STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185227	A. BUILDING _____ B. WING _____	10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE POINTE HEALTHCARE	100 MARSHALL COURT PADUCAH, KY 42001

(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 A COVID-19 Focused Infection Control Survey was initiated on 10/20/2020 and concluded on 10/26/2020 with a deficiency cited at a Scope and Severity of a "D". 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. Total census 67.	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		11/10/20

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

Electronically Signed | 11/20/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185227	A. BUILDING _____ B. WING _____	10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE POINTE HEALTHCARE	100 MARSHALL COURT PADUCAH, KY 42001

(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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185227	A. BUILDING _____ B. WING _____	10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE POINTE HEALTHCARE	100 MARSHALL COURT PADUCAH, KY 42001

(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 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 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. Observation and interview revealed staff who work on the 100 Hall and 200 Hall of the facility enter the building through the facility's 100 Hall and 200 Hall doors after clocking in for work. Staff then go to the Nurse's Station to be screened for signs/symptoms of COVID-19. Further observation revealed the Nurse's Station where staff were screened was in the center of the hallway where resident rooms were located, and not at an entrance to the facility. The findings include: Review of the facility policy, "COVID-19 Employee Screen Policy", dated 03/16/2020, revealed "It is the policy of Superior Care Home to screen and detect, to the best of its ability, signs and symptoms in its staff related to the COVID-19 virus". Further review of the policy revealed "1. At the beginning of each shift, each staff member's temperature will be taken by a licensed nurse. 2. The temperature will be recorded onto the COVID-19 Employee Screen form along with other signs and symptoms such as: cough, sore throat, shortness of breath, or other respiratory symptoms. 3. If the staff	F 880	1. Between the hours of 5a-8a, all staff or contracted healthcare providers will be COVID19 screened at the rear entrance of the facility and prior to entering a resident area. If the person being screened meets criteria (ie afebrile, no s/s of COVID19), that person will be released to begin his/her shift and permitted to go to a resident area. Between the hours of 8a-5p, all staff, visitors, contracted healthcare providers, and vendors will be screened at the front desk and will not be permitted to continue into the facility and into a resident area until the screening process is completed and the screen is passed. All people who are screened and do not meet criteria to enter will be asked to leave the facility immediately. 2. All residents had the potential to be affected by the deficient practice. 3. The facility, as of 10/25/2020, established and will 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. As of 10/25/2020, all staff were re-educated by the DON, CON, Infection Preventionist, and Staffing Coordinator regarded the screening	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185227	A. BUILDING _____ B. WING _____	10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE POINTE HEALTHCARE	100 MARSHALL COURT PADUCAH, KY 42001

(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 3 member has a temperature, that staff member will be excused from his/her duties and will be asked to see his/her PCP. 4. If the staff member is found to have a positive COVID-19 screen from his/her PCP, that staff member will be excused from his/her duties for a 14-day period. The facility's sick leave policy will apply. 5. The staff member may return to work only after the date the staff member's PCP has written on a doctor's excuse". Observation during a walk-through of the facility, and interview with the Infection Control Nurse, on 10/22/2020 at 3:15 PM, revealed staff were screened at the Nurse's Station on 100 Hall, 200 Hall, 300 Hall, and 400 Hall; however, on the 100 Hall and 200 Hall, staff have to pass by resident rooms prior to being screened at the Nurse's Station. Interview with Licensed Practical Nurse (LPN) #1, on 10/26/2020 at 9:28 AM, revealed staff would come to their assigned units before being screened and nightshift would come in the front door, directly on the 100 Hall, through a resident care area before being screened. She stated she thought this was changed on Friday (10/23/2020). Interview with the Environmental Services (EVS) Supervisor, on 10/23/2020 at 12:15 PM, revealed EVS staff were going to the Nurse's Station, wherever they were assigned, which meant going through a resident care area to get screened. The EVS Supervisor stated as of this morning (10/23/2020), EVS would use the back door near Maintenance to enter the facility and get screened there, which was not a resident care area. If no one was there, then staff should call the Nurse's Station, so he or she will come screen you.	F 880	process, and the signs and symptoms of COVID19. As of 10/25/2020 designated staff were trained by the DON, CON, and Infection Preventionist on the proper screening procedure. 4. The facility's performance will be monitored through the QA process to ensure that all people entering the facility are screened prior to entering the facility or a resident area. The DON, Infection Preventionist, or designee will review the screening process daily for one week then weekly for 2 weeks. Then, on-going, once weekly. If a deficient practice is identified, it will be reported to the QA committee immediately and the deficient practice corrected through the QA process. The QA committee consists of the Medical Director, Administrator, DON, Infection Preventionist, Social Services, Clinical Directors, Staffing Coordinator, MDS Coordinator, Dietatian, Therapy Program Managers, and the Resident Life Coordinator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185227	A. BUILDING _____ B. WING _____	10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE POINTE HEALTHCARE	100 MARSHALL COURT PADUCAH, KY 42001

(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 4	F 880		

Interview with Registered Nurse (RN) #1, on 10/26/2020 at 10:09 AM, revealed prior to today she would enter the building through the back door by the service area, go to the training room to get Personal Protective Equipment (PPE), fill out a questionnaire, then go to the Nurse's Station on the 100 Hall to get her temperature taken by the nurse, and get screened at that time. She stated effective today (10/26/2020), she had to come to the front door for screening.

Interview with the Director of Nursing (DON), on 10/26/2020 at 3:50 PM, revealed staff should always be screened prior to being in a resident care area. She stated the facility was constantly making changes depending on whatever was going on in the community, through prevention and monitoring.

Interview with the Administrator, on 10/21/2020 at 9:00 AM, revealed according to test results from Monday (10/19/2020), there were five (5) staff who tested positive, and were currently out of the building. However, they were waiting for more rest results. She stated they continued to test staff and residents twice per week every week.

Interview with the facility's Nurse Consultant, on 10/23/2020 at 1:04 PM, revealed the facility had to reinforce the screening process the last few days, as some of the staff had become relaxed in the screening process. She stated the facility continued to monitor for proper screening.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185227	A. BUILDING _____ B. WING _____	10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE POINTE HEALTHCARE	100 MARSHALL COURT PADUCAH, KY 42001

(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 10/20/2020 and concluded on 10/26/2020. There was no deficient practice identified at 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 | 11/20/2020

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.

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100312	A. BUILDING: _____ B. WING _____	10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE POINTE HEALTHCARE	100 MARSHALL COURT PADUCAH, KY 42001

(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) COMPLETE DATE
N 000	Initial Comments A COVID-19 Focused Infection Control Survey was initiated 10/20/2020 and concluded on 10/26/2020. The facility was found not to be in compliance pursuant to 42 CFR 483.80.	N 000		

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

Electronically Signed | 11/20/20