STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185474	A. BUILDING _____ B. WING _____	09/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE WILLOWS AT CITATION	1376 SILVER SPRINGS DRIVE LEXINGTON, KY 40511

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, record review, staff interview, review of Sanitizer Wipes Manufacturer's Product Information, and review of the facility policies entitled Enhanced Prevention and Control Program for COVID-19 and Guidelines for Donning and Doffing Personal Protective Equipment (PPE), the facility failed to 1) implement their policy to follow CDC (Centers for Disease Control and Prevention) guidelines to ensure disposable face shields were dedicated to one staff member when caring for two (2) of two (2) new admission sample residents on isolation precautions for unknown COVID-19 status (Resident #1 and #4). The facility did not have a procedure for sanitizing the foam headband or the securing strap of the disposable face shield between uses; which had the potential for cross contamination. The facility also failed to 2) ensure a staff member wore eye protection and performed hand hygiene when providing care to one (1) of two (2) new admission sample residents on isolation precautions for unknown COVID-19 status (Resident # 4). These failures occurred during a COVID-19 Pandemic. The findings include: 1. During an interview with the Director of Nursing on 9/8/20 at 3:15 p.m., she indicated that newly admitted residents, without COVID-19 symptoms, were placed on transmission based precautions in a private room for a 14 day observation period due to unknown COVID-19 status. Resident #1 was admitted on [DATE] and had unknown COVID-19 status. Review of the Physician Orders dated 9/1/20 revealed Resident #1 was on contact and droplet precautions. Resident #4 was admitted on [DATE] and had unknown COVID-19 status. Review of the Physician Orders dated 9/4/20 revealed Resident #4 was on contact and droplet precautions. Observation of the multi-drawer isolation cart, located in the hallway outside the entrance to Resident #1's room on 9/8/20 at 4:00 p.m., revealed two (2) unlabeled face shields stored on the handrail just above the isolation cart. Further observation revealed the face shields were made of a clear flexible plastic looking material, with a foam head band that would rest on the wearers forehead and an elastic looking strap that snapped onto each side of the top of the face shield to secure it to the wearers head. Observation of the multi-drawer isolation cart, located in the hallway outside the entrance to Resident #4's room on 9/8/20 at 4:01 p.m., revealed three (3) unlabeled face shields stored on the handrail just above the isolation cart. On 9/9/20 at 10:44 a.m. Therapy Staff Member #1 was observed wearing a face shield while standing in the doorway of Resident #4's room, with his back to the room's inside and facing out into the hallway. He then exited Resident #4's doorway, approached the isolation cart, located in the hallway just outside Resident #4's room, and with his back to the Federal Surveyor, he was observed placing the face shield inside the bottom drawer of the isolation cart without cleaning or sanitizing it. The face shield was not labeled with the wearer's name or date and was stacked on top of other face shields in the drawer. During an interview with Therapy Staff Member #1 on 9/9/20 at 10:45 a.m., he stated that he had sanitized the face shield while inside Resident #4's room. He indicated that he did not have a dedicated face shield to use and confirmed the shield area was supposed to be sanitized with a wipe before and after use. When informed that the Federal Surveyor observed him wearing and then placing the face shield in the drawer, without sanitizing, he maintained that he had previously sanitized the face shield. Further observation of the face shield revealed it did not appear wet. Therapy Staff Member #1 was then observed sanitizing the face shield. Review of the Manufacture's information for the sanitizing wipes used to disinfect the face shields revealed, May be used on hard nonporous surfaces. On 9/9/20 at 11:30 a.m., observation of the bottom drawer of isolation cart, located in the hallway outside Resident #1's room, with the Director of Nursing (DON), revealed multiple face shields stacked on top of each other. Further inspection of two (2) of the face shields revealed the plastic shield area appeared unclear with one of the two obscured by a cloudy residue/film. The DON acknowledged the face shield with residue was not useable and needed replacement. The DON further revealed that staff did not have dedicated face shields due to the difficulty in storing them if each staff member had their own. During an interview with the DON on 9/11/20 at 8:00 a.m., she acknowledged that the facility did not have a method to adequately sanitize the foam head band on the disposable face shields between uses by more than one staff member. Review of the facility policy entitled, Enhanced Prevention and Control Program for COVID-19 revealed Refer to CDC updated guidance for Optimizing Strategies for PPE (Personal Protective Equipment) https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html. Review of the above referenced CDC document dated July 16, 2020 entitled, Optimizing Supply of PPE and Other Equipment during Shortages revealed a link to specific guidance regarding face shields in a document, dated June 28, 2020 entitled, Strategies for Optimizing the Supply of Eye Protection. Review of this guidance revealed, If a disposable face shield is reprocessed, it should be dedicated to one HCP (Health Care Professional) and reprocessed whenever it is visibly soiled or removed (e.g., when leaving the isolation area) prior to putting it back on. 2. On 9/9/20 at 9:00 a.m. Licensed Practical Nurse #1 (LPN #1) was observed in Resident #4's room wearing a gown, gloves, and a KN95 mask. She was not wearing eye protection. LPN #1 was standing approximately two feet in front of the resident and administering medication. Upon exiting Resident #4's room, LPN #1 did not perform hand hygiene after doffing her personal protective equipment (PPE) or before donning clean gloves and sanitizing the vital sign machine, she had been using in the room. Observation of the Droplet Precautions signage on the door to Resident #4's room revealed eye protection was required. During an interview with LPN #1 on 9/9/20 at 9:04 a.m., she stated that she should have worn a face shield when she went in Resident #4's room and a surgical mask over her KN95 but didn't because there were none available on the isolation cart. Observation of the isolation cart outside Resident #4's room on 9/9/20 at 9:05 a.m., revealed there was a stack of surgical masks in the top drawer and approximately five (5) face shields stacked on top of each other in the bottom drawer. The face shields were unlabeled and appeared previously used. During an interview with the Director of Nursing (DON) on 9/10/20 at 9:00 a.m., the DON stated that LPN #1 should have worn eye protection when in Resident #4's room providing medications and should have performed hand hygiene immediately after removing her gown and gloves. Review of the facility document entitled, Guidelines for Donning and Doffing Personal Protective Equipment (PPE) revealed Immediately perform hand hygiene after removing any PPE.

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