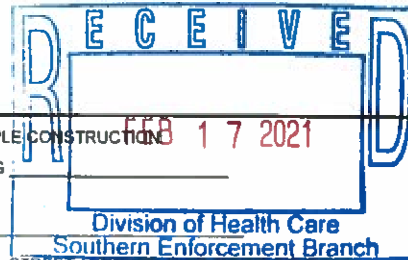
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 02/16/2021
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
	185061	A. BUILDING ______ B. WING ______	01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENWOOD HEALTH AND REHABILITATION CENTER	130 MEADOWLARK DRIVE RICHMOND, KY 40475

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F 000	INITIAL COMMENTS A COVID-19 focused infection control survey was conducted on 01/07/2021. The facility was found to be out of compliance with 42 CFR 483.80 Infection Control. Deficient practice was identified with the highest scope and severity at D level. The total census was 53.	F 000		
F 865 SS=D	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 observation, interview, review of the facility's policy, and review of the Plan of Correction (POC) for the COVID-19 focused infection control survey, dated 09/23/2020, it was determined the facility failed to maintain a Quality Assurance Performance Improvement (QAPI) Program that developed and implemented	F 865	The completion and submission of this credible allegation of compliance does not constitute an admission that the facility agrees with the allegation in the 2567. The facility is completing the allegation of the compliance because it is required by state and federal law. The facility	2/9/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/01/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 865	Continued From page 1 effective plans of action to correct quality deficiencies. During a focused infection control survey with an exit date of 09/23/2020, the facility was cited at CFR 483.80 Infection Control (F-880). The facility submitted a plan of correction, which included staff training on the use of Personal Protective Equipment (PPE) for COVID-19 with a correction date of 11/16/2020. However, observation on 01/07/2020, revealed State Registered Nurse Aide (SRNA) #1 and SRNA #2 entered a resident room on the COVID unit without donning the appropriate PPE (a gown) as required by facility policy. Refer to F880. The findings include: A review of the facility policy for quality assurance titled "Quality Assurance Performance Improvement Plan (QAPI) Standard of Practice" with a revision date of June 2020 revealed the Quality Assurance committee met monthly to review data from audit tools gathered throughout the month. According to the policy, audits in quality review areas to include infection prevention and control were reviewed and performance improvement plans were developed in identified areas of concern. A review of the medical record for Resident #1 revealed the resident tested positive for COVID-19 on 12/29/2020 and resided in the facility's designated COVID unit. Observation of the facility designated COVID unit on 01/07/2021 at 9:25 AM, revealed two staff members [State Registered Nurse Aides (SRNA) #1 and SRNA #2] entered the room of Resident #1 without donning the required PPE. Both staff	F 865	disagrees with the dispute and the alleged deficiencies as stated and the scope and severity at which they are cited. Further, the facility disputes and disagrees with the accuracy of statements and other information relied upon in support of the alleged deficiency. This includes but is not limit to the alleged contents/summary of interviews and the timing/chronological sequence of events and contact with heath care professionals and the description of the care provided to the residents. The facility reserves its rights to continue disputing, appealing and contesting these alleged deficiencies and any action related to or arising therefrom in any other forum as needed. 1. There were no negative outcomes for Resident #1 as a result of the alleged deficient practice, as evidenced by no acute changes in the resident s status. Vital signs including pulse, respirations, lung sounds, temperature and oxygen saturation are assessed for each resident a minimum of every shift, to assess for potential changes of condition. Upon notification of the alleged deficient practice, SRNA #1 and SRNA #2 received verbal re-education by the Director of Nursing regarding the facility policy for PPE on the designated COVID unit. A signed education was obtained on 1/8/2021. 2. Residents residing on the facility designated COVID unit would have the potential to be affected by the alleged deficient practice.	

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F 865	Continued From page 2 failed to don a gown in accordance with facility policy. Interview with SRNA #1, on 01/07/2021 at 1:05 PM, who provided care to Resident #1, revealed the staff member did not recall if she donned the required PPE (a gown) before entering Resident #1's room. Interview with SRNA #2, on 01/07/2021 at 1:07 PM, revealed she and SRNA #1 went into Resident #1's room to reposition the resident in bed and neither she nor SRNA #1 donned a gown before providing care to the resident. A review of the POC for the focused infection control survey with an exit date of 09/23/2020, revealed the facility alleged the deficient practice cited at F880 would be corrected as of 11/16/2020. The POC included corrective actions, which included in-service training for all staff on the use of PPE with return competency testing starting on 11/09/2020 and completed 11/15/2020. Further review of the POC revealed ten staff would be audited daily for four weeks to identify concerns with the staff use of PPE. A review of training records and competency test dated 11/13/2020, revealed SRNAs #1 and #2 were trained in the use of PPE and competency validated with a test. A review of daily PPE audits ending the first week of December 2020 and the weekly audit tools completed weekly for December 2020, revealed no concerns were identified with staffs' use of PPE. An interview with the Director of Nursing (DON), on 01/07/2021 at 1:22 PM, revealed that all residents in the COVID unit were on droplet	F 865	3. Education on the regulatory intent of F865 was provided by the Regional Director of Operations on 1/29/2021 to members of the facility Quality Assurance and Process Improvement (QAPI) Team that included the Administrator, Director of Nursing and Infection Preventionist. This education included: The facility must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The intent of F865 is to ensure facilities develop a plan that describes the process for conducting QAPI/QAA activities, such as identifying and correcting quality deficiencies as well as opportunities for improvement. Key components of the process include: " Tracking and measure performance; " Establishing goals for performance measures; " Identifying and prioritizing quality deficiencies; " Systematically analyzing underlying causes of systemic quality deficiencies; " Developing and implementing corrective action or performance improvement activities; and " Monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed. An example of non-compliance of F865 would include, but is not limited to: " Failure to maintain an effective plan of correction for a cited deficiency.	

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F 865	Continued From page 3 precautions. Staff were required to wear a mask and face shield at all times on the unit and were required to put on gloves and gowns before entering resident's rooms on the COVID unit. According to the DON, daily audits of staff per the POC was conducted for four weeks, and then decreased to weekly audits. The DON stated the audit had been ongoing as a part of the routine quality assurance to monitor compliance with infection control. The DON stated no concerns with staff use of PPE had been identified. An interview with the Administrator, on 01/07/2021 at 3:10 PM, revealed the Administrator and the DON conducted the facility's Quality Assurance Program as a team (both served as coordinator of the program). In addition, the Administrator and the DON reviewed the audits as a part of the facility's ongoing Quality Assurance Program monthly. According to the Administrator, no recent concerns had been identified with the staffs' use of required PPE.	F 865	A root cause analysis (RCA) was completed on 1/29/2021 to review in detail the cited noncompliance with F865 and identify systemic opportunities, and to develop solutions and system changes needed for sustained compliance. The RCA identified an opportunity to expand the timeframe of the auditing/monitoring process of infection control practices as well as opportunity to designate grounds maintenance and clean-up. Included in the RCA review were the Administrator, Director of Nursing, the Infection Preventionist, Regional Quality Manager, Chief Nursing Officer and the Regional Director of Operations (Governing Body representative). 4. Beginning the week of 2/1/2021, the Reginal Director of Operations and/or the Regional Quality Manager will review the facility's current plan of correction presented in the weekly Quality Assurance meeting. The facility QAPI team includes, but not be limited to, the Administrator, Director of Nursing, and Infection Preventionist. The status of the plan, all audits of employee donning and doffing PPE and exterior grounds monitoring audit will be reviewed to determine or identify the potential need to alter the plan, success of the plan or provide additional education to facility staff. These audits will continue for a minimum of 8 weeks, and results of this review will be presented to the facility IDT QAPI Committee weekly X 2 months for review and recommendation. The QAPI team consists of, but is not limited to, the	

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F 865	Continued From page 4	F 865	Administrator, Director of Nursing, Infection Preventionist, MDS, Social Services, Activities, Dietary, Therapy, and the Medical Director a minimum of quarterly.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		2/9/21

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F 880	Continued From page 5 (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 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 a review of the facility policy "Infection	F 880	1. There were no negative outcomes for Resident #1 as a result of the alleged	

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F 880	Continued From page 6 Prevention and Control Policy and Procedure Subject: Novel Coronavirus" it was determined the facility failed to follow their policy related to the use of Personal Protective Equipment (PPE) to prevent possible transmission of COVID-19 for one (1) of five (5) sampled residents (Resident #1). On 01/07/2021, two staff were observed to enter the room of Resident #1, who was in droplet precautions, on the facility designated COVID-19 unit without donning the required PPE (gown). In addition, the facility fail to ensure the safe disposal of PPE. Observation on 01/07/2021, upon entry to the building and during tour, revealed used PPE (gloves and surgical facemasks) was lying on the ground in the parking lot, on the front and back lawn, and in the facility courtyard. The findings include: A review of the facility policy for infection control titled "Infection Prevention and Control Policy and Procedure Subject: Novel Coronavirus" with a revision date of 11/03/2020 revealed the facility would conduct infection control and prevention strategies to reduce the risk of transmission of the corona virus. According to the policy, COVID positive residents would be placed on the facility designated COVID unit under transmission based precautions. Further review of the policy revealed staff were required to utilize a gown, mask, goggles/face shield and gloves before entering a resident room on the COVID unit. 1. A review of the medical record for Resident #1 revealed the facility admitted the resident on 08/10/17, with diagnosis of Quadriplegia, Dementia, Sepsis, Morbid Obesity, Pneumonia,	F 880	deficient practice, as evidenced by no acute changes in the resident s status. Vital signs including pulse, respirations, lung sounds, temperature and oxygen saturation are assessed for each resident a minimum of every shift, to assess for potential changes of condition. Upon notification of the alleged deficient practice, SRNA #1 and SRNA #2 received verbal re-education by the Director of Nursing regarding the facility policy for PPE on the designated COVID unit. A signed education was obtained on 1/8/2021. Upon notification of the alleged deficient practice, the PPE identified on the grounds was removed and properly disposed of by the Maintenance Supervisor. 2. All residents would have the potential to be affected by the alleged deficient practice. 3. Facility staff(all disciplines/ all employees) is being provided education by the Director of Nursing and Infection Preventionist that includes the videos: " CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: PPE Lessons " Demonstration of Donning (Putting On) Personal Protective Equipment (PPE) " Demonstration of Doffing (Taking Off) Personal Protective Equipment (PPE) This education reviews the types of and significance of the PPE utilized at the facility, and the appropriate donning and doffing practices; and that PPE is to be	

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F 880	Continued From page 7 and COVID 19 Positive. Observation of the facility designated COVID unit, on 01/07/2020 at 9:25 AM, revealed two staff members [State Registered Nurse Aides (SRNA) #1 and SRNA #2] entered the room of Resident #1 without donning a gown, as required by the facility policy. Interview with SRNA #1, on 01/07/2021 at 1:05 PM, revealed the staff member did not recall if she donned the required PPE (a gown) before entering the Resident #1's room. According to SRNA #1, staff were required to wear full PPE before entering the residents' rooms on the COVID unit and remove the PPE and discard it when exiting the room to prevent the spread of the COVID-19 virus. Interview with SRNA #2, on 01/07/2021 at 1:07 PM, revealed she and SRNA #1 went into Resident #1's room to reposition the resident in bed and neither she nor SRNA #1 donned a gown before providing care to the resident because they were only in the room for a short time. According to the SRNA, full PPE, to include a gown was to be donned before entering the resident's room and removed and discarded when exiting the room because the resident had COVID-19 and it could be spread. An interview with the Director of Nursing (DON), who was also the backup Infection Preventionist, on 01/07/2021 at 1:22 PM, revealed all residents in the COVID unit were on droplet precautions. The DON stated staff were required to wear a mask and a face shield at all times in the unit and were required to put on gloves and gowns before entering residents' rooms on the COVID unit.	F 880	discarded appropriately after use. This education is to be completed by 2/8/2021. A post- test is being required of all participants to ensure understanding of the education content. A root cause analysis (RCA) was completed on 1/29/2021 to review in detail the cited noncompliance with F880 and F865 and identify systemic opportunities, and to develop solutions and system changes needed for sustained compliance. The RCA identified an opportunity to expand the timeframe of the auditing/monitoring process of employees donning and doffing PPE for appropriate infection control practices and exterior grounds monitoring to ensure doffing of PPE is disposed of in the correct manner. Included in the RCA review were the Administrator, Director of Nursing, the Infection Preventionist, Regional Quality Manager, Chief Nursing Officer and the Regional Director of Operations (Governing Body representative). 4. Beginning the week of February 1, 2021, the Director of Nursing, the Infection Preventionist and/or the Licensed Nurse Unit Managers will audit observed infection control practices. This audit will include a minimum of 10 employee observations daily and include a sample from all 3 shifts specifically monitoring for the proper donning and doffing of personal protective equipment (PPE). This audit will continue daily for a minimum of 8 weeks or until compliance	

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F 880	Continued From page 8 Staff were to remove (PPE) gowns and gloves and discard when exiting the residents' rooms. According to the DON, she made rounds daily to monitor staff's use of PPE and had not identified any recent concerns. Further interview with the DON revealed if staff did not wear the correct PPE when required it was an infection control hazard that could potentially spread infections. 2. An interview with the Administrator, on 01/07/2021 at 3:10 PM, revealed the facility did not have a policy regarding picking up trash outside the facility; however, it was procedure for used PPE and trash to be disposed of in designated receptacles, trash cans and dumpsters. Observations during the initial tour, on 01/07/2021 from 9:05 AM to 10:05 AM, revealed a disposable glove was in the parking lot near the facility front entrance, three (3) disposable gloves and two (2) facemasks were on the ground in the facility courtyard. Further observation revealed four (4) disposable gloves and two (2) facemasks were on the grass on the east side of the building. Three (3) disposable gloves were observed lying on ground in the parking area on the south side of the building near the dumpster, and two (2) gloves and a surgical mask was lying in the grass on the west side of the building. Interview with Maintenance Staff, on 01/07/2021 at 2:21 PM, revealed maintenance occasionally tried to pick up trash outside the facility and to check for appearance and curb appeal. According to the Maintenance Staff, he had not noticed the PPE lying on the grounds of the facility. The Maintenance Staff member stated PPE not being disposed of properly and lying	F 880	has been achieved through the Quality Assurance meeting. Any identified concern observed during the monitoring will be addressed with re-education immediately at the time of discovery. Also beginning the week of February 1, 2021, the Administrator, Maintenance Director and/or Housekeeping Manager will complete an exterior rounding of the facility to ensure no PPE is found to have not been disposed of properly. This audit will continue daily X 4 weeks. Exterior grounds will be monitored ongoing as part of daily duties of maintenance staff to ensure exterior of building is free of any improper discarded PPE. Any concerns will be addressed immediately and reviewed in QAPI meeting for revisions and or success of the plan. Any identified concern observed during the monitoring will be addressed immediately at the time of discovery. The results of the monitoring/audits will be presented to the facility Quality Assurance Process Improvement (QAPI) team for review and recommendation. The QAPI team consists of, but is not limited to, the Administrator, Director of Nursing, Infection Preventionist, MDS, Social Services, Activities, Dietary, Therapy, and the Medical Director a minimum of quarterly. The Regional Director of Operations or the Regional Quality Manager will review weekly the results of the audits of employee donning and	

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F 880	Continued From page 9 around outside could be an infection hazard. Interview with the Housekeeping Supervisor, on 01/07/2021 at 2:25 PM, revealed she had not been told to pick up any trash outside the facility recently and picking up trash outside was not on the cleaning schedule for housekeeping. The Housekeeping Supervisor stated she had seen the PPE lying on the ground outside, but had not told anyone. According to the Housekeeping Supervisor, the PPE lying on the ground outside could be an infection control hazard. An interview with the Administrator, on 01/07/21 at 3:10 PM, revealed the facility had a computerized maintenance task to have maintenance pick up trash and debris outside the facility weekly. According to the Administrator, he was not aware of the PPE lying on the ground outside until he arrived at the facility after being notified of the survey. Further interview with the Administrator revealed he checked the outside of the building weekly if weather permitted and had not noticed any build up of trash and debris. According to the Administrator, if trash and PPE were not disposed of properly, it was an infection control hazard.	F 880	doffing PPE and grounds rounding audits presented in the Quality Assurance meeting to identify concerns and offer needed suggestions for revisions and/or success of the plan beginning February 1, 2021.	