STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185408	A. BUILDING _____ B. WING _____	**07/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIBERTY CARE AND REHABILITATION CENTER	**616 S WALLACE WILKINSON BLVD LIBERTY, KY 42539**

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, record review, review of the facility's policies/procedures, and review of the Centers for Disease Control and Prevention (CDC) guidelines, it was determined the facility failed to prevent the possible spread of COVID-19. On 07/15/2020, two (2) State Registered Nurse Aides (SRNAs) were observed entering the room of a resident that had tested positive for COVID-19 without donning a face shield. One of the SRNAs (SRNA #1) exited the resident's room with a mechanical lift and transported the lift to the central shower without wearing gloves to protect her from transmitting COVID-19. Furthermore, the Housekeeping Supervisor and the Staff Development Coordinator (SDC) were observed transporting a resident (who was positive for COVID-19) out of his/her room to the COVID-19 Unit without placing a face mask on the resident until he/she was halfway down the hallway. The findings include: Review of the facility's policy, Isolation - Categories of Transmission-Based Precautions, with a revision date of October 2018, revealed when a resident was placed on droplet precautions a mask would be placed on the resident during transport from his/her room. Review of the facility's COVID-19 Guidelines, dated 06/29/2020, revealed if a person was confirmed to have COVID-19 the current recommendations were for airborne or droplet isolation precautions to include: single patient room in a dedicated COVID Unit and the patient must wear a mask until transported to an appropriate room. The guidelines further stated that staff were to wear eye protection when providing care to residents that were infected with COVID-19. Review of the CDC Guidance, Preparing for COVID-19 in Nursing Homes and Long-Term Care Facilities, updated 06/25/2020, revealed if transport personnel must prepare the patient for transport, personnel should wear all recommended PPE (gloves, a gown, respiratory protection that is at least as protective as a fit tested NIOSH (National Institute for Occupational Safety and Health) certified disposable N95 filtering face piece respirator, and eye protection (e.g., goggles or disposable face shield that covers the front and sides of the face)). This recommendation is needed because these interactions typically involve close, often face-to-face, contact with the patient in an enclosed space (e.g., patient room). Observations on 07/15/2020 at 11:21 AM revealed SRNA #1 and SRNA #2 entered Resident A's (who had tested positive for COVID-19 on 07/15/2020) room to transfer the resident with a mechanical lift from his/her bed to a wheelchair. Both SRNA #1 and SRNA #2 failed to don a face shield/eye protection prior to entering Resident A's room and while transferring the resident with a mechanical lift. Further observation at 11:32 AM revealed SRNA #1 transported the mechanical lift utilized for Resident A to the Central Shower without wearing gloves. Observation on 07/15/2020 at 11:40 AM revealed Resident A was being transported out of his/her room to the COVID-19 Unit by the SDC and Housekeeping Supervisor; halfway down the hallway the SDC realized Resident A was not wearing a face mask and then placed a face mask on Resident A. Interview with SRNA #1 on 07/15/2020 at 8:53 PM revealed she should have donned a face shield when entering Resident A's room and transferring the resident with a mechanical lift. She stated Resident A tested positive for COVID-19 on 07/15/2020 and was being transported to the COVID-19 Unit. She further stated she should have worn gloves when transporting the mechanical lift used with Resident A to the Central Shower to be disinfected to prevent transmitting [MEDICAL CONDITION]. She stated she received education on utilizing a face shield when providing care to a resident that was COVID-19 positive. Interview with SRNA #2 on 07/15/2020 at 7:48 PM revealed she should have worn a face shield when providing care to Resident A because the resident tested positive for COVID-19 that morning. She stated she was in-serviced to wear a face shield when providing care to COVID-19 positive residents. Interview with the Housekeeping Supervisor on 07/17/2020 at 2:48 PM revealed Resident A should have had a face mask on prior to exiting his/her room for transport to the COVID-19 Unit. Interview with the SDC on 07/17/2020 at 4:06 PM revealed staff should wear gloves when transporting a piece of equipment that was utilized with a COVID-19 positive resident to limit their exposure. She further stated that staff were required to wear all personal protective equipment including face shields when providing care to a resident that was COVID-19 positive. She stated Resident A should have had a face mask on when being transported from his/her room to the COVID-19 Unit and she realized halfway down the hall that he/she did not, therefore, she placed a face mask on the resident. Interview with the Director of Nursing (DON) on 07/17/2020 at 5:21 PM revealed staff should wear gloves when transporting equipment used on COVID-19 positive residents to be disinfected because the equipment was considered contaminated. She stated face shields were required for utilization when working with a resident that tested positive for COVID-19. Further interview with the DON revealed Resident A should have had on a face mask prior to being transported out of his/her room to the COVID-19 Unit.

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.