STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185171	A. BUILDING _____ B. WING _____	11/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING & REHABILITATION CENTER	**544 LONE OAK ROAD PADUCAH, KY 42003**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was initiated on 11/18/2020 and concluded on 11/20/2020. There was no deficient practice identified with 42 CFR 483.73 related to E-0024 (b)(6).	E 000		

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

Electronically Signed | 12/18/2020

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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	185171	A. BUILDING _____ B. WING _____	R 03/12/2021

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{F 000}	INITIAL COMMENTS An Onsite Revisit conducted on 03/12/21, determined the facility was in compliance on 12/21/2020, as alleged in acceptable PoC.	{F 000}		

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F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was initiated on 11/18/2020 and concluded on 11/20/2020. The facility was found not to be in compliance with 42 CFR 483.80 infection control regulations and has not implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Deficient practice was identified at "D" level. Total census: 164	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals 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	F 880		12/21/20

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F 880	Continued From page 1	F 880		

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 infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its

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F 880	Continued From page 2 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to ensure infection control practices were implemented related to following the screening process of individuals entering facility, and ensuring red zippered plastic wall barrier to COVID-19 unit was secured. The findings include: Review of facility policy titled, "Standard and Transmission Based Precautions: Guide to Infection Prevention and Control", dated 10/07/2020 revealed purpose of the policy was to provide a framework to minimize the risk of potential exposure to COVID-19 in the long-term care (LTC) facility. It stated the facility would follow the core principles of COVID-19 Infection Prevention as outlined below and defined by CMS and CDC to mitigate COVID-19 entry into the facility. The facility would screen all who enter the facility for signs/symptoms (s/s) of COVID-19 (e.g. temperature checks, questions or observations about signs or symptoms) and would deny entry of those with signs and symptoms. Review of facility policy titled, "COVID-19 Mitigation and Management", dated 06/16/2020, revealed the facility would screen 100% of all visitors, vendors, and contractors prior to entering the facility with temperature checks and questionnaire a about symptoms and potential exposure.	F 880	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were found to have been affected by the deficient practice. On 11/21/20, The Regional Director of Clinical Services (RDCS) provided education to the Executive Director (ED) and Director of Nursing (DON) on the facility policy, Coronavirus (COVID-19) (SARS-CoV-2) which includes process of screening and securing COVID Unit entries. On 11/20/2020, the DON provided education to the associate that did not screen the visitor and with the laundry associate who did not secure the zippered wall to the COVID unit. Associates verbalized understanding. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 11/21/2020, the Licensed Nurses completed respiratory assessments on all residents and were reviewed by the DON and Infection Control Nurse for new signs/symptoms of COVID-19 infection; no residents were identified to have any	

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F 880	Continued From page 3 Review of the facility guidance for screening to be done form, not dated revealed to ask name, check temperature and if temperature was greater than 99, recheck; if recheck still 99 or above, call Executive Director (ED) or Director of Nursing (DON). Ask every question, every time, to every person; after they pass temperature check and answer all questions. Ask them to clean face shield, and use hand sanitizer before leaving desk; and make sure mask is worn properly, covering mouth and nose. Review of Coronavirus Screening (for Visitors) Transmission Based Precautions: guide to Infection Prevention and Control form, last revised 10/16/2020, revealed the following questions: 1. Fever - temperature of >100.0, if Yes, do not allow visit. 2. S/S of COVID-19 - chills, repeated shaking with chills, mew/change in cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste of smell, sore throat, congestion, runny nose, nausea, vomiting, diarrhea, new sputum production, hemopsytosis - if yes, do not allow. 3. Have you been diagnosed with COVID-19 and have not completed the time/symptom-based requirements (10/20 days and 24 hours of no fever) to come out of isolation - if yes, do not allow visit. 4. Have you had close personal contact with a COVID-19 diagnosis - If yes, do not allow visit. 5. Restricted - international travel to countries with sustained transmission (see CDC website for current list) or cruise ship travel in last 14 days. -if yes, do not allow visit.	F 880	new sign/symptoms of COVID-19 infection. On 11/21/2020, licensed nurses initiated respiratory assessments every shift on all residents and are continuing to be completed every shift on all residents by a licensed nurses to identify any new signs/symptoms of COVID-19 infection and reviewed by the DON, Assistant Director of Nursing (ADON), Infection Preventionist (IP), and /or a licensed nurse. 3. What measure will be put into place or systemic changes made to ensure that the deficient practice will not reoccur? On 12/14/2020, the Infection Preventionist (IP), began educating all associates on the facility policy, Coronavirus (COVID -19) (SARS-CoV-2), which includes the procedure for screening of associates, visitors, vendors and contractors (Per Directed Plan of Care (DPoC) and the securing of zippered walls on COVID units. Education emphasized that surveyors must also be screened appropriately (RCA Intervention). Education will be completed by 12/21/2020. Any associate who has not completed training by 12/21/2020 will not be allowed to provide direct resident care until training is completed. *The Infection Preventionists (IP) or Director of Nursing (DON) will provide education to all new associates upon hire during orientation. Beginning on 12/14/2020 the Infection Preventionist educated all associates on Keep COVID-19 Out! located at	

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F 880	Continued From page 4 6. If applicable for "person under arrangement"or certain other visitors, document the result and date of most recent COVID-19 test. If date is outside of the time frame, the facility required for testing, do not allow visit. Surveyor entered facility on 11/16/2020 at 12:40 PM, and the person at the entrance of the facility obtained surveyor's temperature ; however, failed to ask any signs/symptoms of COVID-19 questions. Interview with Screener/Certified Nursing Assistant (CNA) #1, on 11/18/2020 at 1:55 PM, revealed she was supposed to take the surveyor's temperature and ask all the questions. She stated she failed to ask the COVID screening questions to the surveyor because she did not know to ask the questions. However, review of COVID-19 Screener Competency form dated 08/26/2020, revealed Screener/CNA #1 had signed the form indicating she understood that she was to screen individuals visiting the facility for fever, respiratory systems, history of travel to high-risk places, and/or contact/or exposures with individuals with symptoms or history of travel to high risk places. In addition, the form indicated she demonstrated the documentation requirements when utilizing the visitor screening tool for individuals visiting the facility. Interview with Staff Development Coordinator (SDC), on 11/18/2020 at 4:39 PM, revealed the screening process was taught to all staff and the form says on the bottom to ask all the questions to staff and visitors. The SDC stated the screening process was taught to staff by the Infection Control Nurse (IFCN), the night-time supervisor, and herself. She further revealed that	F 880	https://youtu.be /7srwrF9MGdw (per DPOC). Education will be completed by 12/21/2020. *Any associate who has not completed training by 12/21/2020 will not be allowed to provide direct resident care until training is completed. An Infection Preventionist (IP) or DON will provide education to all new associates upon hire during education. Effective 12/14/2020 the Executive Director will be responsible for oversight to ensure the screening program and process of associates, visitors, vendors, and contractors is fully implemented and the oversight to ensure if COVID units are present with zippers they will be completely zipped at all times. (per DPoc) 4. How the facility plans to monitor its performance to make sure that solutions are sustained. The Executive Director (ED), Director of Nursing (DON), and/or licensed nurse will audit daily screening logs to ensure all associates, visitors, vendors, and contractors have been screened per facility policy [Per DPoC]. The ED, DON and or Licensed Nurse will also monitor two daily screenings each shift and random audits at various times throughout the week to ensure screener compliance. Effective 12/18/2020, these audits will be conducted 5 (five) times a week for 4 (four) weeks, then 3 (three) times a week	

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F 880	Continued From page 5 the screeners had to go through the screening process and they had to pass competencies before able to screen anyone. Interview with the IFCN/Assistant Director of Nursing (ADON), on 11/18/2020 at 3:52 PM, revealed screenings were completed at the front entrance, and included asking the infection control questions, and taking temperatures. The IFCN/ADON stated the screener was supposed to ask visitors their name and purpose of visit, and write on visitor log. Then the screener should ask the screening questions, take the person's temperature, and document the answers and temperature on form. She further revealed the screener should then have the visitor sanitize hands and notify them there was COVID in the building. She stated vendors sat at front door and maintenance would take care of the vendor so they would not have to come in building. Interview with Administrator, on 11/20/2020 at 11:09 AM, revealed screeners were supposed to take visitors' temperature and ask the visitor a series of questions. The Administrator stated the staff were trained through competencies prior to screening anyone. 2. Review of facility policy titled, "Standard and Transmission Based Precautions: Guide to Infection Prevention and Control, Coronavirus (COVID 19) (SARS-CoV2), dated 10/07/2020 revealed the facility would follow core principles of COVID-19 Infection Prevention as outlined below and defined by Center for Medicare and Medicaid Services (CMS) and CDC (Center for Disease Control and Prevention). Airborne transmission of COVID 19 could occur under special circumstances and there was enough virus	F 880	for 4 (four) weeks, then 1 (one) time a week for 4 (four) weeks. The Executive Director (ED) and/or Director of Nursing (DON) will provide education within 48 hours for any incidents of non-compliance. The Executive Director (ED), Director of Nursing (DON) and/or licensed nurse will audit daily each shift all COVID zippered walls to ensure zippers are closed/secured. Effective 12/18/2020, these audits will be conducted 5 (five) times a week for 4 (four) weeks, then 3 (three) times a week for 4 (four) weeks, then 1 (one) time a week for 4 (four) weeks. The Executive Director (ED) and/or Director of Nursing (DON) will provide education within 48 hours for any incidents of non-compliance. Beginning on 12/18/2020 with the completion date of 12/21/2020, The Executive Director (ED), Director of Nursing (DON) and/or Licensed Nurse will provide a questionnaire to associates in response to securing COVID unit zippered walls and the screening process of all visitors. Associates will obtain 100 percent on questionnaire or immediate re-training will occur until 100 percent is achieved. Beginning on 12/18/2020, the Executive Director will ensure in the event of a zippered wall usage, signage on wall will include a reminder that a zipper must be completely zipped at all times even for short entries and exits. The facility currently has zero active COVID units at	

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F 880	Continued From page 6 present in the space to cause infections in people who were more than six (6) feet away or who passed through a space soon after infectious person had left; or in enclosed spaces within which an infectious person either exposed susceptible people at the same time or to which susceptible people were exposed shortly after the infectious person had left the space. Further review of the policy revealed dedicated Health Care Personal (HCP) would be assigned to the COVID 19 care unit and to the extent possible restrict access of ancillary personnel to the unit and ensure that HCP practice control measures are in common areas. Observation on 11/18/2020 at 1:20 PM, revealed a sign posted outside the entrance to the 200 COVID Unit which read "Do not enter the red zone unless you are authorized behind the wall". Further observation revealed Laundry Aide #1 was at the double doors receiving laundry from staff on the COVID Unit. She had already passed through the red zippered wall and had failed to zip it closed. Interview with Laundry Aide #1, on 11/18/2020 at approximately 1:28 PM, revealed she was standing at the double doors of the COVID Unit with a laundry bin wearing gloves, shield, and mask. She stated the staff in the unit opened the door and put the dirty linen in the bin. She stated she normally zipped up the red zipper plastic wall before proceeding to the double doors but did not this time. Interview with the Maintenance Assistant, on 11/19/2020 at 2:48 PM, revealed he helped set up the COVID Unit, and there was a plastic wall with zipper that sealed off the entire COVID hall	F 880	this time or zippered walls. Monthly, beginning in December x 3 months (January, February and March) results of the audits and questionnaires will be reported by the Executive Director (ED) to the Quality Assurance and Performance Improvement (QAPI) Committee .The QAPI Committee will review these results; and if deemed necessary by the committee, additional corrective action(s), measures, and/or systematic changes may be initiated. If at any time non-compliance is identified audits will be extended per the QAPI committee determination. QAPI Committee Members include: Executive Director, Medical Director, Director of Nursing, and Assistant Director of Nursing, Infection Preventionist, Director of Rehab, Director of Social Services, Director of Activities, Director of Human Resources, Business Office Manager, Director of Environmental Services, Director of Maintenance, Director of Health Information Management, and Clinical Dietary Manager.	

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F 880	Continued From page 7	F 880		

placed before the double doors into the unit. He stated this was done this way to provide a space for staff to don the required PPE before entering the unit and to prevent infection from coming through to the rest of building. He revealed the red zipper on plastic wall should stay zipped at all times and only be unzipped to go through the barrier and zipped back up immediately once through the barrier.

Interview with Housekeeping and Laundry Manager, on 11/19/2020 at 4:39 PM, revealed when laundry staff pick up laundry they unzipped the plastic wall and go to double doors to receive laundry. She stated the staff should zip it closed prior to going to double doors and do the same when exiting. She revealed the barrier needed to stay zipped at all times for infection control prevention.

Interview with IFCN/ADON, on 11/19/2020 at 5:03 PM, revealed they followed CDC, and Corporate guidelines, and were in touch with the health department on a daily basis. The ICFN/ADON stated the red zipper should be zipped at all times because it was a barrier to the COVID Unit. She revealed she expected staff to ensure the zipper was closed at all times except when entering or exiting through the barrier.

Interview with Administrator, on 11/20/2020 at 11:09 AM, revealed the zippered barriers were to separate the COVID Unit from the general population. The Administrator stated this separated the hall from the rest of the building and kept airborne or droplets from dispersing from the COVID Unit to the rest of building. She revealed she expected the zippered barriers to be zipped at all times.

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{N 000}	Initial Comments An Onsite Revisit conducted on 03/12/21, determined the facility was in compliance on 12/21/2020, as alleged in acceptable PoC.	{N 000}		

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N 000	Initial Comments A COVID-19 Focused Infection Control Survey was initiated 11/18/2020 and concluded on 11/20/2020. There was deficient practice identified pursuant to 42 CFR 483.80.	N 000		

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