STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185173	A. BUILDING _____ B. WING _____	**09/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CUMBERLAND NURSING AND REHABILITATION CENTER	**200 NORFLEET DRIVE SOMERSET, KY 42501**

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 -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of the facility's policies/procedures, it was determined the facility failed to prevent the possible spread of COVID-19. Observations on 09/08/2020 revealed a nurse on the facility-designated COVID Unit entering a resident's room, who was on transmission-based precautions, without donning the required Personal Protective Equipment (PPE). Housekeeping staff was observed on the B Hall with a mask positioned below the nose. In addition, laundry staff was observed on 09/08/2020 to transport a laundry cart from the designated COVID Unit and enter the designated clean side of the laundry without cleaning or sanitizing the cart. The findings include: A review of the infection control policy titled, Infection Prevention and Control Policy and Procedure, with a revision date of 03/25/2020, revealed the facility will conduct infection control and prevention strategies to reduce the risk of transmission of the novel [MEDICAL CONDITION] (COVID-19). A review of the facility guidance for use of Personal Protective Equipment (PPE) for patients who were COVID positive revealed staff were required to wear Full PPE, to include eye protection, gown, gloves, and mask. All facility staff were required to wear eye protection and a mask at all times because the facility has current active cases of COVID-19 in residents and staff. A review of the facility policy for transporting linen titled, Handling, Transport and Storage of Laundry, with a revision date of 07/22/2020, revealed laundry was required to be transported and handled by staff with appropriate measures to prevent cross-contamination. Further review revealed clean linen must always be kept separate from contaminated linen through the use of separate rooms or designated spaces to reduce the risk of accidental contamination. (a) Observation of the B Wing hall during an initial tour on 09/08/2020 at 10:12 AM revealed Housekeeper #1 wearing a K95 facemask positioned below the nose with nares exposed, mopping resident room B-9. An interview with Housekeeper #1 on 09/08/2020 revealed he was supposed to wear the mask covering his nose and mouth but had the mask pulled down so he could breathe easier. (b) Observations conducted on the facility-designated COVID Unit on 09/08/2020 at 10:45 AM revealed RN #1 entered room D-10 without donning a required gown and gloves. A sign was observed on the room door for transmission-based precautions. An interview with RN #1 on 09/08/2020 at 10:50 AM revealed the RN was not aware she was required to wear a gown when entering the resident rooms due to a recent change in the use of PPE on the COVID Unit. Per the RN, she had been trained on the use of PPE but was confused. (c) Observation on 09/08/2020 at 11:00 AM revealed a laundry staff person transporting a linen cart from the facility-designated COVID Unit to the clean side of the laundry without the cart being cleaned or sanitized. An interview with the Laundry Worker on 09/08/2020 at 11:00 AM revealed she was nervous because the surveyor was observing the COVID Unit. The Laundry Worker stated she did not realize she had entered the designated clean side of the laundry with the cart after leaving the COVID Unit. An interview with the Laundry/Housekeeping Supervisor on 09/08/2020 at 1:25 PM revealed staff were required to wear a mask at all times covering the mouth and nose, and use the required PPE when cleaning resident rooms based on the type of precautions the residents require. Further interview revealed any carts or equipment used for laundry on the COVID Unit was required to be cleaned/sanitized and should not be transported to the clean side of the laundry until cleaned/sanitized. According to the Laundry/Housekeeping Supervisor, she makes daily rounds to observe and monitor staff and to identify problems. The Laundry\Housekeeping Supervisor had not identified any concerns. Interview with the Director of Nursing on 09/08/2020 at 2:25 PM revealed nurses on the COVID Unit were required to wear a K95 mask and face shield at all times and were required to don a gown and gloves when entering resident rooms. The DON further stated the nurses were required to remove and discard the gloves and gown when exiting the resident rooms. According to the DON, since the facility no longer had a shortage of gowns, the facility was no longer reusing gowns and now used disposable gowns. The DON stated the change in PPE use (use of disposable gowns) had occurred last week and staff were trained on this change. Further interview with the DON revealed RN #1 should have donned a gown and gloves prior to entering room D-10. The DON stated she had not been on the COVID Unit to monitor and was not aware of any concerns. An interview with the Administrator on 09/08/2020 at 2:37 PM revealed the facility had experienced an outbreak of COVID-19 starting on 08/14/2020 when a resident tested positive. As of 09/08/2020, the facility had 39 current resident cases of COVID-19. Testing was being done weekly to identify any additional positive cases and if a resident tested positive, they were moved to the COVID Unit on the C and D Hall. According to the Administrator, she made rounds throughout the day in the facility to include the COVID Unit and addressed problems. However, the Administrator stated she was not aware of staff (RN #1 and Housekeeper #1) not utilizing PPE as required (masks, gown, and gloves) or of staff transporting a contaminated laundry cart to the clean side of laundry.

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