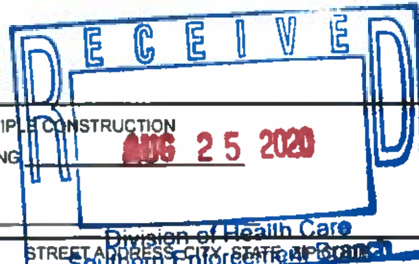
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185244	A. BUILDING ___ B. WING ___	08/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANFORD CARE AND REHAB, LLC	105 HARMON HEIGHTS STANFORD, KY 40484

(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 conducted on 08/05/2020. 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 70.	F 000	THE COMPLETION AND SUBMISSION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION THAT THE FACILITY AGREES WITH THE DEFICIENCIES AS CITED. THE FACILITY IS COMPLETING THE PLAN OF CORRECTION BECAUSE IT IS REQUIRED BY STATE AND FEDERAL LAW.	8/26/2020
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	F 880	1. Resident #1 no longer resides at facility. He/she was discharged home on 8/21/2020. Resident was COVID negative upon readmission to the facility on 7/8/2020. He was admitted to the precautionary (yellow zone) related to hospital admission. Resident remained COVID negative throughout stay. 2. We do not have any COVID positive Residents or Staff in the facility. Resident #1 was independent with dressing and grooming and had placed dirty clothes in the trash bag for the aide to pick up and take to laundry. The aide pulled the privacy curtain and closed the door to provide privacy during dressing and remained at least 6 ft away from resident. Resident remained on Yellow Zone prior to discharge due to frequent appointments outside the facility. For corrective action purposes all Residents in Yellow zone were assessed with no negative outcomes noted.	8/26/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Penny Upton, LNHA	Administrator	8/25/2020

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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F 880	Continued From page 1 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 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 880	3. All staff (licensed and unlicensed including administration, nurses, aides, maintenance, therapy, dietary and housekeeping) watched the following training course: Keep COVID-19 Out! https://youtu.be/7srwrF9Gdw. They also received copies of Facemask dos and don'ts from: https://www.ckc.gov/coronavirus/2019-ncov/downloads/hcp/fs-facemask-dos-donts.pdf. The training will be completed on Aug 25, 2020 and is documented with sign in sheets and a staff roster checklist. An attestation of training from the Director of Nursing, acting in the role of Infection Preventionist temporarily (IP is on leave) is attached hereto. All newly hired staff ,will be trained in orientation prior to working. Agency staff, if utilized, will be reeducated prior to working the floor. 4. SRNA #1 was properly trained per facility's policy regarding face shields on 8/5/2020 by the Director of Nursing. The Administrator and Director of Nursing reviewed https://www.cms.gov/Medicare/Provider-Enrollment-and Certification/QAPI/downloads/Guidance for RCA.pdf regarding RCA on 8/24/2020. The QAPI Committee and a member of the Governing Body met on August 6,2020 and performed a RCA regarding the deficiency. The RCA identified a need for additional reinforcement of proper utilization of face shields. Additional training was provided as specified in #3 above. The Director of Nursing or Unit Managers will perform random audits for Infection Prevention & Control, including the use of face shields, on Yellow Zone units 5 times weekly for one month and then weekly for three months. The DON and/or Unit Manager will report any concerns to Administrator immediately and reinforcement of policy with staff member immediately. The Administrator will report the findings to the QAPI Committee monthly for Three months for further review and any further recommendations.	

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F 880	Continued From page 2	F 880		

and review of the facility policy and Centers for Disease Control and Prevention (CDC) recommendations, it was determined the facility failed to prevent the possible spread of COVID-19. Observation on 08/05/2020 revealed State Registered Nurse Aide (SRNA) #1 was not wearing a face shield when exiting the room of Resident #1, who was under physician-ordered precautions/isolation.

The findings include:

Review of the facility policy, "Coronavirus Disease (COVID-19) Prevention and Control," March 2020, revealed the facility would follow current Centers for Disease Control and Prevention (CDC) guidelines for infection prevention and control.

Review of the website, https://www.cdc.gov/coroonavirus/2019-ncov/infection-control-recommendations.html, dated 07/15/2020, revealed staff who directly care for persons with suspected or confirmed COVID-19 infection would need to wear personal protective equipment (PPE) consisting of facial mask, gown, gloves, and eye protection (face shield).

Observation of double doors prior to entering rooms 200-211, during initial tour, revealed a sign on the door that stated Yellow Zone. There were also gowns and gloves outside the double doors. Prior to entering this area, this surveyor was provided with a face shield.

Observation on 08/05/2020 at 9:10 AM revealed SRNA #1, assigned to the Yellow Zone, was exiting the room of Resident #1 and was not wearing a face shield (eye protection).

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F 880	Continued From page 3	F 880		

Continued From page 3

Review of the medical record revealed Resident #1 was admitted to the facility on 01/31/2020 and had diagnoses of Malignant Neoplasm Base of Tongue, Gastrostomy status, and Unspecified Severe Protein-Calorie Malnutrition. The record also revealed the resident had been readmitted to the facility on 07/08/2020 from an acute care facility. Further review revealed a physician order, dated 07/22/2020, stating the resident was to be under Droplet/Contact/Eye Protection Precautions. The medical record also revealed the resident had tested negative for COVID-19 on 07/17/2020 and 07/29/2020.

Interview with the Administrator on 08/05/2020 at 8:55 AM, revealed the facility had three zones; the Green Zone housed those residents without suspicion of COVID-19 and did not leave the facility frequently. The Yellow Zone housed those residents who had to leave the facility frequently due to physician appointments and dialysis. The Red Zone was the dedicated COVID-19 unit and the residents there had all tested positive for COVID-19 and were still in the recovery phase.

Interview with SRNA #1 on 08/05/2020 at 9:10 AM revealed she could not find her face shield. She stated she usually worked the Red Zone and her equipment was on that unit. When asked if she had asked anyone for a face shield she replied that she had not. She further revealed that face shields were required in the Yellow Zone.

Interview with SRNA #2 on 08/05/2020 at 10:44 AM, working in the Green Zone, revealed that she was instructed to wear a face shield whenever providing care to a resident and that face masks

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F 880	Continued From page 4 were required at all times. Interview with Licensed Practical Nurse (LPN) #1 on 08/05/2020 at 9:00 AM, assigned to the Yellow Zone, revealed the PPE required in this area was a gown, gloves, face mask, and face shield. She stated there were currently three (3) residents in this area and two (2) of them required dialysis. Interview with LPN #2, agency staff, on 08/05/2020 at 10:35 AM, revealed she had been instructed that while working the Green Zone she had to wear a mask at all times and when performing resident care she would need to don a face shield. Interview with Registered Nurse (RN) #1 on 08/05/2020 at 9:20 AM revealed a face shield must be worn when providing resident care. RN #1 was observed exiting a room on the Green Zone, wearing a mask and face shield. Per the RN, he had been performing oral care. Interview with the Director of Nursing (DON) on 08/05/2020 at 10:50 AM, revealed the Infection Preventionist is on medical leave and she is currently performing those duties. The DON reviewed the three (3) separate areas of the facility at present. The DON stated the Red Zone housed those residents who were COVID-19 positive and the required staff PPE was gown, glove, mask, and face shield. The Yellow Zone was for those residents who had been readmitted or required frequent travel outside the facility and the PPE requirements were the same as the Red Zone. The Green Zone was for those residents who had tested negative and were displaying no symptoms of COVID-19. She stated the Green Zone required face masks at all times and face	F 880		

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F 880	Continued From page 5 shields when providing direct resident care. The DON stated the SRNA should have donned a face shield on the Yellow Zone as that is the required PPE for that area. The DON also revealed they perform routine surveillance, a couple of times a day, for proper PPE wear and handwashing and stated any issue observed is remediated at that time.	F 880		

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E 000	Initial Comments A COVID-19 focused Emergency Preparedness survey was conducted on 08/05/2020. The facility was found to be in compliance with 42 CFR 483.73 Emergency Preparedness related to E0024. No deficient practice was identified.	E 000		

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Office of Inspector General

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N 000	Initial Comments A COVID-19 focused infection control survey was conducted on 08/05/2020. Deficient practice was identified pursuant to 42 CFR 483.80.	N 000		

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