STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185227	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Pointe Healthcare	100 Marshall Court Paducah, KY 42001

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44370 Based on observation, interview, and review of facility policy, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Observation of the walk in coolers revealed multiple food items which had been opened and were unlabeled and undated. These failures had the potential to affect 85 of the facility's 86 residents who consumed food from the kitchen. The findings include: Review of the facility policy, Food Receiving and Storage, revised 10/2017, revealed foods were to be received and stored in a manner that complied with safe food handling practices. Further review revealed all food stored in the refrigerator or freezer was to be covered, labeled, and dated with a used by date. Review of a document provided by the facility titled, United States Department of Agricultural Food Safety and Inspection Services for Food Safety Information Basics for Handling Food Safely, revised 08/2013, revealed safe steps in food handling, cooking, and storage were essential to prevent food borne illness. Continued review revealed leftover food was to be used within four days. Observation with the Dietary Manager (DM), during initial tour of the kitchen on 08/13/2024 at 6:37 AM, revealed a tray that contained five servings of banana pudding and one plate of prepared salad not labeled or dated located in a reach in cooler. Continued kitchen observation revealed the following items located in the walk in cooler: an opened, undated bag of shredded cheese 1/4 full; a small container of sloppy joe mixture, 1/4 full, dated 08/08-08/12/2024; a small container of mandarin oranges, dated 08/10-08/12/2024; a small container of sliced apples dated 08/09/2024-08/11/2024; an opened package of delicatessen (deli) turkey not labeled or dated; a container of chopped garlic 1/4 full, not labeled or dated; a large opened container of cantaloupe, 1/2 full with an opened date of 08/05/2024; and a large container of honeydew melon, 1/2 full with an opened date of 08/05/2024. The DM stated products were good for 7 days after opening. In interview with the DM on 08/13/2024 at 6:37 AM, during the kitchen tour, he stated food products were good for seven days after being opened. The DM stated food items placed in the cooler or walk-ins were also good for seven days. He further stated he expected staff to label and date all items as required. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185227	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Pointe Healthcare	100 Marshall Court Paducah, KY 42001

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview with the former Registered Dietitian (RD) on 08/15/2024 at 2:28 PM, she stated the expectation was for all dietary staff to label and date items when placed in the cooler or the walk-ins. She stated all staff in the kitchen were aware items were to be labeled and dated. The RD stated items were to be dated for three days out. She further stated serving outdated food items could contribute to food borne illness. In an interview with the Administrator on 08/16/2024 at 2:01 PM, she stated she expected dietary staff to follow facility policy and procedure related to labeling and dating of stored food.

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(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. 49350 Based on observation, interview, record review, and review of the facility policy, 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 diseases and infections for 2 of 22 sampled residents (R)87 and R45. 1. During observation of provision of direct care for R87, the two nurse aides failed to follow the enhanced barrier precautions (EBP) for the resident who was on EBP related to having an indwelling Foley catheter. 2. During observation of meal service CNA 4 entered R45's room, without donning an N95 mask (disposable filtering facepiece respirator) when entering a known COVID positive resident's room that was designated to have Droplet Precautions. The findings include: Review of the facility policy titled, Enhanced Barrier Precautions (undated), revealed it was the intent of the policy to protect residents who were the most susceptible for infections. Continued review revealed the use of EBP triggered for any resident in the facility with an open wound, an indwelling device, or who was colonized with multi drug resistant organisms. Review of the medical record for R87 revealed the facility admitted the resident on 08/09/2024, with diagnoses that included: right middle cerebral artery cerebral infarction, Type 2 diabetes mellitus, and Atrial fibrillation. Resident #87 medical record reflected urinary retention requiring indwelling Foley catheter placement which required enhanced barrier precautions. EBP supplies are in place in the hallway outside of the room entry door of Resident #87. The hallway has the standard PPE setup in place with gowns and gloves. Review of R87's comprehensive care plan revealed the facility care planned the resident on 08/09/2024, for a problem for R87 being placed on EBP due to an indwelling Foley catheter. Continued review revealed the goal as R87's risk for infection to be managed through the next review date. Further review revealed the interventions included using a gown and gloves for high contact activities, such as transferring R87 and providing the resident's hygiene care. Observation on 08/15/2024 at 4:34 PM, of CNA 14 and CNA 15 providing incontinent care for R87, revealed the aides had not followed the EBP's for wearing a gown when providing incontinent care (a high contact activity) for the resident. In interview at the time of observation, Certified Nursing Assistant (CNA) 15 stated she had forgotten to wear a gown as R87 needed to be changed and the resident did not want to wait. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview on 08/16/2024 at 10:22 AM with CNA 15 she stated she had seen R87's care plan in the Kardex during report and that information was also shared by the nursing staff as well. She stated a nurse reported to her that R87 had been placed on EBP, prior to the observation of care. The CNA stated she was provided in-service education when EBP began at the facility, and also had re-education yesterday (08/15/2024) and again today about the EBP process. CNA 15 stated, I should have worn a gown, closed the curtain, and washed my hands, which were the main things she should have done during R87's care. She stated she was aware if the resident's care plan and EBP guidelines were not followed, a spread of infection could take place for that resident. In interview 08/15/2024 at 11:34 AM, the Assistant Director of Nursing (ADON) stated she served as the facility's Infection Preventionist (IP). The ADON stated the facility had some problems in the beginning with EBP compliance by staff and getting them to understand what to do, but that had gotten better. In a follow up interview on 08/16/2024 at 10:15 AM, the ADON stated staff members involved in the care of R87 the day before, had both received initial EBP training when it was first launched at the facility. She stated both those staff members came forward yesterday to leadership and said they had made a mistake regarding EBP. Per the ADON's interview, the facility provided re-education of both staff members that day (08/16/2024). The ADON stated one of the nurse aides involved was a senior nurse aide and if she could forget to follow EBP, she (ADON) felt like the facility needed to reinforce the EBP education with everyone. She stated the Kardex care plan was available to the nurse aides to refer to and staff members not following a resident's EBP care plan, could potentially spread infection. 50153 2. Review of the policy titled, Isolation - Categories of Transmission-Based Precautions with a revision date of September 2022, revealed transmission-based precautions were initiated when a resident developed signs and symptoms of a transmissible infection. Continued review revealed transmission-based precautions were also initiated when a resident arrived for admission with symptoms of an infection, had a laboratory confirmed infection, or was at risk of transmitting infection to other residents. Per policy review, revealed transmission-based precautions were additional measures that protected other residents, staff, and visitor from being infected. Further review revealed the three types of transmission-based precautions were contact, droplet and airborne. In addition, review revealed for droplet precautions Masks are worn when entering the room. Record review for R45 revealed the facility admitted the resident on 04/01/2022, with diagnoses that included: Chronic Diastolic (Congestive) Heart Failure; Hypertensive Heart and Chronic Kidney Disease with Heart Failure. Review of R45's Physician's orders revealed R45 was placed in droplet isolation precautions on 08/04/2024, related to COVID positive test result, every shift for 10 days. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R45's care plan revealed a focus area of COVID 19 Active infection: Risk for worsening respiratory symptoms related to positive COVID 19 test as of 08/04/2024 initiated on 08/04/2024. Per review, the interventions included droplet isolation precautions with appropriate personal protective equipment (PPE) in accordance with PPE optimization guidelines initiated on 08/04/2024. Further review revealed the interventions also included, Single room droplet isolation precautions. All care to be performed in room, with an initiation date of 08/08/2024. During observation of meal service on the Lower Town unit on 08/14/2024 at 12:43 PM, CNA 4 was observed to enter R45's room, without donning a N95 mask, who was to be on droplet precautions for being COVID positive. Continued observation revealed CNA 4 was wearing a gown, gloves, and a face shield that was tipped backward at the level of the nose, leaving the mouth exposed. Per observation, CNA 4 had no face mask observed in use. Further observation revealed Droplet Precautions signage posted and visible outside R45's room and PPE available outside the room that included gowns, gloves and N95 masks. In interview with CNA 4 on 08/14/2024 at 12:45 PM, she stated it was important to wear a mask, but there were no masks located in the PPE bin that was located outside of R45's room. The State Survey Agency (SSA) Surveyor observed the PPE container, located outside R45's room, with CNA 4 and N95 masks were visualized as accessible and available in the second drawer of the PPE container. In interview with LPN/UM 2 on 08/14/2024 at 12:43 PM, she validated CNA 4 had not been wearing a mask when inside R45's room, who was COVID positive and on droplet isolation precautions. LPN/UM 2 stated it was important for staff to wear an N95 mask in a room of a resident on droplet precautions for infection control purposes and for preventing spread of the infection. In interview on 08/16/2024 at 3:32 PM, the DON stated it was her expectation for staff to use PPE as indicated to prevent the spread of COVID infection.