STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	04/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JOHNSON MATHERS NURSING HOME	2323 CONCRETE ROAD CARLISLE, KY 40311

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 interview, record review, review of the facility's policies, and review of the Center for Disease Control (CDC) guidelines, 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 disease and infections for one (1) of three (3) sampled residents (Resident #1). Staff interviews and record review revealed on 04/01/2020, Resident #1 had a change in condition including an elevated temperature of ninety-nine (99) degrees Fahrenheit and shortness of breath. A telehealth video conference was conducted in the resident's room with the Attending Physician/Medical Director on that date to assess the resident for COVID-19. During the video conference, the Physician noticed staff in the room were only wearing surgical masks and were not wearing proper Personal Protective Equipment (PPE) including N95 masks, gown, and gloves based on the symptoms the resident was presenting, as per the Center for Disease Control (CDC) guidelines. Additionally, physician's orders [REDACTED].#1 to be placed on Droplet Precautions. However, the resident was not moved to a private room until two (2) days later, on 04/03/2020. Furthermore, during the transfer, the resident was not wearing a facemask as required per CDC guidelines. The findings include: Review of the Long Term Care Facility Guidance Principle Inc, dated 04/03/2020, revealed Long Term Care facilities should ensure all staff are using appropriate Personal Protective Equipment (PPE) when they are interacting with patients and residents, to the extent PPE is available and per CDC guidance on conservation of PPE. Additionally, full PPE should be worn per CDC guidelines for the care of any resident with known or suspected COVID-19. Review of the facility's Pandemic Policy for Coronavirus 2020, revised 02/03/2020, revealed the purpose of the policy is to provide a safe and healthy workplace for all employees. The pandemic policy for coronavirus outlines our overall response based on CDC guidelines. This will be part of our emergency preparedness plan. This plan will guide you through steps to take to safeguard employees, and residents while ensuring Principle Long Term Care's ability to maintain essential operations. Prevention steps for people confirmed to have, or being evaluated for coronavirus include placing the resident on contact isolation (Droplet Precautions). Review of the Center for Disease Control (CDC) guidelines regarding droplet isolation revealed the following: CDC guidelines V.C.1. Use droplet precautions as recommended in Appendix A for patients known or suspected to be infected with pathogens transmitted by respiratory droplets (i.e., large-particle droplets >5 micrometer) that are generated by a patient who is coughing, sneezing or talking. CDC guidelines V.C.@.a.iii <mailto:V.C.@.a.iii>. Avoid placing patients on droplet precautions in the same room with patients who have conditions that may increase the risk of adverse outcome from infection or that may facilitate transmission (e.g., those who are immunocompromised, have or have anticipated prolonged lengths of stay). CDC guidelines V.C.4.b. If transport or movement in any healthcare setting is necessary, instruct patient to wear a mask and follow CDC's Respiratory Hygiene/Cough Settings. Review of Education and Training records, dated 03/01/2020 through 04/09/2020 revealed staff in all departments received ongoing training and education regarding the Pandemic Policy for Coronavirus 2020, to include PPE, handwashing and sanitizing, respiratory hygiene and strategies for minimizing the spread of COVID-19. Review of the Office of Inspector General (OIG) Intake Report, received 04/09/2020, revealed the facility called the Physician to assess a resident for COVID-19 and the Physician noticed during the telehealth video conference with the alleged resident (resident unknown) that the staff in the background were noticed to be without PPE for the resident who had symptoms of COVID-19. Interview on 04/13/2020 at 11:50 AM, with the Compliance Officer (CO) for the local hospital, revealed on 04/03/2020, the Medical Director of Johnson Mathers Nursing Home informed him he had a concern with an infection prevention practice he observed at Johnson Mathers. The CO stated the Medical Director conveyed that while conducting a telehealth video conference with the resident (resident unknown), the Physician observed staff in the room during the telehealth video conference were not wearing proper PPE for droplet isolation/precautions for a resident with suspected COVID-19. Review of Resident #1's medical record revealed the facility admitted the resident on 05/03/13 and readmitted the resident on 10/04/15 with [DIAGNOSES REDACTED]. Review of the Annual Minimum Data Set Assessment, dated 03/17/2020, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of fifteen (15) out of fifteen (15) indicating no cognitive impairment. Further review revealed the facility assessed the resident as having no infections. Review of Resident #1's Progress Note, dated 04/01/2020 at 14:07 (2:07 PM), written by Registered Nurse (RN) #1, revealed a new order was received by the Physician to place the resident on Droplet Precautions and to perform a flu swab X one (1). Per the Note, this was related to an elevated temperature of ninety-nine (99) degrees Fahrenheit, Blood Pressure (B/P) 128/65, Pulse-77, Respirations-20 and oxygen saturation ninety-four percent (94%) on two (2) liters of oxygen per nasal cannula. According to the Note, RN #1 notified the resident's responsible party of the clinical change and the new order. However, further review of the medical record, revealed there was no documented evidence Resident #1 was transferred to a private room on 04/01/2020 after receiving the orders for Droplet Precautions. Review of the Progress Note, dated 04/03/2020 at 12:46 PM, revealed Licensed Practical Nurse (LPN) #1 documented Resident #1's temperature increased to 100.6 degrees Fahrenheit. Per the Note, the resident was sitting up in the wheelchair eating lunch independently. Resident states he/she did not feel short of breath, but did have a sharp pain to the right side when taking deep breaths. Hand grips equal and strong, peripheral pulses palpable bilaterally. Resident continues to be lethargic, but was able to communicate with clear speech and understanding others. No [MEDICAL CONDITION] or cyanosis noted. Lungs continue to be diminished bilaterally with expiratory wheeze. Interview with LPN #1, on 04/14/2020 at 3:00 PM, revealed she was assigned to Resident #1 on 04/01/2020, and the resident had an increased temperature and shortness of breath on that date. Per interview, a telehealth video conference with the Attending Physician/Medical Director was conducted on 04/01/2020 and the Physician was quite upset that staff was not wearing correct PPE while in the room with Resident #1 who was suspected to have COVID-19. She stated she was wearing a surgical mask, not N95, and was wearing gloves and a gown during the telehealth video conference. Per interview, other staff in the room including RN #1, RN #2 and the Director of Nursing (DON) were only wearing a surgical mask, and no gloves or gown during the telehealth video conference. When questioned what PPE should be worn for a resident who was suspected to have COVID-19, she stated Droplet Precautions should be initiated with PPE including gowns, gloves, and N95 masks. Further interview with LPN #1, revealed after receiving orders for Droplet Precautions for Resident #1 on 04/01/2020, the resident should have been immediately moved to a private room; however, she did not immediately initiate this room change as she was waiting on the DON and Administrator's approval for the room change. LPN #1 stated Resident #1 was moved to a private room on 04/03/2020, and she witnessed the move on that date. Per interview, Resident #1 was not wearing a mask or any PPE during the move. When questioned about the need for PPE during the move as the resident would have been in the hallway, LPN #1 stated the Administrator told staff it was not necessary to have the resident wear PPE during the room change. She stated to her recollection she and other staff caring for the resident were wearing proper PPE for Droplet Precautions after the order was received on 04/01/2020. The State Survey Representative attempted to interview RN #2 via phone on 04/15/2020 at 11:30 AM; however, there was no answer and a message could not be left to return the call. Interview via phone on 04/15/2020 at 10:30 AM, with RN #1, revealed she was

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) in Resident #1's room during the telehealth video conference with the Attending Physician/Medical Director on 04/01/2020. She stated the telehealth video conference was initiated as the resident was suspected to have COVID-19. Per interview, all staff in the room during the telehealth video conference only had on surgical masks, not N95 masks, and staff was not wearing gloves, gowns, or eye shields. She stated the Physician became quite upset with staff for not wearing appropriate PPE for a suspected COVID-19 resident as they had been trained on COVID-19 and appropriate PPE to be worn. She further stated the Physician again educated the staff during the telehealth video conference on proper PPE. Further interview revealed orders were received during the telehealth video conference for Droplet Precautions for Resident #1. Further interview with RN #1, revealed after the orders were received for Droplet Precautions, the Administrator stated she would take care of moving the resident to a private room since it was time for change of shift; however, the resident was not moved to a private room until 04/03/2020. Continued interview revealed she did wear N95 mask, gown and gloves while caring for the resident after orders were received for Droplet Precautions; however, she did witness some staff was sloppy with isolation precautions and did not always wear proper PPE for this resident after the isolation orders were received on 04/01/2020. Interview with the Infection Control Nurse on 04/13/2020 at 3:24 PM, revealed she had been with the facility for two (2) years and had observed facility protocols to be effective. Per interview, the facility was implementing the infection control policy to its fullest and the facility had enough PPE available for staff. She stated it was her expectation staff follow facility policies and CDC guidance related to residents who were diagnosed with [REDACTED]. Further interview revealed it was her expectation that every suspected COVID-19 resident would be wearing PPE when transferred through the halls of the facility to include gown, gloves, and N95 mask. She stated Resident #1 should have been transferred immediately to a private room on 04/01/2020 when orders were received for Droplet Precautions. Interview on 04/13/2020 at 3:17 PM with the Director of Nursing (DON), revealed she was in the room with Resident #1 on 04/01/2020 during the telehealth conference. She stated she was wearing a surgical mask instated of a N95 mask during the telehealth video conference, and was not wearing gloves or a gown. She further stated she did not recall what PPE other staff was wearing during the telehealth conference as she was holding the phone and was focusing on the resident. Further interview with the DON, revealed staff should wear N95 mask, gown and gloves while caring for any resident with COVID-19 or during care for any resident with suspected COVID-19. Per interview, she should have ensured all staff in Resident #1's room on 04/01/2020 had on proper PPE during the telehealth video conference with the Attending Physician/ Medical Director, as the resident had suspected COVID-19 at the time. Further interview with the DON, revealed she should have ensured Resident #1 was moved to a private room on 04/01/2020 after orders were received for Droplet Precautions, and ensured appropriate isolation/Droplet precautions were being implemented for the safety of the residents and staff. Continued interview revealed she did assist with transferring Resident #1 to a private room on 04/03/2020, and the resident was not wearing a mask or PPE during the move. Per interview, she did not think about the need to ensure the resident was wearing a mask and PPE during the transfer, even though she was aware of the orders for Droplet Precautions. Interview via phone on 04/13/2020 at 4:40 PM, and 04/15/2020 at 8:30 AM, with Resident #1's Attending Physician/Medical Director, revealed he became very upset while evaluating Resident #1, via telehealth video conference, due to staff was not donned in contact or droplet PPE. He stated staff had on surgical masks instead of N95 masks, and no gloves or gowns were being worn. Per interview, when he questioned the staff as to why isolation was not being employed, he was told the Administrator told them the PPE they were wearing for this resident was adequate. He stated at that point, he educated them the PPE was not adequate for the resident who was suspected of having COVID-19. Per interview, he educated staff that they should be wearing N95 masks, gowns and gloves. He stated had previously educated staff extensively prior to this incident on the importance of adequate PPE for residents diagnosed with [REDACTED]. Further interview with the Attending Physician/Medical Director, revealed he was quite upset that Resident #1 had not been moved out of the semi-private room, to a private room, until two (2) days after he had ordered isolation for Droplet Precautions and he voiced his concerns to the Administrator. Per interview, he did not order a COVID-19 test for Resident #1 after his assessment, as a COVID-19 test was not warranted due to the resident's long history of allergies and respiratory issues. Interview via telephone interview on 04/15/2020 at 3:30 PM, with the Advanced Practice Registered Nurse (APRN), revealed she was in the facility and witnessed the Resident #1 being transferred to a private room on 04/03/2020. She stated the resident was not wearing a face mask and did not have a gown nor gloves on. She further stated during this transfer she asked why the resident did not at least have on a mask and the DON whispered to her that the Administrator said it would be fine to transfer the resident without a mask. Interview with the Administrator, on 04/13/2020 at 4:00 PM, revealed she was present in the facility on 04/01/2020 when the Physician ordered the Droplet Precautions for Resident #1. Per interview, staff in the room with Resident #1 during the telehealth video conference should have been wearing appropriate PPE for a suspected COVID-19 resident. The Administrator verified Resident #1 was in a semi-private room on 04/21/2020 at the time the orders were written, and was not moved to a private room until two (2) days later, on 04/23/2020. Per interview, just because Resident #1 was not in a private room did not mean the resident was not in Droplet Precautions/Isolation. However, she did acknowledge there could be transmission of infection if a resident ordered Droplet Precautions was in a semi-private room with a resident who was not ordered isolation precautions. Continued interview with the Administrator, revealed Resident #1 was wearing a mask when transferred to the private room on 04/03/2020; however, she could not recall if the resident was wearing a gown or gloves. Further interview revealed it was her expectation facility staff employ the CDC, local health department as well as facility policies in order to prevent the transmission of disease and infection.