

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185065	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/12/2024
NAME OF PROVIDER OR SUPPLIER  Landmark of Lancaster Rehabilitation and Nursing C		STREET ADDRESS, CITY, STATE, ZIP CODE  308 West Maple Avenue Lancaster, KY 40444	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>49360</p> <p>Based on observation, interview, and facility policy review, the facility failed to provide a safe, clean, comfortable, and homelike environment.</p> <p>Observation during initial tour of the facility, on 07/09/2024 from 8:30 AM until 9:55 AM, revealed resident room doors had scuff marks at the bottom of the doors; resident rooms and bathrooms had scuff marks on the floors; resident rooms had sticky floors, and there was a strong urine odor. This affected Rooms and/or bathrooms for PN9, PN10, PN12 PN13, PN14, PN15, PN16, and PN17.</p> <p>Additionally, observation on 07/09/2024 at 9:15 AM, of the flooring outside Room PN13, revealed the white tile and brown flooring was chipped at the entrance to the room.</p> <p>The findings include:</p> <p>Review of the facility's policy, titled Resident Rights, effective 11/28/2016, revealed the facility must provide residents with a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Review of the facility's Memorandum on Preventive Maintenance Program, revised 08/18/2014, revealed maintenance staff would check all nurses' stations and housekeeping carts during morning rounds to pick up the Maintenance Request Logs and take care of the requests as time allows. Continued review revealed if an issue was urgent in nature, it would be addressed immediately.</p> <p>Review of the facility's Environment of Care Procedure for Cleaning Residents' Rooms, undated, revealed the facility had a purpose to provide a clean, attractive, and safe environment for residents, visitors, and staff. Continued review revealed the facility used basic disinfectant to clean surfaces and floors. Additionally, housekeeping staff would immerse the mop in the bucket of disinfectant cleaner and wring it out, but the mop should be wet enough to allow the disinfectant cleaner to dwell on the floor, which allowed the disinfectant to work.</p> <p>Observation on 07/09/2024 of Room PN9 at 8:30 AM; Room PN15 at 9:22 AM; and Room PN17 at 9:48 AM, revealed the rooms had sticky floors.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 07/09/2024 of the bathroom in Room PN9 at 8:43 AM; bathroom in PN10 at 8:50 AM; bathroom in PN14 at 9:14 AM; bathroom in PN13 at 9:20 AM; and bathroom in PN15 at 9:24 AM, revealed strong urine odors.</p> <p>Observation on 07/09/2024 of the doors for Room PN10 at 8:44 AM; and PN12 at 9:07 AM, revealed scuff marks on the bottom of both doors.</p> <p>Observation on 07/09/2024 at 9:15 AM, revealed the white tile and brown flooring was chipped at the entrance to Room PN13.</p> <p>Observation on 07/09/2024 at 9:27 AM, of the flooring in Room PN16; and at 9:55 AM, of the bathroom flooring in room PN17, revealed scuff marks on the floors.</p> <p>During interview with Resident (R)12, on 07/09/2024 at 8:34 AM, she stated the floor in her room was usually sticky. R12 further stated, they mop it sometimes, but it's dirty water. You can't clean with dirty water.</p> <p>During an interview with R29, on 07/09/2024 at 9:27 AM, she stated the scuff marks on the floor in her room had been there since her admission to the facility in January 2024. R29 stated the staff told her the scuff marks were made when the bed was moved and the wheels of the bed scuffed the floor.</p> <p>During an interview with State Registered Nursing Assistant (SRNA)2, on 07/09/2024 at 8:56 AM, she stated she had seen the scuffed marks and the chipped flooring, but she figured someone else had already reported this and therefore she didn't fill out a work order. SRNA2 stated she could smell the urine smell in rooms on the PN unit. She further stated most residents on the PN unit were able to take themselves to the bathroom and some residents did not flush the commode afterwards, which resulted in the urine scent.</p> <p>During an interview with Licensed Practical Nurse (LPN)3, on 07/10/2024 at 8:56 AM, she stated she had worked in the facility since November 2023 and most of the scuffed areas on the doors and floors had been there since she was hired. Further, she stated she was aware of the chipped tile and flooring. LPN3 stated she had noticed these environmental issues in the facility, and although she had received education related to filling out work orders and turning them in during orientation, she had not filled out a work order on any of these concerns. She further stated she had told housekeeping about the sticky floors and the urine smells and they would clean the resident rooms, but the floors were still sticky. LPN 3 stated she felt the urine smell was due to residents who were incontinent and dribbled on themselves.</p> <p>During interview with LPN4, on 07/10/2024 at 10:05 AM, she stated she was educated in orientation over work orders. LPN4 stated she was trained on how to fill one out, and where to put it for maintenance staff. LPN4 stated she was not aware of the chipped tile and flooring and therefore and not completed a work order for those issues. She further stated she had noticed the sticky floors. LPN4 stated she saw housekeeping sweeping and mopping the floors, but it didn't seem to help with the sticky floors. LPN4 stated she had nasal issues and could not smell any urine scent.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with Housekeeper (HSKP)1, on 07/09/2024 at 10:01 AM, she stated she could smell urine in the hallway and she was in the process of cleaning and mopping. HSKP1 stated she thought the stickiness of the floors was due to the type of disinfectant they had to use on the floors, but she had not reported the issue to anyone because she thought staff knew this about the floors. She stated housekeeping staff cleaned and mopped the resident rooms and bathrooms daily, and at intervals the rooms and bathrooms were deep cleaned which involved moving the furniture around and cleaning everything in the room, and mopping and dusting. HSKP1 stated she had not paid attention to the chipped tile and flooring, but was aware of the scuffed areas on the hallway and in resident rooms. HSKP1 stated the scuff marks were from staff moving the beds in the rooms.</p> <p>During an interview with the Maintenance Director, on 07/12/2024 at 2:06 PM, he stated he had worked in the facility since 2006. He further stated he was also head of housekeeping at the facility. Per interview, the facility had recently implemented the technology for safer environment and life safety compliance (TELS), which was a computer program designed for staff to place work orders for maintenance staff to review what needed repaired in the facility. However, he stated the facility was still using paper work orders during the transition phase. The Maintenance Director stated there were no current work orders for environmental issues in the facility on the TELS system or the paper system.</p> <p>During continued interview with the Maintenance Director, on 07/12/2024 at 2:06 PM, he stated he made rounds daily in the facility, but relied on the floor staff to report any environmental issues. He stated he just mainly looked at the bigger issues for concerns like plumbing or ceiling issues and did not pay attention to the floors which had been chipped. He stated he planned on bringing up these new issues in the next morning meeting with the rest of the team. He stated his staff had recently started painting scuffed areas on the doors, but no other environmental issues were on the table to be fixed at this time. The Maintenance Director stated he tried to spot paint areas monthly, but it did not always happen. In further interview, he stated the housekeeping staff would deep clean two (2) rooms monthly, but would deep clean rooms as needed. He stated deep cleaning involved pulling out all of the furniture and cleaning the floors, dusting the shelves, and cleaning the bathroom commodes along with bathroom flooring.</p> <p>During an interview with the Director of Nursing (DON), on 07/12/2024 at 3:02 PM, she stated she expected the residents to have a safe, clean environment. The DON stated she expected her staff to alert the maintenance staff and the housekeeping staff for any issues, in order for repairs or housekeeping issues to be taken care of in a timely manner. The DON stated she was not aware of any environmental issues in the facility, but the facility did have normal wear and tear as it was an older building. The DON further stated she was unaware of the sticky floors but she was aware of the urine smell which she attributed to routine incontinence care of the residents.</p> <p>During an interview with the Administrator, on 07/12/2024 at 4:20 PM, she stated the residents had the right to a comfortable and clean environment. She stated she made rounds daily in the facility and talked with the residents and staff. The Administrator stated she expected her staff to fill out work orders for any repairs or maintenance needed in order for maintenance staff to address these concerns. When questioned about the sticky floors in resident rooms and bathrooms and the urine scent, she stated housekeeping staff worked hard to keep the facility clean. She stated the residents had the right to a comfortable and clean environment.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>44974</p> <p>Based on observation, interview, and review of facility policy, the facility failed to ensure residents receive food and drink at a safe and appetizing temperature.</p> <p>Observation on 07/09/2024 at 12:50 PM, of the lunch test tray, revealed the following temperatures: milk 55.5 degrees Fahrenheit (F), juice 57 degrees F, and pureed pork tenderloin 110-degrees F. Point of service temperature for the pureed pork tenderloin was not hot enough; and point of service temperatures for the milk and juice were not cold enough, resulting in these temperatures being in the danger zone.</p> <p>The findings include:</p> <p>Review of facility's policy titled Food Storage, dated 08/12/2023, revealed all food stock and prepared food products are to be stored at safe temperatures ranges at all times. However, the policy did not address what point of service temperatures should be.</p> <p>A policy related to food temperatures at point of service was not submitted for review.</p> <p>Review of <a href="https://www.fda.gov/food/buy-store-serve-safe">https://www.fda.gov/food/buy-store-serve-safe</a>, content current as of 03/05/2024, revealed per the Food and Drug Administration (FDA), keep hot foods at 140 F or warmer, and cold foods at 40 F or colder. The Danger zone is 40-140 degrees F.</p> <p>Review of Resident Counsel Minutes, dated February 2024, revealed concerns with food not cooked properly.</p> <p>Review of Resident Counsel Minutes, dated March 2024, revealed concerns of cold food, soggy bread, and tough hamburger.</p> <p>Review of Resident Counsel Minutes, dated April 2024, revealed concerns of cold burgers and hard bread.</p> <p>During interview, on 07/09/2024 at 9:27 AM, with Resident (R) 37, he stated the eggs were not hot, and he would like another piece of toast. The resident was sitting up in bed eating breakfast which consisted of cereal, eggs, coffee, juice, milk, and chopped/minced bacon in a bowl.</p> <p>During the Group Interview, conducted by the State Agency Representative, on 07/10/2024 at 2:00 PM, interviews with residents revealed food such as hamburgers were served too cold to taste good. Further interview revealed portion sizes were too small, and milk and juices were not cold.</p> <p>(continued on next page)</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation on 07/09/2024 at 12:50 PM, of the last meal tray on the last food cart (test tray), which was removed from an insulated meal cart, revealed temperatures as follows: milk 55.5 degrees Fahrenheit (F), juice 57 degrees F, pureed pork tenderloin 110 degrees F, pork tenderloin slices 135 degrees F, chopped meat 140 degrees F, mashed potatoes 145 degrees F and sweet potato 172.9 degrees F. Therefore, the point of service temperature for the pureed pork tenderloin was not hot enough; and the point of service temperatures for the milk and juice were not cold enough, resulting in these temperatures being in the danger zone.</p> <p>During an interview with the Dietary Manager (DM), on 07/09/2024 at 5:50 PM, he stated there had been a shortage of milk cartons, and he would need to keep the milk on ice in order for it to maintain the appropriate temperature after being placed on the cart. In continued interview, he stated he would have to check the temperatures of the meat more often to ensure it stayed above the recommended temperatures. The DM further stated when hot food temperatures dropped to dangerous levels or if cold food/drink temperatures were not held at a cold enough temperature, it could cause food borne illnesses to residents. During further interview, he stated it was his responsibility to keep the food temperatures within normal limits and out of the danger zone. Per interview, he had only been in this position for a month, and was working on properly training dietary staff.</p> <p>During an interview, on 07/10/2024 at 9:18 PM, with Cook1, she stated the steam table kept the temperatures about 189 degrees F, which was the desired temp. Cook1 stated she would check the well water temperature before she put the food into the steamer to make sure it was at least 182 degrees or more; then she would check the food temperatures right before she plated the food for the first cart only and write the food temperatures down on the production sheet/log. Cook1 stated the steam table would keep food hot for an hour and half, and then the meat temperatures would decrease. She further stated when the temperatures dropped below safe levels, she could not serve the food, because residents could get sick.</p> <p>During interview, with the Regional Dietary Manager (RDM), on 07/12/2024 at 3:45 PM, she stated she had recently started in her position, and had not yet been to the facility. She further stated the Dietary Manager received the new education/training packets for the dietary staff and was responsible for providing that education. Per interview, the requirements for training included three (3) days of onsite training for the cooks, and two (2) days of onsite training for the Dietary Aides (DA). The RDM stated she was not sure if the Dietary Manager had started the training, as he was fairly new to the position.</p> <p>Attempts to contact the Dietician by phone, on 07/10/2024 at 8:09 PM, and 07/11/2024 at 4:53 PM, were unsuccessful. Interview with the Administrator, on 07/09/2024 at 6:00 PM, revealed the facility Dietician was out of the country at this time.</p> <p>During further interview with the Administrator, on 07/09/2024 at 6:00 PM, she stated it was her expectation appetizing and palatable food and drink was served to residents to encourage them to increase the amount they ate and drank. Improved nutrition and hydration status could help prevent, or aid in the recovery from illness or injury. She further stated it was her expectation all meals be served within optimal temperature ranges. The Administrator stated, failure to maintain temperatures at optimal temperatures could result in residents becoming ill.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44974</b></p> <p>Based on observation, interview, and review of facility policies, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety.</p> <p>Observation during the initial kitchen tour, on [DATE] starting at 8:25 AM, revealed the reach in refrigerator contained a bottle of chocolate syrup, a container of cottage cheese, a one (1) pound bag of shredded cheddar cheese, two (2) 32 ounce containers of dairy drink, two (2) gallons of whole milk, one (1) box of cake mix, and a two (2) pound bag of powdered sugar which were all opened and were not labeled with the date opened. Also, there was a one (1) gallon jug of thousand island dressing and a quart of sour cream which were both opened and were not labeled with the date opened and both items were expired according to the manufacturer's expiration date.</p> <p>Additionally, observation during the initial kitchen tour, on [DATE], revealed the walk-in refrigerator, contained a cart with eight (8) trays containing cups of pre-poured portions of juice, tea, and milk without secure covers; lids were either off or floating in the beverage. Also the walk-in refrigerator contained two (2) opened gallon jugs of milk with no opened date; and a tray with two (2) fruit cups and three (3) cups of applesauce which were opened and uncovered.</p> <p>Also, observation during the initial kitchen tour, on [DATE], of the walk in freezer, revealed an opened blue plastic bag containing mixed frozen vegetables, with no opened date.</p> <p>Further observation during the initial kitchen tour, on [DATE], revealed the filter on the juice dispenser was covered with gray matter.</p> <p>Moreover, observation on [DATE] at 11:55 AM, during the lunch tray line, revealed the same cups of pre-poured portions of juice, tea and milk cups that were in the walk in refrigerator earlier during initial tour, without secure covers, were being placed on resident trays. The loose and missing lids were placed on the cups as the drinks were placed on the residents' trays.</p> <p>Furthermore, observation on [DATE] at 4:50 PM, revealed Cook1 left the steam table, going to the clean dish area with gloves on to obtain clean dishes; and then returned to the steam table without performing hand hygiene and donning new gloves.</p> <p>Additionally, observation on [DATE] at 4:50 PM, revealed Dietary Aide6, who had a beard, was observed plating beans in bowls during tray line without wearing a beard guard or hair net.</p> <p>In addition, observation on [DATE] at 5:15 PM, revealed Dietary Aide1 placed drinks and utensils on the meal trays during tray line without wearing gloves; and was observed pulling at or touching mask and/or face.</p> <p>The findings include:</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>1. Record review of the facility document titled, Dietary Manager Responsibility, undated, revealed it was the Dietary Manager's (DM) responsibility to ensure all food was stored properly, covered, labeled, dated, and outdated food removed.</p> <p>Review of the facility's policy titled, Labeling and Dating Foods, reviewed [DATE], revealed the purpose of the policy was to decrease the risk of food borne illness. Foods are labeled with the date received, the date opened and the date by which the item should be discarded. Once opened these items are refrigerated and labeled with the date opened and with discard or use by date. Bulk condiments with a Best if Used By date such as catsup, mustard and salad dressings are shelf stable for longer periods as indicated by Best if Used By date.</p> <p>Observation during the initial kitchen tour, on [DATE] starting at 8:25 AM, revealed the following:</p> <p>Observation of the reach in refrigerator revealed a bottle of chocolate syrup, a container of cottage cheese, a one (1) pound bag of shredded cheddar cheese, two (2) 32 ounce containers of dairy drink, two (2) gallons of whole milk, one (1) box of cake mix, and a two (2) pound bag of powdered sugar, which were all opened and were not labeled with the date opened or date by which the item should be discarded. Additionally, a one (1) gallon jug of thousand island dressing and a quart of sour cream were both opened and were not labeled with the date opened or date by which the item should be discarded; and both items were expired according to the manufacturer's expiration date.</p> <p>Observation of the walk-in refrigerator, revealed a cart with eight (8) trays containing cups of pre-poured portions of juice, tea, and milk without secure covers; lids were either off or floating in the beverage. Several cups in the trays were standing in the liquid. Also noted in the walk-in refrigerator were two (2) opened gallon jugs of milk with no opened date or date by which the item should be discarded. Additionally, there was a tray with two (2) fruit cups and three (3) cups of applesauce which were opened and uncovered.</p> <p>Observation of the walk in freezer, revealed an opened blue plastic bag containing mixed frozen vegetables, with no opened date or date by which the item should be discarded.</p> <p>2. Further observation during the initial kitchen tour, on [DATE] starting at 8:25 AM, revealed the filter on the juice dispenser was covered with gray matter.</p> <p>3. Observation on [DATE] at 11:55 AM during the lunch tray line, revealed the same cups of pre-poured portions of juice, tea and milk cups that were in the walk in refrigerator earlier during initial tour without secure covers, were being placed on resident trays. The loose and missing lids were placed on the cups as the drinks were placed on the residents' trays.</p> <p>4. Observation on [DATE] at 4:50 PM, revealed Cook1 was behind the steam table preparing trays. Cook1 left the steam table going into the clean dish area with gloves on, to obtain clean dishes. She then returned to the steam table without washing hands and changing gloves.</p> <p>During interview with [NAME] 1, on [DATE] at 4:50 PM, she stated she was unaware she could not leave the steam table to go get clean dishes. She then stated, by leaving the steam table and coming back without washing her hands and changing gloves, she could contaminate the food and cause residents to become sick.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>5. Review of the facility's policy titled Hair Restraints/Jewelry/Nail Polish, revealed Food and Nutrition Services employees shall wear hair net, hat, or hair restraint at all times. The policy did not address beard nets.</p> <p>Observation on [DATE] at 4:50 PM, revealed Dietary Aide6, who had a beard, was observed plating beans in bowls during tray line without wearing a beard guard or hair net.</p> <p>During interview with Dietary Aide (DA)6, on [DATE] at 6:00 PM, he stated he didn't know he was to wear a beard guard and hair net. However, he stated he could see how by not wearing the beard guard and hair net, hair could fall into the food. He stated he had some training related to dietary sanitation, but couldn't recall when he received the training.</p> <p>6. Observation on [DATE] at 5:10 PM, revealed Dietary Aide1 placed drinks and utensils on the meal trays during tray line without wearing gloves. Additionally, Dietary Aide1 was observed pulling at or touching mask and/or face.</p> <p>During interview with the Dietary Manager, on [DATE] at 6:15 PM, he stated he had only been in his position for a month, and he was working on getting everything in the kitchen in order. He stated it was his responsibility to make sure all food was dated when opened with the opened date, prior to placing it back in the refrigerators and freezers. Further, he stated any foods or drinks should be sealed properly before placing them in the refrigerators or freezer. Per interview, the cups of pre-poured milk and juice which did not have tight lids and were not properly sealed, should have been disposed of and should not have been served during the lunch meal on [DATE]. Furthermore, he stated the juice dispenser should have been cleaned, and he was working on creating a schedule of duties for kitchen staff.</p> <p>Additional interview with the Dietary Manager, on [DATE] at 9:35 AM, revealed all dietary staff needed to wear a hair net or a hat, and if they had a beard, they were to wear a beard net. In continued interview, he stated it was his expectation food was stored, prepared and served in a sanitary manner to prevent cross contamination. He further stated he had a certification in Serve Safe and Food Handler, and would be training dietary staff on kitchen expectations and infection control. He stated it was his expectation staff followed dietary policies.</p> <p>During interview with the Administrator, on [DATE] at 10:30 AM, she stated it was her expectation dietary staff wore hair nets or hats; and wore beard guards when they had a beard. Further, she stated when dietary staff was working behind the steam table, and moved to another part of the kitchen, they were to wash hands and don new gloves prior to working at the steam table again. In continued interview, she stated dietary staff was to wear gloves when working in the kitchen plating food or placing utensils or drinks on the meal trays. Further, staff was to use good hand hygiene in the kitchen after touching their face or mask. She stated dietary staff was to follow facility dietary policies and regulations related to storing, preparing, and serving food.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46651</b></p> <p>Based on observation, interview, record review, and review of facility policies, it was determined the facility failed to establish and maintain an infection prevention and control program to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (1) 1 of 34 sampled residents, Resident (R)78</p> <p>Observation on 07/09/2024 at 9:48 AM, revealed signage on R78's room door, stating Special Droplet/Contact Precautions. Further observation revealed State Registered Nurse Aide (SRNA)3 exited R78's room and removed her mask and gown in the hallway, and then carried the soiled mask and gown across the hall. She then used her gloved hand to engage the keypad to open the door to the room labeled Men's Shower/Biohazard, where she disposed of the soiled mask, gown, and gloves in a trash receptacle in the room.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Infection Control/Isolation Guidelines effective date 02/14/2023 and last revised 04/12/2024, revealed for any type of precaution, remove gown and gloves and perform hand hygiene prior to exiting the resident's environment/room.</p> <p>Review of the facility policy titled, Use of Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected Covid-19, issued by the Centers for Disease Control (CDC), dated 06/03/2020, revealed the three (3) step process for Doffing (taking off the gear), included: 1) remove gloves, 2) remove gown and 3) Health Care Professional may now exit the patient room.</p> <p>Review of R78's medical record Face Sheet, revealed the facility admitted the resident on 10/03/2023 with diagnoses including metabolic encephalopathy, severe protein-calorie malnutrition, and major depression.</p> <p>Review of R78's Physician's Orders, dated 06/27/2024, revealed orders for Transmission Based Contact/Droplet Isolation-COVID-19.</p> <p>Review of R78's laboratory data, dated 07/02/2024, revealed a positive Covid-19 result.</p> <p>Observation on 07/09/2024 at 9:48 AM, revealed signage on R78's room (E-09) door, stating Special Droplet/Contact Precautions. Further, the signage stated, only essential personnel should enter this room. If you have questions, ask the nursing staff. Everyone, including visitors, doctors and staff must: Clean hands when entering and leaving the room. Wear a mask: (Fit tested N-95 or higher required when performing aerosol-generating procedures). Wear eye protection (face shield or goggles). Gown and glove at the door. Keep the door closed. Use patient dedicated or disposable equipment. Clean and disinfect shared equipment.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185065	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/12/2024
NAME OF PROVIDER OR SUPPLIER  Landmark of Lancaster Rehabilitation and Nursing C		STREET ADDRESS, CITY, STATE, ZIP CODE  308 West Maple Avenue Lancaster, KY 40444	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further observation on 07/09/2024 at 9:48 AM, revealed SRNA3 exited R78's room and removed her mask and gown in the hallway, and then carried the soiled mask and gown across the hall, and used her gloved hand to engage the keypad to open the door to the room labeled, Men's Shower/Biohazard. She then disposed of the soiled mask, gown, and gloves in a trash receptacle in the room, and washed her hands.</p> <p>During interview, on 07/09/2024 at 9:48 AM, with SRNA3, she stated she had worked at the facility for three (3) months and was educated on infection control, but could not remember the guidance on whether she should remove the Personal Protective Equipment (PPE) before exiting an isolation room or after exiting the room. SRNA3 further stated she disposed of her PPE including gown, mask and gloves in the regular trash can in the shower/biohazard room. She stated she knew she was supposed to discard her gloves prior to using the key pad. She stated she did wash her hands immediately after removing her gloves.</p> <p>During a follow up interview, on 07/11/2024 at 9:00 AM, with SRNA3, she stated since speaking with the State Agency Representative on 07/09/2024, she had gone to her supervisor to ask for clarification related to removing PPE, and was informed PPE was to be removed inside the room prior to exiting. SRNA3 further stated, normally she would have thrown the PPE in the trash just outside the door way, but when she exited the room the trash bin was gone so she had to take the soiled PPE to the biohazard room. She stated she should have removed her mask, gown and gloves and then washed her hands prior to exiting room E-09.</p> <p>During interview on 07/10/2024 at 5:05 PM, with the Assistant Director of Nursing/Infection Preventionist (ADON/IP), she stated staff should don PPE prior to entering a Covid positive room, and after providing care, remove the soiled PPE including mask, gown, and gloves, and place it in the garbage can inside the room. The ADON further stated, biohazard cans were no longer mandatory for disposing COVID PPE. Per interview, after doffing PPE in an isolation room, staff should exit the room, and then use the closest hand sanitizer to perform hand hygiene. She stated it was not acceptable for staff to exit an isolation room wearing PPE, and remove it outside the room.</p> <p>During further interview, on 07/10/2024 at 5:05 PM. with the ADON/IP, she stated staff should never wear gloves out in the hall, and it was not acceptable to wear gloves when coming out of any precaution room because staff could cross contaminate objects such as door knobs, and through cross contamination, could cause other residents, visitors or staff to become ill. She stated if she saw staff coming out of an isolation room wearing dirty gloves, she would write the staff member up. She stated she educated all new hires on how to don and doff PPE during orientation, but she did not check them off until they had worked on the floor a few days and then she would audit them. In further interview, she stated sometimes due to her busy schedule, she did not get to audit all staff members.</p> <p>During an interview, on 07/12/2024 at 2:42 PM, with the Administrator, she stated it was her expectation all facility infection control policies and regulations be followed and all staff be [NAME] related to infection control guidelines to prevent the spread of infection.</p>		