STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185349	A. BUILDING _____ B. WING _____	**09/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT JEFFERSON PLACE REHAB & WE	**1705 HERR LANE LOUISVILLE, KY 40222**

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.** Based on observation, interview, and record review it was determined the facility failed to maintain and implement an effective infection prevention and control program to provide a safe, sanitary environment and help prevent the transmission of communicable diseases and infections, including the COVID-19 virus. Observations during survey revealed staff not wearing masks in the reception area of the facility. The findings include: Review of facility policy Novel Coronavirus (COVID-19), revised 08/18/2020, revealed the policy provided clarification of the steps the facility took to insure the health and safety of the facility's residents. In addition, review of the policy revealed for the duration of the state of emergency/COVID-19 pandemic, all direct care stakeholders wore a surgical facemask and face shield or goggles in the facility. Non-direct care workers utilized a microbe safety mask when working in non-resident care areas. Observation, on 09/08/2020 at 8:10 AM, upon entering the facility, revealed staff at a screening table and a receptionist behind a half wall and neither person was wearing a mask. Interview with the Receptionist, on 09/08/2020 at 9:30 AM, revealed it was her understanding she did not have to wear a mask when at her desk, not in a resident care area. Continued observation and interview with the Receptionist revealed without a mask she walked out from behind the half wall and directed the State Survey Agency staff down the hallway. The Receptionist stated it was important to wear masks to prevent transmission of disease between people. Interview with the Director of Nursing (DON), on 09/08/2020 at 2:00 PM, revealed everyone in the facility was to wear a mask even in the front area of the building. Additionally, the DON stated the receptionist should wear a mask as that position is in contact with multiple persons. The DON stated it was important to wear masks to prevent the spread of COVID-19. Interview with the Administrator, on 09/08/2020 at 2:00 PM, revealed his understanding of the mask policy was that staff did not have to wear a mask when not providing direct resident care.

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.