STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185252	A. BUILDING _____ B. WING _____	**05/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHADY LAWN NURSING AND REHABILITATION CENTER	**2582 CERULEAN ROAD CADIZ, KY 42211**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, was determined the facility failed to ensure infection control practices were implemented. The Advanced Registered Nurse Practitioner (ARNP) failed to remove personal protective equipment (PPE) prior to leaving a resident's room where the resident was on isolation precautions. The findings include: Review of facility policy titled, Novel Coronavirus last revised 03/25/2020, revealed isolation gowns should be removed before leaving the patient care area to prevent possible contamination of the environment outside the patient's room. Remove PPE at doorway before leaving patient room or in anteroom, which includes gown, gloves, goggles, and mask. Review of facility policy titled, Personal Protective Equipment Guidance for COVID 19, revealed to remove all PPE before exiting the room except for respirator. Observation on 05/21/2020 at 10:30 AM revealed the ARNP exited Resident #1's room who was on isolation precautions wearing PPE (gown gloves, and mask), then removed the PPE outside of the room. The ARNP stood outside of Resident #1's room door, looked at surveyor, and stated she did not see the bin to dispose of the PPE in the room, only a red bin that had dirty linen written on it. ARNP was then observed to roll up PPE in her hands and go down hall to the back exit hallway and then go back up the hall past Resident #1's room and ask the Activities Director about disposal of the PPE, The ARNP then walked past the next room (room past Resident #1's room) to ask an aide about disposal of PPE. Certified Nursing Assistant (CNA) #2 informed the ARNP, the PPE disposal bin should be in Resident #1's room. The ARNP then returned to Resident #1's room donning another set of PPE and went in the room to dispose of the PPE she was wearing and the PPE still in her hand. Interview with the ARNP, on 05/21/2020 at 4:08 PM revealed she normally takes off PPE at the door and normally there is a red bag to drop the used PPE in, but she did she did not see one in Resident #1's room. The ARNP stated that she had the PPE in her hand and went to the left where no other patient rooms were located. The ARNP revealed the PPE is usually taken off in resident room and disposed of in resident room. Interview with Registered Nurse (RN) #1 on 05/21/2020 at 3:40 PM revealed, if have PPE on in a room, staff should take the PPE off in the room and put in the red bag before exiting the room. Review of Specific Facts provided to state entity on 05/22/2020 by Administrator revealed: Psychiatric ARNP donned PPE and entered Resident #1's room (located at the very end of the hallway) to visit a resident for an assessment. It should be noted that this resident is a [MEDICAL TREATMENT] patient, and is in an observation room as a precautionary measure due to required trips to [MEDICAL TREATMENT]; upon exiting the room, the ARNP doffed the PPE and was unable to locate the red trash bin. Unknown to the ARNP, Resident B (roommate/spouse) had moved the red trash bin into the bathroom as the ARNP was preparing to leave the room. ARNP reports stepping out of the room with clean gloves to go dispose of PPE in the Janitor closet next door, which was locked. The ARNP immediately returned to room, donned new PPE and discarded all PPE (prior use PPE and the PPE just donned) properly in the red bin, and exited the room. Again, this room is considered observation, with isolation PPE in use only as precaution for the [MEDICAL TREATMENT] resident. Interview on 05/21/2020 at 3:15 and on 05/21/2020 at 3:17 PM with Administrator and Director of Nursing (DON) revealed Resident #1 was on isolation precautions as she was a [MEDICAL TREATMENT] patient and left the facility routinely for [MEDICAL TREATMENT]. The Administrator stated all resident that leave the facility on [MEDICAL TREATMENT] are placed on isolation precautions. The DON and Administrator further revealed PPE is to be removed at the door and disposed of inside the resident's room, before exiting. The Administrator stated it is not acceptable to be going up/down the hallway carrying PPE.

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.