:25 PM, revealed RN #2 was not aware she had touched the wheelchair of one (1) resident and then physically touched several other residents without performing hand hygiene. Per the interview, she stated she had received IPC education and training within the last couple of months. She stated training included, "Sanitizing your hands between working with different residents, that sort of thing."

Interview with the Administrator, on 08/05/2021 at 5:56 PM, revealed she expected staff to follow the facility's policies related to IPC practices and CDC guidelines for hand hygiene. She stated following established policies and guidelines was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	R-C 08/05/2021

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{F 880}	Continued From page 17 important for the health and safety of residents.	{F 880}		

Root Cause Analysis for F880:

Define the Problem:

- Select Cambridge Place employees conducted improper infection control practices 8/3/21-8/5/21.

Why is that happening? (The 5 Whys)

#1 Why - Staff not following policies

#2 Why - Policies not clear, policies not enforced

#3 Why - Policies have had multiple revisions to meet current CDC guidelines, Staff unaware of impact to infection control program

4 Why - While education has been provided emphasis andmonitoring has not been focused on impact to infection control program, emphasis placed on task but not outcome

#5 Why - Easier to monitor task, more difficult to change full understanding and compliance

Identified Root Cause:

Select Cambridge Place staff performed improper infection control practices during the time period of 8/3-8/5/21. The staff members have been educated on correct Infection Control practices in the past; however, the root cause is that the emphasis from supervisors/management was placed more on education to staff but less enforcement on monitoring the compliance of infection control tasks. Staff were unaware of the impact of infection control errors and did not perform the tasks correctly.

Action/Plan to Address the Problem:

- Facility staff will have completed review of the CDC YouTube videos "Use Personal Protective Equipment (PPE) Correctly for COVID-19" and "Sparkling Surfaces," as directed by the Administrator, Director of Nursing, and/or Infection Preventionist by 8/31/21. An attestation statement that staff completed both assigned CDC YouTube videos was written by the DON and Infection Preventionist on 8/31/21.

- The facility developed and implemented a Performance Improvement Project (PIP) as part of the facility QAPI program. This PIP outlines the following information: Infection Control areas identified for improvement; the Specific, Measurable, Attainable, Realistic, and Time-Bound (SMART) goals; the Root Cause Analysis of the infection control area for improvement using the "5 Whys" done with the assistance of the IP, QAPI Committee, Governing Body; potential barriers; and the Plan for ongoing monitoring of the interventions implemented. Key implementation team members for the PIP include the Administrator, Director of Nursing (DON), Infection Preventionist (IP), ADON (Assistant DON), Housekeeping Supervisor, and contracted Inspectors/Consultants.

- The Administrator, DON, ADON, and IP reviewed and/or revised the Cleaning and Disinfecting of Environmental Surfaces policy, Handwashing/Hand Hygiene policy, and Source Control—Pandemic Coronavirus policy on 8/16/21. Staff members in the departments of nursing, dietary, housekeeping, laundry, etc. will have received education by the Administrator/DON/ADON/Supervisors by 8/31/21 on the compliance of infection control guidelines, including topics such as: cleaning and disinfecting of environmental surfaces, handwashing/hand hygiene, and source control in order to prevent the spread of potential infection.

- The facility Performance Improvement Project (PIP) will be completed by the assigned Team Members by 8/31/21.

- The QAPI audit tool addressing the compliance of infection control procedures including but not limited to the proper procedure for hand sanitizing, disinfecting of shared
medical equipment, and correct wearing of face masks was developed by the Administrator on 8/15/21 and approved by the QAPI committee on 8/16/21. This QAPI audit tool will be utilized by the DON/ADON/IP/Supervisors/Inspectors/ Designees on varied shifts including 8 randomly selected staff five (5) days per week x 2 weeks, weekly x 4 weeks, monthly X 2 months, then quarterly thereafter as per the established QAPI calendar, under the supervision of the Director of Nursing or Administrator.

- The Administrator, or designee, will present the PIP and QAPI audit results at the monthly QAPI Committee meeting. The QAPI team will then determine if any further interventions will need to be added to the PIP and will decide the ongoing frequency of QAPI audit tool.

The QAPI Committee, which includes the Medical Director and Infection Preventionist, in addition to the Governing Body, have conducted, reviewed, and agree upon this "Root Cause Analysis" for F880—Infection Prevention and Control.

8/25/21

Cara W. Clark, Cambridge Place Administrator

Attestation Statement of Completion:

Cambridge Staff including nursing, housekeeping, laundry, dietary, and department heads will have received online training via the YouTube.com CDC channel titled "Use of PPE Correctly for COVID-19" and "Sparkling Surfaces" under the direction of the Director of Nursing/Infection Preventionist by 8/31/21. This serves as an attestation statement that this online training will be completed by Cambridge Place employees on or before 8/31/21 by the Director of Nursing/Infection Preventionist as proof of completed online training of the staff.

Michelle Purdham, Director of Nursing

Deidre McAtee, Infection Preventionist

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. BUILDING _____ B. WING _____	R-C 09/09/2021

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{F 000}	INITIAL COMMENTS	{F 000}		

A second onsite revisit was initiated on 09/08/2021 and concluded on 09/09/2021. Based on the acceptable Plan of Correction (POC) received on 08/27/2021 and the onsite revisit survey, it was determined the facility had achieved substantial compliance, as alleged on 09/01/2021.

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

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.

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100461	A. BUILDING: _____ B. WING _____	R-C 09/09/2021

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CAMBRIDGE PLACE GROUP, LLC	**2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504**

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{N 000}	Initial Comments A second onsite revisit was initiated on 09/08/2021 and concluded on 09/09/2021. Based on the acceptable Plan of Correction (POC) received on 08/27/2021 and the onsite revisit survey, it was determined the facility was in compliance as alleged on 09/01/2021.	{N 000}		

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

CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL

Andy Beshear
Governor

1055 Wellington Way, Suite 125
Lexington, KY 40513
859-246-2301
fax 859-246-2307
https://chfs.ky.gov/agencies/os/oig

Eric C. Friedlander
Secretary

Adam Mather
Inspector General

September 17, 2021

E-mail
Cclark@cambridgepl.com

Ms. Cara Clark
Cambridge Place Group, Llc
2020 Cambridge Drive
Lexington, KY 40504-1999

Dear Ms. Clark:

Thank you for submitting your proposed plan of correction regarding the deficiencies noted during the survey completed on August 5, 2021. Upon reviewing this plan, we found it to be acceptable.

Based on implementation of your plan of correction, and the revisit survey completed on 09/09/2021, it was determined your facility had achieved compliance as of 09/01/2021. Therefore, we will recommend that your nursing facility be relicensed and recertified for continued participation in the Title XVIII/XIX program(s).

Your cooperation is appreciated. If you have any questions regarding this information, please contact our office.

Sincerely,

Gae Vanlandingham RN, RPM

Gae Vanlandingham, RN, RPM
Human Services Program Branch Manager

jb

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

FORM APPROVED

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
185444	CAMBRIDGE PLACE GROUP, LLC

Type of Survey (select all that apply)

A	M	D		

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

D				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 29137	09/08/2021	09/09/2021	1.00	0.00	14.00	0.00	2.00	2.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 4.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 1.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

Cambridge Place Group LLC SA Copy 09/08/2021

Infection Prevention, Control & Immunizations

Infection Control: This facility task must be used to investigate compliance at F880, F881, F882, F883, F885, F886, and F887. For the purpose of this task, "staff" includes all facility staff (direct and indirect care functions), contracted staff, consultants, volunteers, others who provide care and services to residents on behalf of the facility, and students in the facility's nurse aide training programs or from affiliated academic institutions. The infection prevention and control program (IPCP) must be facility-wide and include all departments and contracted services. If a specific care area concern is identified, it should be evaluated under the specific care area, such as for pressure ulcers, respiratory care, catheter care, and medication pass observations which include central lines, peripheral IVs, and oral/IM/respiratory medications.

Entry and screening procedures as well as resident care guidance have varied over the progression of COVID-19 transmission in facilities. Facilities are expected to be in compliance with CMS requirements and surveyors will use guidance that is in effect at the time of the survey. Refer to QSO memos released at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to- States-and-Regions.

If citing for noncompliance related to COVID-19, the surveyor(s) must include the following language at the beginning of the Deficient Practice Statement or other place determined appropriate on the Form CMS-2567: "Based on [observations/interviews/record review], the facility failed to [properly prevent and/or contain – or other appropriate statement] COVID-19."

Please Note:
Surveyors conducting a COVID-19 Focused Infection Control (FIC) Survey for Nursing Homes (not associated with a recertification survey), must evaluate the facility's compliance at all critical elements (CE) with the exception of CE #8 and CE #9. The surveyor must also examine the facility's compliance at §483.73(b)(6) or E0024 (at Appendix Z) if the full Emergency Preparedness survey is not being conducted.

Infection Prevention, Control & Immunizations

Coordination:

☑ Each surveyor is responsible for assessing the facility for breaks in infection control throughout the survey and is to answer CEs of concern (e.g., standard and transmission-based precautions, source control).

☑ One surveyor performs or coordinates (e.g., immunization review) the facility task to review for:

- Standard and transmission-based precautions
- Resident care for COVID-19
- Infection Prevention and Control Program (IPCP) standards, policies, and procedures
- Infection surveillance
- Visitor entry
- Education, monitoring, and screening of staff
- Staff and resident COVID-19 testing
- Suspected or confirmed COVID-19 reporting to residents, representatives, and families
- Laundry services
- Antibiotic stewardship program
- Infection Preventionist
- Influenza, pneumococcal, and COVID-19 immunizations

☑ Sample residents/staff as follows:

- Sample three staff, include at least one staff member who was confirmed COVID-19 positive or had signs or symptoms consistent with COVID-19 (if this has occurred in the facility), for purposes of determining compliance with infection prevention and control national standards such as exclusion from work, as well as screening, testing, and reporting.
- Sample three residents for purposes of determining compliance with infection prevention and control national standards such as transmission-based precautions, as well as resident care, screening, testing, and reporting.
  - Include at least one resident who was confirmed COVID-19 positive or had signs or symptoms consistent with COVID-19 (if any).
  - Include at least one resident on transmission-based precautions (if any), for any reason other than COVID-19.
- Sample five residents for influenza, pneumococcal, and COVID-19 immunizations (select COVID-19 unvaccinated residents).
- Note: If there are less than five COVID-19 unvaccinated residents, review all unvaccinated COVID-19 residents first. Then, select residents who are fully vaccinated to complete the sample.
- Sample five unvaccinated staff for COVID-19 immunization review.
  Note: If there are less than five COVID-19 unvaccinated staff, the sample can contain less than five staff.

Standard and Transmission-Based Precautions (TBPs)

State and Federal surveyors should not cite facilities for not having certain supplies (e.g., Personal Protective Equipment (PPE) such as gowns, N95 respirators, surgical masks) if they are having difficulty obtaining these supplies for reasons outside of their control (e.g., national or regional shortage). However, we do expect facilities to take actions to mitigate any resource shortages and show they are taking all appropriate

Infection Prevention, Control & Immunizations

steps to obtain the necessary supplies as soon as possible. For example, if there is a shortage of PPE, the facility should contact their healthcare coalition (https://www.phe.gov/Preparedness/planning/hpp/Pages/find-hc-coalition.aspx) or public health authorities for assistance, follow national and/or local guidelines for optimizing their current supply, or identify the next best option to care for residents. Among other practices, optimizing their current supply may mean prioritizing use of gowns based on risk of exposure to infectious organisms, blood or body fluids, splashes or sprays, high contact procedures, or aerosol generating procedures (AGPs), as well as possibly extending use of PPE (follow national and/or local guidelines). Current CDC guidance for healthcare professionals is located at: https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html and healthcare facilities is located at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/us-healthcare-facilities.html. Guidance on strategies for optimizing PPE supply is located at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html. If a surveyor believes a facility should be cited for not having or providing the necessary supplies, the State Agency should contact the CMS Regional Location.

General Standard Precautions:

☑ Staff are performing the following appropriately:

- Respiratory hygiene/cough etiquette,
- Environmental cleaning and disinfection, and
- Reprocessing of reusable resident medical equipment (e.g., cleaning and disinfection of glucometers per device and disinfectant manufacturer's instructions for use).

Hand Hygiene:

☑ Appropriate hand hygiene practices (i.e., alcohol-based hand rub (ABHR) or soap and water) are followed.

☑ Staff wash hands with soap and water when their hands are visibly soiled (e.g., blood, body fluids), or after caring for a resident with known or suspected C. difficile infection (CDI) or norovirus during an outbreak, or if endemic rates of CDI are high. ABHR is not appropriate to use under these circumstances.

☑ Staff perform hand hygiene (even if gloves are used) in the following situations:

- Before and after contact with the resident;
- After contact with blood, body fluids, or visibly contaminated surfaces;
- After contact with objects and surfaces in the resident's environment;
- After removing personal protective equipment (e.g., gloves, gown, eye protection, facemask); and
- Before performing a procedure such as an aseptic task (e.g., insertion of an invasive device such as a urinary catheter, manipulation of a central venous catheter, and/or dressing care).

☑ When being assisted by staff, resident hand hygiene is performed after toileting and before meals. How are residents reminded to perform hand hygiene?

Infection Prevention, Control & Immunizations

☑ Interview appropriate staff to determine if hand hygiene supplies (e.g., ABHR, soap, paper towels) are readily available and who they contact for replacement supplies.

Personal Protective Equipment (PPE) Use For Standard Precautions:

☑ Determine if staff appropriately use and discard PPE including, but not limited to, the following:

- Gloves are worn if potential contact with blood or body fluid, mucous membranes, or non-intact skin;
- Gloves are removed after contact with blood or body fluids, mucous membranes, or non-intact skin (and hand hygiene performed);
- Gloves are changed and hand hygiene is performed before moving from a contaminated body site to a clean body site during resident care;
- An isolation gown is worn for direct resident contact if the resident has uncontained secretions or excretions (e.g., changing a resident and their linens when excretions would contaminate staff clothing);
- Appropriate mouth, nose, and eye protection (e.g., facemasks, goggles, face shield) along with isolation gowns are worn for resident care activities or procedures that are likely to contaminate mucous membranes, or generate splashes or sprays of blood, body fluids, secretions or excretions;
- All staff are wearing a facemask (e.g., a cloth face covering can be used by staff where PPE is not indicated, such as administrative staff who are not at risk of coming in contact with infectious materials) in accordance with national standards;
- When COVID-19 is present in the facility, staff are wearing an N95 or equivalent or higher-level respirator, instead of a facemask for aerosol generating procedures;
- PPE is appropriately discarded after resident care, prior to leaving room (except in the case of extended use of PPE per national and/or local recommendations), followed by hand hygiene;
- During the COVID-19 public health emergency, PPE use is extended/reused in accordance with national and/or local guidelines. If reused, PPE is cleaned/decontaminated/maintained after and between uses; and
- Supplies necessary for adherence to proper PPE use (e.g., gloves, gowns, masks) are readily accessible in resident care areas (e.g., nursing units, therapy rooms).

☑ Interview appropriate staff to determine if PPE supplies are readily available, accessible, and used by staff, and who they contact for replacement supplies.

- Are there sufficient PPE supplies available to follow infection prevention and control guidelines? In the event of PPE shortages, what procedures is the facility taking to address this issue?
- How do you obtain PPE supplies before providing care?
- Who do you contact for replacement supplies?

Source Control for COVID-19:

☑ Ensure residents (when receiving visitors or while outside of their room), visitors, and others at the facility are donning a cloth face covering or facemask, in accordance with national standards, while in the facility or while around others outside.

Infection Prevention, Control & Immunizations

Transmission-Based Precautions (TBP):

☑ Determine if appropriate transmission-based precautions are implemented, including but not limited to:

- For a resident on contact precautions: staff don gloves and isolation gown before contact with the resident and/or his/her environment;
- For a resident on droplet precautions: staff don a facemask and eye protection (goggles or face shield) within six feet of a resident and prior to resident room entry (certain PPE should already be in use because of COVID-19);
- For a resident on airborne precautions: staff don a fit-tested N95 or higher-level respirator prior to room entry of a resident;
- For a resident with an undiagnosed respiratory infection (and tested negative for COVID-19): staff follow standard, contact, and droplet precautions (i.e., facemask, gloves, isolation gown) with eye protection when caring for a resident unless the suspected diagnosis requires airborne precautions (e.g., tuberculosis);
- For a resident with known or suspected COVID-19: staff wear gloves, isolation gown, eye protection and an N95 or higher-level respirator if available. A facemask is an acceptable alternative if a respirator is not available. When COVID-19 is identified in the facility, staff wear all recommended PPE (i.e., gloves, gown, eye protection and respirator or facemask) for the care of all residents on the unit (or facility-wide based on the location of affected residents), regardless of symptoms (based on availability).
    - Some procedures performed on residents with known or suspected COVID-19 could generate infectious aerosols (i.e., aerosol-generating procedures (AGPs)). In particular, procedures that are likely to induce coughing (e.g., sputum induction, open suctioning of airways) should be performed cautiously. If performed, the following should occur:
        - Staff in the room should wear an N95 or higher-level respirator, eye protection, gloves, and an isolation gown;
        - The number of staff present during the procedure should be limited to only those essential for resident care and procedure support;
        - AGPs should ideally take place in an airborne infection isolation room (AIIR). If an AIIR is not available and the procedure is medically necessary, then it should take place in a private room with the door closed; and
        - Clean and disinfect the room surfaces with an appropriate disinfectant. Use disinfectants on EPA's List N: Disinfectants for Coronavirus (COVID-19) or other national recommendations.
- Dedicated or disposable noncritical resident-care equipment (e.g., blood pressure cuffs, blood glucose monitor equipment) is used, or if not available, then reusable resident medical equipment is cleaned and disinfected according to manufacturers' instructions using an EPA-registered disinfectant for healthcare settings and effective against the identified organism (if known) prior to use on another resident.
- Objects and environmental surfaces that are touched frequently and in close proximity to the resident (e.g., bed rails, over-bed table, bedside commode, lavatory surfaces in resident bathrooms) are cleaned and disinfected with an EPA-registered disinfectant for healthcare settings and effective against the organism identified (if known) at least daily and when visibly soiled.
- Signage on the use of specific PPE (for staff) is posted in appropriate locations in the facility (e.g., outside of a resident's room, wing, or facility-wide).

Infection Prevention, Control & Immunizations

☑ Observe staff to determine if they use appropriate infection control precautions when moving between resident rooms, units and other areas of the facility.

☑ Interview appropriate staff to determine if they are aware of processes/protocols for transmission-based precautions and how staff is monitored for compliance.

☑ If concerns are identified, expand the sample to include more residents on transmission-based precautions.

1. Did the staff implement appropriate standard (e.g., hand hygiene, appropriate use of PPE, environmental cleaning and disinfection, and reprocessing of reusable resident medical equipment) and transmission-based precautions (if applicable)? ☑ **Yes** ☐ **No F880**

Resident Care for COVID-19

☑ Residents on transmission-based precautions are restricted to their rooms except for medically necessary purposes. If these residents have to leave their room, they are wearing a facemask or cloth face covering, performing hand hygiene, limiting their movement in the facility, and performing social distancing (efforts are made to keep them at least 6 feet away from others).

☑ The facility ensures only COVID-19 negative, and those not suspected or under observation for COVID-19, participate in group outings, group activities, and communal dining. The facility is ensuring that residents are maintaining social distancing (e.g., limited number of people in areas and spaced by at least 6 feet), performing hand hygiene, and wearing cloth face coverings, in accordance with national standards.

☑ The facility has a plan (including appropriate placement and PPE use) to manage residents that are new/readmissions under observation, those exposed to COVID-19, and those suspected of COVID-19. These actions are based on national (e.g., CDC), state and/or local public health authority recommendations.

☑ The facility has a plan to prevent transmission, including a dedicated space in the facility for cohorting and managing care for residents with COVID-19. These actions are based on national (e.g., CDC), state and/or local public health authority recommendations.

☑ For residents who develop severe symptoms of illness and require transfer to a hospital for a higher level of care, the facility alerts emergency medical services and the receiving facility of the resident's diagnosis (suspected, observation, or confirmed COVID-19) and precautions to be taken by transferring and receiving staff as well as place a facemask or cloth face covering on the resident during transfer (as tolerated).

☑ For residents who need to leave the facility for care (e.g., dialysis, etc.), the facility notifies the transportation and receiving health care team of the resident's suspected, observation, or confirmed COVID-19 status.

☑ During a Focused Infection Control Survey in response to an outbreak, interview staff to determine how the facility ensures that only fully vaccinated residents engage in the practice of not physically distancing and not wearing face coverings.

2. Did staff provide appropriate resident care for COVID-19 related concerns? ☑ **Yes** ☐ **No F880**

IPCP Standards, Policies, Procedures and Education:

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☑ The facility established a facility-wide IPCP including written IPCP standards, policies, and procedures that are current and based on the facility assessment [according to 483.70(e)] and national standards (e.g., for undiagnosed respiratory illness and COVID-19).

☑ The facility's policies or procedures include which communicable diseases are reportable to local and/or state public health authorities and contain when to notify if there are clusters of respiratory illness or cases of COVID-19 that are identified or suspected. The facility has a current list of reportable communicable diseases.

☑ Staff (e.g., nursing and unit managers) can identify and describe the communication protocol with local/state public health officials (e.g., to whom and when communicable diseases, healthcare-associated infections (as appropriate), and potential outbreaks must be reported).

☑ There is evidence the facility has provided education to staff on COVID-19 (e.g., symptoms, how it is transmitted, screening criteria, work exclusions). How does the facility convey updates on COVID-19 to all staff?

☑ The policies and procedures are reviewed at least annually.

☑ Concerns must be corroborated as applicable including the review of pertinent policies/procedures as necessary.

3. Does the facility have a facility-wide IPCP including standards, policies, procedures and education that are current, based on national standards, and reviewed at least annually? ☑ Yes ☐ **No F880**

Infection Surveillance:

☑ The facility has a screening process that all staff must complete prior to or at the beginning of their shift that reviews for signs/symptoms of illness and must include whether fever is present. The facility is documenting staff with signs/symptoms (e.g., fever) of COVID-19 according to their surveillance plan.

☑ Interview staff to determine what the screening process is, if they have had signs/symptoms of COVID-19 during the screening process, who they discussed their positive screening with at the facility and what actions were taken (e.g., work exclusion, COVID-19 testing).

☑ If staff develop symptoms at work (as stated above), the facility:

- Informs the facility's infection preventionist and includes information on individuals, equipment, and locations the person came in contact with; and
- Follows current guidance about returning to work (e.g., local health department, CDC: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html).

☑ The facility identifies the number of residents and staff in the facility, if any, that have fever, respiratory signs/symptoms, or other signs/symptoms related to COVID-19.

☑ The facility identifies the number of residents and staff, if any, that have been diagnosed with COVID-19 and when the first case was confirmed.

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☑ The facility prohibits employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit disease. Staff are excluded from work according to national standards.

☑ The facility has established/implemented a surveillance plan, based on a facility assessment, for identifying, tracking, monitoring and/or reporting of infections. For COVID-19 that includes resident surveillance of fever, respiratory illness, or other signs/symptoms of COVID-19 at least daily, and immediately isolate anyone who is symptomatic.

☑ The plan includes early detection, management of a potentially infectious, symptomatic resident that requires laboratory testing and/or the implementation of appropriate transmission-based precautions/PPE (the plan may include tracking this information in an infectious disease log).

☑ The plan uses evidence-based surveillance criteria (e.g., CDC NHSN Long-Term Care or revised McGeer Criteria) to define infections and the use of a data collection tool.

☑ The plan includes ongoing analysis of surveillance data and review of data and documentation of follow-up activity in response.

☑ The facility has a process for communicating at time of transfer to an acute care hospital or other healthcare provider the diagnosis to include infection or multidrug-resistant organism colonization status, special instructions or precautions for ongoing care such as transmission-based precautions, medications [e.g., antibiotic(s)], laboratory and/or radiology test results, treatment, and discharge summary (if discharged).

☑ The facility has a process for obtaining pertinent notes such as discharge summary, lab results, current diagnoses, treatment, and infection or multidrug-resistant organism colonization status when residents are transferred back from acute care hospitals.

☑ Interview appropriate staff to determine if infection control concerns are identified, reported, and acted upon.

4. Did the facility provide appropriate infection surveillance? ☑ Yes ☐ **No F880**

Visitor Entry

☑ Review for compliance of:

- Screening processes and criteria (i.e., screening questions and assessment of illness);
- Visitation is conducted according to residents' rights for visitation and in a manner that does not lead to transmission of COVID-19; and
- Signage posted at facility entrances for screening and restrictions as well as a communication plan to alert visitors of new procedures/restrictions.

☑ The facility instructs those permitted entry to frequently perform hand hygiene; limit their interactions with others in the facility and surfaces touched; restrict their visit to the resident's room or other location designated by the facility; and follow other current infection prevention and control standards (e.g., social distancing or face covering). What is the facility's process for communicating this information?

☑ The facility advises those permitted entry to monitor for signs and symptoms of COVID-19 and appropriate actions to take if signs and/or symptoms occur.

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5. Did the facility perform appropriate screening, restriction, and education of visitors? ☑ Yes ☐ **No F880**

Suspected or Confirmed COVID-19 Reporting to Residents, Representatives, and Families

This CE is relevant to facilities that have had confirmed cases or clusters of suspected COVID-19 infection.

Identify the mechanism(s) the facility is using to inform residents, their representatives, and families (e.g., newsletter, email, website, recorded voice message):

☑ The facility informed all residents, their representatives, and families by 5 PM the next calendar day following the occurrence of a single confirmed COVID-19 infection or of three or more residents or staff with new onset of respiratory symptoms that occurred within 72 hours of each other.

☑ The information included mitigating actions taken by the facility to prevent or reduce the risk of transmission, including if normal operations in the nursing home will be altered (e.g., visitation or group activities).

☑ The information did not include personally identifiable information.

☑ The facility provides cumulative updates to residents, their representatives, and families at least weekly or by 5 PM the next calendar day following the subsequent occurrence of either: each time a confirmed COVID-19 infection is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occurs within 72 hours of each other.

☑ Interview a resident and a resident representative or family member to determine whether they are receiving timely notifications.

6. Did the facility inform residents, their representatives, and families of suspected or confirmed COVID-19 cases in the facility along with mitigating actions in a timely manner? ☑ Yes ☐ **No F885** ☐ N/A

Staff and Resident COVID-19 Testing

Review the facility's testing documentation (e.g., logs of county level positivity rate, testing schedules, staff and resident records, other documentation). If possible, observe how the facility conducts testing, including the use of PPE and specimen collection. If such observation is not possible, interview an individual responsible for testing and inquire how testing is conducted (e.g., "what are the steps taken to conduct each test?").

☑ The facility conducts testing of unvaccinated staff based on the county level positivity rate according to the recommended frequency.

☑ Based on observation or interview, the facility conducts testing and specimen collection in a manner that is consistent with current standards of practice for conducting COVID-19 tests.

☑ The facility's documentation demonstrates the facility conducts testing of residents or staff with signs or symptoms of COVID-19 in a manner that is consistent with current standards of practice for conducting COVID-19 tests.

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☑ The facility's documentation demonstrates the facility conducts testing of residents and staff based on the identification of an individual diagnosed with COVID-19 in the facility in a manner that is consistent with current standards of practice for conducting COVID-19 tests.

☑ The facility takes actions to prevent the transmission of COVID-19 upon the identification of an individual with symptoms consistent with or who tests positive for COVID-19.

☑ The facility has procedures for addressing residents and staff that refuse testing or are unable to be tested.

☑ If there was an issue related to testing supplies or processing tests, ensure the facility made adequate attempts to obtain supplies by contacting the state and/or local health departments, local laboratories for assistance. If the facility conducts their own tests, they should also contact the supplier.

7. Is the facility in compliance with requirements for staff and resident COVID-19 testing? ☑ **Yes** ☐ **No F886**

Laundry Services:

☐ Determine whether staff handle, store, and transport linens appropriately including, but not limited to:

- Using standard precautions (i.e., gloves) and minimal agitation for contaminated linen;
- Holding contaminated linen and laundry bags away from his/her clothing/body during transport;
- Bagging/containing contaminated linen where collected, and sorted/rinsed only in the contaminated laundry area (double bagging of linen is only recommended if outside of the bag is visibly contaminated or is observed to be wet on the outside of the bag);
- Transporting contaminated and clean linens in separate carts; if this is not possible, the contaminated linen cart should be thoroughly cleaned and disinfected per facility protocol before being used to move clean linens. Clean linens are transported by methods that ensure cleanliness, e.g., protect from dust and soil;
- Ensuring mattresses, pillows, bedding, and linens are maintained in good condition and are clean (Refer to F584); and
- If a laundry chute is in use, laundry bags are closed with no loose items.

☐ Laundry Rooms – Determine whether staff:

- Maintain/use washing machines/dryers according to the manufacturer's instructions for use;
- If concerns, request evidence of maintenance log/record; and
- Use detergents, rinse aids/additives, and follow laundering directions according to the manufacturer's instructions for use.

8. Did the facility store, handle, transport, and process linens properly? ☐ **Yes** ☐ **No F880** ☑ **N/A, not a recertification survey**

Antibiotic Stewardship Program:

☐ Determine whether the facility has an antibiotic stewardship program that includes:

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- Written antibiotic use protocols on antibiotic prescribing, including the documentation of the indication, dosage, and duration of use of antibiotics;
- Protocols to review clinical signs and symptoms and laboratory reports to determine if the antibiotic is indicated or if adjustments to therapy should be made and identify what infection assessment tools or management algorithms are used for one or more infections (e.g., SBAR tool for urinary tract infection (UTI) assessment, Loeb minimum criteria for initiation of antibiotics);
- A process for a periodic review of antibiotic use by prescribing practitioners: for example, review of laboratory and medication orders, progress notes and medication administration records to determine whether or not an infection or communicable disease has been documented and whether an appropriate antibiotic has been prescribed for the recommended length of time. Determine whether the antibiotic use monitoring system is reviewed when the resident is new to the facility, when a prior resident returns or is transferred from a hospital or other facility, during each monthly drug regimen review when the resident has been prescribed or is taking an antibiotic, or any antibiotic drug regimen review as requested by the QAA committee;
- Protocols to optimize the treatment of infections by ensuring that residents who require antibiotics are prescribed the appropriate antibiotic; and
- A system for the provision of feedback reports on antibiotic use, antibiotic resistance patterns based on laboratory data, and prescribing practices for the prescribing practitioner.

9. Did the facility conduct ongoing review for antibiotic stewardship? ☐ Yes ☐ **No F881** ☑ **N/A, not a recertification survey**

Infection Preventionist (IP):

During interview with facility administration and Infection Preventionist(s), determine the following:

☑ The facility designated one or more individual(s) as the infection preventionist(s) who are responsible for the facility's IPCP.

☑ The Infection Preventionist(s) works at least part-time at the facility.

☑ The Infection Preventionist(s) completed specialized training in infection prevention and control.

10. Did the facility designate at least one qualified IP, who is responsible for the facility's IPCP? ☑ Yes ☐ **No F882**

Influenza, Pneumococcal, and COVID-19 Immunizations:

☑ Select five residents in the sample to review for the provision of influenza, pneumococcal, and COVID-19 immunizations.

☑ Select five staff on the COVID-19 vaccination status list.

NOTE: Include COVID-19 unvaccinated residents and staff as indicated on the vaccination status list.

☑ Document the names of residents and staff selected for review.

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☑ Review the records of the five residents (influenza, pneumococcal, and COVID-19) and staff (COVID-19 immunization) for documentation of:

- Screening and eligibility to receive the vaccine(s);
- The provision of education related to the influenza, pneumococcal, and COVID-19 vaccines (such as the benefits and potential side effects);
- The administration of vaccines in accordance with national recommendations, which includes doses administered.
- Facilities must follow the CDC and Advisory Committee on Immunization Practices (ACIP) recommendations for vaccines; and
- Allowing a resident or representative to accept or refuse the influenza, pneumococcal, and COVID-19 vaccines. If not provided, documentation as to why the vaccine(s) was not provided.
- Allowing staff to accept or refuse the COVID-19 vaccine and document vaccination status.

☑ For surveys occurring during influenza season, unavailability of the influenza vaccine can be a valid reason why a facility has not implemented the influenza vaccine program, especially during the early weeks of the influenza season. Similarly, COVID-19 vaccine supplies may be limited. Ask the facility to demonstrate that:

- The vaccine has been ordered and the facility received a confirmation of the order indicating that the vaccine has been shipped or that the product is not available but will be shipped when the supply is available;
- It made efforts to obtain the COVID-19 vaccine and provided information to staff on obtaining the vaccine if it is not available; and
- Plans are developed on how and when the vaccines are to be administered when they are available.

☑ As necessary, determine if the facility developed influenza and pneumococcal vaccine policies and procedures for all facility residents and COVID-19 vaccine policies and procedures for residents and staff. Review policies and procedures and interview facility staff to determine:

- How residents and/or resident representatives, and staff receive education on the benefits and potential side effects before being offered a vaccine. If multiple doses are required, how residents and/or resident representatives, and staff will again receive education on the benefits and potential side effects before being offered the vaccine;
- How staff and residents' vaccination status is tracked; and
- How screening is conducted for eligibility (e.g., medical contraindications, previous vaccination), the vaccines are offered, and consent or refusal is obtained.

11. Did the facility provide influenza and/or pneumococcal immunizations as required or appropriate for residents?
☑ Yes ☐ **No F883**

12. Did the facility provide COVID-19 immunization as required or appropriate for staff and residents? ☑ Yes ☐ **No F887**