STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cambridge Nursing & Rehabilitation Center	2020 Cambridge Drive Lexington, KY 40504

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45990 Based on observation, interview, record review, and review of the facility's policy, the facility failed to have an effective system in place to ensure residents who exhibited wandering behaviors or were assessed at risk for elopement received adequate supervision and monitoring for 1 of 10 sampled residents, Resident (R) 1. On 07/22//2024, R1 was ordered to be on 15 minute checks by the Advanced Practice Nurse Practitioner (APRN)1 due to the resident's diagnosis of dementia, high elopement risk, and history with falls. However, the order was discontinued on 07/30/2024, and the APRN1 stated she did not order the 15 minute checks to be discontinued. Therefore, on 08/02/2024 at approximately 2:00 PM, R1 exited the facility without staff knowledge, unsupervised, and unescorted. Interviews revealed the resident walked with a cane and shuffled, but was able to walk approximately 60 to 70 feet from the facility close to a two lane road. The resident was found on his knees. Per interviews, an alarm sounded to signal to staff the resident had exited the facility; however, staff failed to respond to the alarm in a timely manner. The findings include: Review of the facility's policy titled, Elopement Wander Risk Protocol, revision date 02/2023, revealed every resident would have an Elopement Risk Assessment completed on admission, quarterly, and whenever the resident experienced a significant change in status. Additional review revealed residents who were identified as risk for elopement would have interventions put in place to minimize such risk. Further review revealed residents who actually did attempt to leave the building unauthorized would be monitored every 15 minutes for 24 hours following the elopement attempt. Review of R1's Face Sheet revealed the facility admitted the resident on 02/23/2021 with diagnoses to include psychotic disorder with hallucinations, Alzheimer's, and history of falls and muscle weakness. Review of R1's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 05/17/2024, revealed the resident had a Brief Interview for Mental Status (BIMS) score of zero-zero (00) out of 15, which indicated the resident was severely cognitively impaired. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R1's Elopement Risk Assessment, dated 02/15/2024, revealed R1 did not score as an elopement risk as evidenced by only yes to was the resident physically able to leave the facility on own with or without an assistive device. Review of R1's Elopement Risk Assessment, dated 05/17/2024, revealed R1 scored as an elopement risk as evidenced by answering yes to physically able to leave facility on own with or without assistive device and yes to does resident wander in an exit seeking manner. Review of R1's Fall Risk Assessment scored him as a high fall risk on 12/04/2023, 02/15/2024, 05/17/2024, and 08/14/2024. Review of R1's Order Set, dated 05/28/2024, revealed an order for Wander Guard/Wander Elopement Device due to poor safety awareness and to update the order with the new date when the bracelet was changed. Review R1's Order Set, dated 07/30/2024, revealed the resident's 15 minute checks were discontinued. Review of R1's Comprehensive Care Plan (CCP), dated 08/22/2022, revealed a focus of at risk for complications and or injury related to behaviors and history of wandering with revision date of 07/22/2024. Continued review revealed a focus of resident liked to wander and was at risk for elopement, date initiated 03/09/2021 with revision date of 12/18/2023. Review of interventions included 15 minute checks and if exit seeking offer snack or diversional activity, with initiation date of 08/02/2024. Further review revealed interventions included to allow resident to wander through out the facility with supervision as needed, initiated on 03/09/2021 without revision date noted. Review of R1's Progress Note, dated 07/30/2024 at 10:01 AM and 11:38 AM, revealed the nurse documented that 15 minute checks were discontinued today by the Unit Manager. Review of R1's Progress Note, dated 08/02/2024, and signed on 08/08/2024, by the Advanced Practice Registered Nurse (APRN) 1, revealed R1 was being seen for increased agitation behavior and exit seeking behaviors. Additional review revealed R1 was not followed with psychiatric services for multiple psychiatric diagnoses including poor safety awareness with impulsiveness, likely due to progressive dementia and continuing decline in cognition. Per the note, since R1 was at high risk for elopement, the plan was to continue with 15 minute checks per facility protocol, referrals to facilities with locked memory care units, consult psychiatric services at next facility visit, and Wander Guard bracelet for increased safety when wandering. Review of R1's Frequent Check Flow Sheet revealed 15 minute checks were initiated on 07/22/2024 at 8:00 PM and discontinued on 07/30/2024 at 10:15 AM. Further review revealed 15 minute checks were initiated on 08/02/2024 at 2:00 PM, with no documentation noted after 08/15/2024 at 9:00 AM. Observation on 08/13/2024 at approximately 2:30 PM revealed the area where R1 was found by staff was approximately 60 to 70 feet from the emergency egress door where he exited. Additional observation, on 08/15/2024 at 1:00 PM, revealed the area where R1 was found was approximately 70 feet from a two lane road. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 08/14/2024 at 10:45 AM revealed R1 walking from the bathroom toward the bed with assistance of staff with slow, unsteady, shuffle like gait with a Wander Guard bracelet to his left wrist. Observation on 08/16/2024 at 10:05 AM revealed a Wander guard bracelet to R1's right ankle. During an interview with the East Hall Unit Manager (UM) on 08/13/2024 at 2:55 PM, she stated R1 had exited the facility on 08/02/2024, she thought around 2:00 PM or 2:30 PM. She stated R1 had always had the behavior of going from unit to unit, adding he at times would voice wanting to go home. During an interview with Housekeeper (HK) 1 on 08/13/2024 at 1:20 PM, she stated she had been in a resident room approximately halfway down the [NAME] Hall past the nurses' station, and upon exiting the room, she heard a door alarm at the end of the [NAME] Hall. She stated she walked to the [NAME] Hall nurses' station, which was located between the door alarming and where she had been cleaning. She stated as she approached the station, Registered Nurse (RN) 1 was sitting at the nurses' station on the computer. She stated she asked RN1 if she heard the alarm, and then they both walked toward the sounding alarm which was an emergency egress door at the end of [NAME] Hall. She stated as they approached the door, they could see out the sunroom's windows that R1 was in a grassy area, down on one knee in front of the facility. She stated she had seen R1 earlier in the day walking around on [NAME] Hall, adding he lived on East Hall, but that was not unusual for him. She stated she asked R1 where he was going once getting outside to him, and R1 stated, I am going home. During an interview with RN1 on 08/13/2024 at 1:50 PM, she stated she was sitting at the nurses' station when HK1 came to the area and asked if she heard the alarm. She stated she and HK1 starting walking down the [NAME] Hall where the emergency egress door was alarming. She stated as they approached the door, they could see (through the sun room windows) R1 out in the grassy area in front of the facility, down on one knee. She stated they both then went to the resident, and she assessed him and found no injuries. She stated she, HK1, and R1 returned through the facility's front door. She stated, when asked if she had heard the emergency egress door alarming, she was not sure. In an interview with State Registered Nurse Aide (SRNA) 7 on 08/14/2024 at 12:05 PM, she stated R1 usually had the behavior of always walking around a lot and being confused. She stated she thought R1 had a one-to-one sitter with him on second shift but not on day shift. She stated staff just kept an eye on him. She stated when R1 wandered around the facility she would re-direct him or offer snacks and that would help most of the time. During an interview with Licensed Practical Nurse (LPN) 5 on 08/14/2024 at 1:43 PM, she stated R1 could walk as long as he had his cane. She stated she felt his confusion had worsened over the last month or so and was asking staff how do I get out of here. She stated nurses did not update care plans or add interventions, nor did she look at care plans each day. She stated R1 had been on 15 minute checks due to an altercation with his roommate but was unable to state the exact date. She stated the day he exited the building she could not remember any different behavior. During an interview with Kentucky Medication Aide (KMA)/SRNA3 on 08/14/2024 at 2:25 PM, she stated R1 was either wandering through out the facility all day going to the doors, or going in and out of other resident rooms, or sleeping all day. She stated she was in another resident room at the time of the incident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with SRNA12 on 08/19/2024 at 10:35 AM, she stated R1 was usually disoriented and wandered up and down the hallways and would go to the doors and try to open, but he had always had that behavior. During an interview with the [NAME] Unit Manager on 08/22/2024 at 10:25 AM, she stated she was in a meeting in the conference room with other staff members the day R1 left the facility but was unable to name the others in the meeting. She stated she heard the alarm sound, but she nor anyone else in the conference room responded. She stated alarms were sounding all the time, and she felt like staff was just numb to it. She stated even if staff was numb to all the alarms, her expectation was to respond immediately. During an interview with the Maintenance Director on 08/15/2024 at 9:15 AM, he stated he was working the day R1 had left the facility but could not recall if he heard the alarm. He stated he had performed the door checks and Wander Guard checks the day of the incident, and they all worked. During an interview with the DON on 08/16/2024 at 10:30 AM, she stated she was working the day R1 left the facility, and he was outside without an escort or staff. She stated she was unsure how long R1 had been outside but thought it was about five minutes or so. She stated she would be concerned for a resident's welfare and safety of being outside alone and was aware the highway was close to the facility. Further, she stated she did not investigate the resident's leaving the facility without supervision as the resident remained on the facility's property. During an interview with the DON on 08/22/2024 at 2:09 PM, she stated her expectation was for staff to follow policies to assure the safety of all residents. During an interview with APRN1 on 08/16/2024 at 11:30 AM, she stated she did not order the 15 minute checks for R1 to be discontinued on 07/30/2024. She stated R1 was a high elopement risk and discussions were held in the IDT meetings. She stated she was unable to say when the last meeting was or if there were any resolutions. When asked what concerns did she have when she learned of R1 leaving the facility, she stated his safety due to history of dementia and falls. During an interview with the Administrator on 08/16/2024 at 12:45 PM, she stated she was acting interim Administrator and had started after the incident. She stated her expectations of staff was to respond to door alarms immediately, and it was the staff's responsibility to know the signs of exit seeking behavior. She stated her expectations was that staff provided supervision of the residents. She stated staff should not rely totally on alarms. In an interview with the Regional [NAME] President of Operations on 08/22/2024 at 2:45 PM, she stated her expectations were for staff to respond immediately to any alarm as soon as they heard it.

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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** 45990 Based on observation, interview, record review, review of the facility's policy and signage, and review of the Centers for Disease Control and Prevention (CDC) Guidelines, the facility failed to maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections for 4 of 42 sampled residents, Resident (R) 9, 19, 35, and 36. The findings include: Review of the Centers for Disease Control and Prevention (CDC) guidelines Infection Control Guidance: SARS-CoV-2, dated 06/24/2024, revealed adherence to infection prevention and control practices was essential to providing safe and high quality patient care across all settings where healthcare was delivered. Further review revealed facilities should limit movement of the resident outside of the room to medically essential purposes. Review of the CDC guidelines Healthcare Provider and Facility Operational Considerations, dated 08/06/2024, revealed the CDC recommended using precautions to prevent the spread of infection while performing aerosol-generating procedures (AGPs). The CDC recommended keeping the door closed during the procedure. Further review revealed the guideline stated the Covid-19 positive resident should be in a private room, if not then the roommate should be removed from the room during the procedure. Per the guideline, if the roommate could not be removed, the curtain should be drawn between the beds, and staff should increase ventilation by cracking a window or putting a fan face-out in the window. Review of the facility's policy titled, Covid-19, revised 12/05/2023, revealed in addition to standard precautions, special droplet and contact precautions would be implemented for residents suspected or confirmed to have Covid-19 based on the CDC guidance. The policy stated the facility would follow the CDC published guidance for residents with suspected Covid-19. Further review revealed, for procedures performed on residents with known or suspected Covid-19 that were likely to induce coughing (e.g., nebulizer treatments), staff was to refer to CDC guidance. Additionally, the policy stated residents in transmission based precautions (TBP) were restricted to the room except for medically necessary procedures. Per the policy, if the resident had to leave the room, he/she would be encouraged to wear a face mask or a cloth face covering. Review of the facility's signage Special Droplet/Contact Precautions (procedure to be used) revealed everyone must, including visitors, doctors, and staff, clean hands when entering and leaving the room, wear a facemask, eye protection, and gown and glove at the door. Further review of the signage revealed when doing aerosolizing procedures, a fit tested N-95 respirator with eye protection or higher was required. Additional review revealed to keep the door closed. Review of the facility's signage Sequence for Putting on Personal Protective Equipment (PPE) (procedure to be used), revealed the gown must fully cover the torso from neck to knees, arms to end of wrists, and wrap around the back. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's signage How to Safely Remove PPE revealed to remove all PPE before exiting the patient room except a respirator was removed after leaving the resident's room. Further review revealed if the front of the mask/respirator was contaminated-DO NOT TOUCH. Additional review revealed if hands got contaminated during mask/respirator removal, immediately wash hands or use an alcohol-based sanitizer and discard in a waste container. Review of the facility's signage Enhanced Barrier Precautions (EBP) (procedure to be used) revealed everyone must clean hands before entering and leaving the room and wear gloves and a gown for High-Contact Resident Care Activities which included changing linens. 1. Observation on 08/13/2024 at 1:00 PM revealed State Registered Nurse Aide (SRNA) 1 entered an EBP room without donning (putting on) PPE. During an interview with SRNA1 on 08/13/2024 at 1:15 PM, she stated R9 spilled a soda on the top sheet, and she changed it. SRNA1 stated she had EBP training, and the training included to always wear a gown and gloves when providing care and to wash or sanitize hands. She stated R9 had a wound, but she did not think R9 was on EBP. Review of R9's Face Sheet revealed the facility admitted the resident on 02/21/2024 with diagnoses to include morbid obesity, methicillin resistant staphylococcus aureus infection (multi-drug resistant bacteria) as the cause of disease classified elsewhere, and high blood pressure. Review of R9's Physician's Orders, dated 06/30/2024, revealed an order for EBP. Additional review of an order, dated 05/29/2024, revealed an order for wound treatment to the left gluteus. Review of R9's Comprehensive Care Plan (CCP) with initiation date of 02/22/2024 and revision date of 08/08/2024, revealed a focus identifying R9 at risk for infection related to disease process and communal living situation. Additional review revealed interventions to include EBP with initiation date of 02/29/2024 and revision date of 08/08/2024 to include infection control per facility protocol. Continued review revealed additional interventions to include infection control per facility protocol. Further review revealed the left gluteal wound had resolved with initiation date of 05/29/2024 and resolved date of 06/01/2024. 2. Observation of the East Wing on 08/15/2024 at 1:45 PM revealed a clear plastic garbage bag full of dirty linens was on the floor in the hallway outside of room [ROOM NUMBER], a droplet precaution isolation room. During an interview with SRNA 8 on 08/15/2024 at 1:50 PM, she stated staff should bag dirty linen from a transmission-based precaution (TBP) room, take the bag to the dirty linen room, and place the bag in blue bags, indicating the linen was from an isolation room. SRNA8 stated staff should not place linen on the floor. She stated following infection control protocols was important to prevent the spread of infection and cross-contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Housekeeping Supervisor on 08/21/2024 at 9:40 AM, he stated laundry from isolation rooms were bagged in the room, and staff took contaminated laundry to the dirty utility room. He stated isolation laundry was placed in a blue biohazard bag and put in a laundry bin. He stated staff then took the bin to the laundry. He stated laundry personnel were trained to wash those items separately. He further stated it was important to separate laundry to prevent the spread of infection to residents. 3. a. Observation of the East Wing on 08/15/2024 at 1:45 PM revealed R19, a roommate of R36, who was Covid-19 positive and had been exposed to Covid-19, was seated in her wheelchair in the doorway to her room with a mask on. However, it was not covering her mouth and nose. R36 was unmasked, sitting in bed, and the privacy curtain was not closed. b. Observation of the East Wing on 08/19/2024 at 12:36 PM revealed R35 in room [ROOM NUMBER], who was Covid-19 positive, sitting halfway in the doorway and halfway in the hallway, not wearing a mask. Several staff members passed the resident while handing out meal trays, but none of them encouraged him to wear a mask or return to his room. During an interview with SRNA5 on 08/19/2024 12:45 PM, she stated residents with Covid-19 and in droplet isolation precautions should remain in their rooms. She stated if the resident was in the doorway they must wear a mask. SRNA5 stated she did not see R35 out of his room and if she had seen him, she would have redirected him back to his room. SRNA5 further stated following infection prevention and control practices (IPCP) was important to prevent the spread of infection and cross contamination. During an interview with SRNA8 on 08/19/2024 at 11:05 AM, she stated if a resident was in any TBP isolation other than EBP, they should remain in their rooms. She stated if they were near the doorway or needed to leave, they were redirected to wear a mask to prevent the spread of infection to other residents and staff. During an interview with Kentucky Medication Aide (KMA)/SRNA6 on 08/14/2024 at 2:25 PM, she stated residents with Covid-19 and in droplet isolation precautions should remain in their rooms. She stated if the resident was in the doorway they must wear a mask. KMA/SRNA6 stated she did not see R19 unmasked while sitting in the doorway. She stated if she had she would have redirected her to place the mask over her nose and mouth. During an interview with Licensed Practical Nurse (LPN) 5 on 08/14/2024 at 1:50 PM and on 08/18/2024 at 12:33 PM, she stated that Covid-19 residents should remain in their rooms. She stated if they were near the doorway or needed to leave, they must wear a mask. She further stated staff should encourage residents to wear masks. LPN5 stated following IPCP was important to prevent the spread of infection to at risk residents. During an interview with Registered Nurse (RN) 1 on 08/14/2024 at 2:40 PM, she stated according to facility policy, residents with Covid-19 should remain in their rooms. She stated if they were near the doorway or needed to leave the isolation room, they must wear a mask. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing/Infection Preventionist (DON/IP) on 08/17/2024 at 12:07 PM, she stated according to policy, residents under droplet precaution isolation should stay in their rooms. She stated residents in droplet precautions who were sitting in their doorways or out of their room without a mask should be encouraged to wear a mask. She stated if the resident came out of the isolation room, they must wear a mask to prevent the spread of infection to other residents, staff, and visitors. 4. Observation of the East Wing on 08/15/2024 at 2:50 PM, revealed the door to room [ROOM NUMBER], a droplet precaution isolation room, was wide open. Upon further observation, R36, who tested positive for COVID-19 on 08/13/2024, was observed having a nebulizer treatment. R36 was in the bed near the window, and her privacy curtain was not pulled. R36's roommate, R19, who was not COVID-19 positive, was in her room sitting in her wheelchair near the door during R36's treatment. R19 was wearing a mask, however it was pulled down below her chin. No source control precautions were taken to minimize the spread of potential aerosolization. During an interview with LPN3 on 08/15/2024 at 2:55 PM, she stated she was not aware R36 was receiving a nebulizer treatment. She stated that to prevent the spread of infection, the privacy curtain and door should be closed. She stated, however, that most of the residents in droplet precaution isolation had requested their doors remain open. During an interview with the DON/IP on 08/15/2024 at 9:38 AM, she stated that doors and curtains remained open upon the request of the resident. She stated that according to CDC guidelines, doors and curtains should be closed to prevent the spread of Covid-19. However, she stated the resident had the right to have the door open. 5. Observation on 08/19/2024 at 1:35 PM revealed Housekeeper 2 entered rooms [ROOM NUMBER], removed garbage bags, and replaced each with a new one without donning gloves or practicing hand hygiene. Additional review revealed she took the bags of trash in each room with her and then walked up the hall to the dirty utility room to dispose of the bags. During an interview with Housekeeper 2 on 08/20/2024 at 11:20 AM, she stated she had been employed by the facility for about one year. When asked about entering rooms [ROOM NUMBER], she stated she was replacing garbage bags, and some were empty, and some had trash in them. She stated she was unsure if she wore gloves or not, but she had performed hand hygiene in the bathrooms of each room. During an interview with the Housekeeping Supervisor on 08/21/2024 at 9:55 AM, he stated Housekeeper 2 should have donned gloves prior to emptying garbage from resident rooms, and she told him she thought she had not performed HH because she was nervous since she knew the State Survey Agency (SSA) Surveyor was observing her. He stated it was important to wear gloves anytime staff was emptying garbage to prevent the spread of germs throughout the facility. 6. Observation on 08/19/2024 at 1:40 PM revealed SRNA4 donned PPE to enter a Covid positive room, room [ROOM NUMBER]. Additional review revealed SRNA4 donned one gown which did not fully cover the back side of her clothing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further observation on 08/19/2024 at approximately 1:50 PM revealed SRNA4 exited the same room with an N-95 respirator on and an empty food tray in hand. Continued observation revealed SRNA4 sat the food tray on the floor in hallway outside of room [ROOM NUMBER]. He then removed the N-95 respirator and placed it in a tray, ungloved, without performing hand hygiene (HH) after the placement. Further observation revealed he then bagged both the N-95 respirator and food tray, carried them to the dirty utility room, exited the dirty utility room with the food tray unbagged, and placed it on the meal trolley. During an interview with SRNA4 on 08/19/2024 at 3:10 PM, he stated before entering a Covid positive room all PPE should be donned properly, and before exiting a Covid positive room all PPE should be removed and bagged. He stated he had infection control training by the Assistant Director of Nursing (ADON) and knew that process was important to keep anyone from getting sick. During an interview with the Director of Nursing (DON) on 08/22/2024 at 2:09 PM, she stated she had held the position since 07/03/2024 and was also the Infection Preventionist (IP) nurse. She stated if an isolation gown did not fully cover the staff's clothing, they should don two gowns. She stated HH should be practiced to prevent cross contamination, and if hands were visibly soiled, staff should wash hands. 44001 During an interview with the Assistant Director of Nursing (ADON) on 08/15/2024 at 2:05 PM, she stated the facility followed CDC guidelines for IPCP. She stated it was her expectation that all staff followed facility policies related to IPCP to include hand hygiene and wearing PPE. The ADON stated following infection control guidelines was important to prevent the spread of infection and cross contamination. During an interview with the DON/IP on 08/22/2024 at 2:08 PM, she stated her duties as DON/IP were to supervise all clinical staff to ensure they completed tasks to ensure the safety and well-being of all residents. She stated her expectation was that every employee followed facility protocols and procedures to ensure that residents were cared for and safe. The DON/IP stated the facility followed CDC guidelines and recommendations. She stated she educated staff immediately if there was a breach in infection control protocol. The DON/IP stated she did not conduct formal infection control audits of staff but stated, We do watch them. Per the interview, staff received infection control training upon hire, and it was reviewed many times throughout the year. She stated hand hygiene was essential to prevent the spread of infection. She stated it was her expectation that all staff performed hand hygiene before and after the care of residents by properly donning (putting on) and doffing (taking off) PPE per CDC guidelines. She stated following facility policies was important for the safety and well-being of residents and staff and to prevent the spread of infection and disease. During an interview with the Advanced Practice Registered Nurse provider on 08/17/2024 at 11:25 AM, she stated it was her expectation that staff followed provider orders related to TBP. She stated following IPCP was important to prevent the spread of infection and cross contamination. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185444	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cambridge Nursing & Rehabilitation Center	2020 Cambridge Drive Lexington, KY 40504

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	During an interview with the Interim Administrator 08/22/2024 at 2:32 PM, she stated her current job duties involved managing facility operations in all departments, including nursing. She emphasized the importance of resident safety, which was maintained through training, education, drills, testing, and quizzes. The Interim Administrator stated there was a need for continuous staff re-education and her expectation that all staff followed facility policy and IPCP. She stated nursing leadership should promptly correct breaches in infection control. She stated the facility had a 12-month rolling training program, and the DON/IP educated and audited staff regarding IPCP. The Interim Administrator stated it was her expectation for all staff to follow the facility's IPCPs, which was crucial to protect staff, residents, and visitors from infection and disease. During an interview with the Regional [NAME] President of Operations (RVPO) on 08/22/2024 at 2:45 PM, she stated that it was her responsibility to oversee the administration of operations. She stated it was her expectation for all staff to follow the facility's policies related to infection control and to maintain and adhere to IPCP in order to prevent the spread of disease.