STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215267	A. BUILDING _____ B. WING _____	07/31/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST JOSEPH'S MINISTRIES	331 SOUTH SETON AVENUE EMMITSBURG, MD 21727

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 0711 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview with staff it was determined the physician failed to review the resident's total program of care and write, sign and date progress notes at each visit. This was evident for 1 (#2) of 13 residents reviewed during the survey. The findings include: Resident #2's medical record was reviewed on 7/23/20 at 2:45 PM. The record revealed that on 6/24/20 at 6:54 PM an SBAR Professional Communication form (used to assess a change in condition) was completed by the nurse. It indicated that Resident #2 had a moist productive cough with thick yellow sputum (mixture of saliva and mucous), increased labored respirations of 32 per minute and rhonchi (gurgling type lung sounds). The note indicated that the physician was notified and ordered laboratory tests, a chest x-ray and an antibiotic for 7 days. A nursing progress note dated 6/26/20 indicated that the physician was called with the x ray results and was asked if a COVID-19 test should be completed. It was ordered then cancelled. Further documentation in the record revealed that the resident had a further decline and was transferred to the hospital on [DATE]. A review of the physicians' progress notes revealed a progress note dated 6/1/20. No physician progress notes [REDACTED]. On 7/24/20 Staff #13 (Assistant Health Information Management) was asked for any physicians' progress notes written after 6/1/20 including when the resident had a change of condition on 6/24/20. Staff #13 later provided a physician progress notes [REDACTED]. Review of the physicians progress note revealed the date of service was 7/9/20 and it was electronically signed on 7/22/20. The progress note failed to reflect the resident's change in condition as noted by the nurse on 6/24/20, the interventions that were ordered or the evaluation of the resident and results of the testing that was ordered 6/24/20. It indicated that the resident had no active health concerns, was doing well, had no cough or shortness of breath and had not had any blood work. The Administrator, Director of Nursing and Regional Director of Clinical Operations were made aware of these findings during the exit conference on 7/31/20.
F 0775 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Keep complete, dated laboratory records in the resident's record.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview with facility staff it was determined the facility failed to file the COVID-19 laboratory reports in each residents' clinical record. This was evident for all residents residing in the facility. The findings include: During the entrance conference on 7/22/20 at 8:10 AM Staff #1, the Administrator, Staff #2 the DON (director of nursing) and Quality Nurse #3 revealed the current resident census was 76 and that the facility had no COVID-19 positive staff or residents. Resident #10's medical record was reviewed on 7/22/20 at 1:00 PM. The surveyor was unable to find the resident's COVID-19 test results in his/her Electronic Medical Record (EMR). Upon inquiry Quality Nurse #3 informed the surveyors that all laboratory results, including COVID-19 test results, were kept in the residents' paper records and that the facility did not scan lab results into the EMR. Quality Nurse #3 explained that all residents were COVID tested on [DATE] and again on 7/17/20 - 7/20/20. Review of Resident #10s paper record failed to reveal any COVID-19 test results. Quality Nurse #3 was asked where Resident #10's COVID-19 lab results could be found and brought a stack of COVID-19 test results to the surveyors indicating they were results from the testing conducted on all residents on 6/1/20, further indicated they were in the DON's office. On 7/27/20 at 1:45 PM the surveyor again inquired where to find the COVID-19 test results for all residents that were conducted on 6/1/20. Staff #2 and Quality Nurse #3 indicated that they were still in the DON's office and that the results from the testing conducted from 7/17/20 - 7/20/20 were there as well and still trickling in. The residents' COVID-19 lab results were not filed in the residents' medical record once obtained by the facility. The Administrator, Director of Nursing and Regional Director of Clinical Operations were made aware of these findings during the exit conference on 7/31/20.
F 0880 **Level of harm -** Immediate jeopardy **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, staff interview and record review, it was determined that the facility failed to (1) develop and implement an effective infection prevention control program tailored to the individualized needs of the facility and predicated on the required facility-wide assessment; (2) failed to isolate and observe residents who developed symptoms associated with COVID-19; (3) appropriately isolate residents after an Immediate Jeopardy situation was identified on 7/24/2020; (4) ensure that symptomatic staff did not and could not work during the declared health emergency; (5) report the known Staff case of COVID-19 as required; (6) ensure communication to staff of critical isolation precautions information; (7) develop a system to conduct surveillance monitoring of staff infection control practices to determine effectiveness and need for quality improvement training; (8) follow guidelines for proper use of disposable PPE. This was evident for (1) facility wide; (2) 5 Residents on 3 floors (Resident #1, Resident #2, Resident #3, Resident #4 and Resident #5); (3) 3 residents (Resident #1, Resident #6 and Resident #7); (4) 1 staff member (Staff #8), (5) facility wide; (6) all staff; (7) facility wide; (8) all staff. During the survey, on July 24, 2020 at 2:00 PM an Immediate Jeopardy was called related to the facility's failure due to this interralted failures. A plan to remove the immediacy was submitted by the facility and accepted by Office of Health Care Quality on July 24, 2020 at 11:16 PM while surveyors remained onsite. The Immediate Jeopardy was removed on July 31, 2020 at 10:30 AM. After removal of the immediacy, the deficient practice remained with a potential for more than minimal harm at a scope and severity of E. The immediate jeopard was determined for example #1. The findings include: (2) With no evidence of an individualized infection prevention and control program to meet the local needs of the facility population, the facility failed to place residents with new symptoms known associated with COVID-19 on isolation precautions. On 5/13/20, the Centers for Disease Control and Prevention published updated guidance on COVID-19 symptoms. As of 5/13/20 in addition to fever, cough, and shortness of breath, the list of symptoms associated with COVID-19 included fatigue, congestion or runny nose, chills, repeated shaking with chills, muscle pain, headache, sore throat, new loss of taste or smell, persistent pain or pressure in the chest, trouble breathing, new confusion, inability to arouse, and bluish lips or face, nausea, vomiting and diarrhea. On 4/30/2020, the Centers for Disease Control and Prevention (CDC) published guidance entitled Responding to Coronavirus (COVID-19) in Nursing Homes. This guidance provided that a resident with new-onset suspected or confirmed COVID-19 is isolated and cared for using all recommended COVID-19 PPE (and) place the resident in a single room if possible pending results of [DIAGNOSES REDACTED]-CoV-2 testing. Related, on 5/8/20 the Centers for Disease Control and Prevention (CDC) published guidance associated with a facility self-assessment tool entitled, Coronavirus Disease 2019 (COVID-19) Preparedness Checklist for Nursing Homes and other Long-Term Care Settings. The Maryland Office of Health Care Quality required all long-term care facilities in Maryland to review and complete this assessment. Guidance within the assessment indicated that the facility should ask residents to report if they feel feverish or have respiratory symptoms. They should actively monitor all

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.

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) residents upon admission and at least daily for fever and symptoms of COVID-19 (fever, new or worsening cough, difficulty breathing, chills, repeated shaking with chills, muscle pain, headache, sore throat, and new loss of taste or smell). If they have a fever (temperature of 100.0 F or higher) or symptoms, they should be restricted to their room and put into appropriate Transmission-Based Precautions. Resident #1 showed cough and congestion on 7/20/20. During survey, on 7/24/20, Resident #1 had not been placed on isolation precautions and had not been re-tested for COVID-19. Isolation precautions were not ordered and were not implemented. Resident #2 showed cough and congestion on 6/24/20. During survey, on 7/24/20 Resident #2 had not been placed on isolation precautions and had not been re-tested for COVID-19. Review of the medical record revealed that Resident #2 had COVID-19 risk factors of hypertension and diabetes. The practitioner was notified of new symptoms on 6/26/20 but the resident was not seen until 7/9/20, and isolation precautions were not ordered and were not implemented timely. Resident #3 was admitted on [DATE] and developed cough and congestion on 6/5/20. The practitioner was not notified of the new symptoms, the resident was not seen by the practitioner, and isolation precautions were neither ordered nor implemented. Resident #4 was admitted during 2019 and developed new symptoms (cough and congestion) on or by 6/7/20. The resident was seen on 6/7/20 but isolation precautions were neither ordered nor implemented. Resident #5 was admitted on [DATE] and developed a cough on 6/20/20. The resident was seen by the practitioner but isolation precautions were not ordered and were not implemented. In addition to isolating residents with new symptoms associated with COVID-19 staff must promptly notify clinical staff of any new symptoms suggestive of COVID-19. On 4/29/20, the Maryland Department of Health (MDH) issued an Amended Directive and Order Regarding Nursing Home Matters replaced and superseded the Directives and Orders Regarding Nursing Home Matters, dated April 29th, April 24th, April 9th, and April 5th. In addition, this Amended Directive and Order replaced and superseded the Maryland Department of Health Recommendations for Infection Control & Prevention of COVID-19 in Facilities Serving Older Adults, dated March 10, 2020. The 4/29/2020 MDH Directive and Order provided as the clinical status of individuals infected with COVID-19 may change quickly and nursing home residents may have an atypical presentation of the infection, each nursing home resident shall be evaluated daily to check for COVID-19 by the nursing home's clinical staff. The evaluation shall include vital signs as well as the identification of new or worsening signs or symptoms. In addition to the daily evaluation, all interdisciplinary team members shall report findings that might represent a significant change of condition to the charge nurse or staff nurse for further assessment. All evaluations shall be documented in the resident's medical record. The nursing staff shall timely convey significant findings to a physician, nurse practitioner, or physician assistant for follow up face-to-face in-person or via telehealth. Facility staff shall document telephone calls and medical practitioners shall document face-to-face in-person and telehealth visits in the resident's medical record. On 6/19/20 and 7/24/20 revisions to the Amended Directive and Order Regarding Nursing Home Matters continued these same requirements. Resident #3 was admitted on [DATE] and developed cough and congestion on 6/5/20. The practitioner was not notified of the new symptoms, the resident was not seen by the practitioner, and isolation precautions were neither ordered nor implemented. On 7/24/20, the surveyor observed that the facility had a dedicated COVID-19 unit with multiple open rooms available where residents could have been isolated and observed but it was not being utilized. In a 7/23/20 interview at 9:45 AM, Quality Nurse #3 reported the unit is not utilized due to staffing shortage. As a result of the above findings the Office of Health Care Quality determined an immediate jeopardy situation existed and the facility was notified of this on 7/24/20 at 2:00 PM. The facility submitted multiple plans to remove immediacy that did not meet minimum standards. On 7/24/20 the facility submitted a revised plan at 11:16 PM that was reviewed and accepted by the survey team and OHCQ. The provisions of the plan to remove the immediacy included the following: 1) Resident #1 was placed on droplet precautions in a private room and their physician was notified of coughing. The resident will be retested for COVID-19 on 7/24/20. 2) Current residents will be monitored at least every 8 hours for signs and symptoms of COVID-19 as outlined by the CDC, Frederick County Health Department updates and weekly Corporate Covid meetings. Residents with new or worsening symptoms will be placed into a private room with monitoring every 4 hours, their physician will be notified and testing completed per physician orders. Routine weekly testing of residents and employees will occur per the State of Maryland recommendations. 3) Current nursing staff will be re-educated by the Infection Preventionist/ Director of Nursing (DON) on 7/24/20 on the facility infection control processes, including those related to COVID-19, isolation of residents with new or worsening symptoms of COVID-19 per CDC guidelines, Frederick County Department of Health and Ascension Living. Nurses will be trained on clinical features, epidemiological risk and action to be taken when there is a person of interest for COVID in the facility including calling their physician for orders and updating Nursing Administration, prevention guidelines, COVID testing, PPE, handwashing, isolation and post mortem care. 4) Physicians will be educated by the DON by close of business on 7/28/20. 5) The DON will be called when Nursing Staff calls resident physicians to inform of COVID signs and symptoms to ensure that orders are written for COVID testing and isolation for the resident. 6) Education of all Nursing Staff and Physicians will be completed by close of business 7/28/20. The removal plan indicated the measures to remove the immediacy would be put in place by close of business on 7/28/20, however, the Immediate Jeopardy could not be removed until 7/31/2020 at 10:30 AM after on-site confirmation of the facility's plan of removal. (2) The facility failed to implement an effective, individualized infection prevention and control program that was predicated on the required facility assessment and that therefore considered the specific facility needs, strengths, weaknesses, and resources. During the entrance conference on 7/22/20 at 8:10 AM, Quality Nurse #3 was identified as the facility's acting Infection Preventionist. During an interview on 7/27/20 at approximately 2:00 PM, Quality Nurse #3 was asked to provide the surveyors with the facilities Infection Control Policy and Procedure manual. Quality Nurse #3 explained that the policies and procedures are available online and there was no paper copy available. They further stated that they were unable to provide the surveyor with access to the electronic version but could print any section the surveyors wanted to review. Quality Nurse #3 indicated that all facility staff had access to the electronic version. Quality Nurse #3 was informed that the surveyors needed to review the facility's entire Infection Control Policy and Procedure manual. As of 3:35 PM on 7/27/20 the surveyors did not have access to the infection control policy and procedures. On 7/28/20 at 9:00 AM, Quality Nurse #3 provided an unlabeled red binder and indicated this was the facility's policies and procedures for infection control. Quality Nurse #3 stated that each unit has the same binder and when asked if they were recently placed on the units, said they have been there and each unit has one. The title page indicated Ascension Policy and Procedures for Infection Control. A date at the bottom of each printed page indicated that the information was retrieved 7/27/20. Red binders were also observed on the Mountain View unit at 9:53 AM and Garden view unit at 10:16 AM on 7/28/20 with the pages dated as retrieved 7/27/20. There was no indication that these policies had been reviewed and approved or revised by the facility administration. On 7/28/20 at 2:53 PM Staff #1, the Administrator, and Staff #12, the Regional Director of Clinical Operations, were made aware of the above concerns. On 7/29/20 at 2:58 PM the surveyor received an email from Staff #12 with an attached (IPCP) Infection Control Policy and Procedure Manual. Staff #12 explained at that time that the Policies and Procedures are reviewed and revised by the Ascension corporate office and are used in all of the Ascension facilities. Staff #12 indicated that they were not reviewed and updated by the individual facilities. When asked how the corporate office takes into consideration the various state regulations and individual facility needs, Staff #12 indicated that they try to take them all into consideration. There was no evidence to indicate that the facility established and updated the IPCP based on their facility assessment, or that the facility's administration conducted an annual review of its IPCP and updated their program as necessary. (3) The facility failed to appropriately isolate residents after an Immediate Jeopardy situation was identified on 7/24/2020. On 4/30/2020 the Centers for Disease Control and Prevention (CDC) published guidance entitled Responding to Coronavirus (COVID-19) in Nursing Homes. This guidance provided that for a resident with new-onset suspected or confirmed COVID-19, roommates of residents with COVID-19 should be considered exposed and potentially infected and, if at all possible, should not share rooms with other residents unless they remain asymptomatic and/or have tested negative for [DIAGNOSES REDACTED]-CoV-2 14 days after their last exposure (e.g., date their roommate was moved to the COVID-19 care unit). Exposed residents may be permitted to room share with other exposed residents if space is not available for them to remain in a single room. Resident #1 showed cough and congestion on 7/20/20 and was not isolated or re-tested for Covid-19. Isolation precautions were not ordered and were not implemented. As noted above, an Immediate Jeopardy was declared on 7/24/2020 at 2:0 PM. The facility placed Resident #1 on droplet precautions and placed the resident under isolation observation pending 7/24/20 COVID-19 test results. On and prior to 7/24/20, Resident #6 shared the same room with Resident #1. Resident #6 was therefore exposed to Resident #1 who had presented symptoms associated with COVID-19 infection. Nonetheless, on 7/27/20 Resident #6 was moved into another room with Resident #7. Residents #1, #6 and #7 were not restricted to their rooms after being placed on isolation precautions. On 7/21/20 the Maryland Department of Health (MDH) issued updated guidance entitled Preparing for and Responding to COVID-19

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) in Nursing Homes and Assisted Living Facilities. The MDH indicated to cancel communal dining and all group activities in the facility, unless otherwise allowed based on a facility's phase in the relaxation of restrictions. Residents who have signs or symptoms of illness, are on a COVID-19 observation unit, or with suspected or confirmed COVID-19 (including those without symptoms) must remain in their room with the door shut if possible until they have been cleared from observation or Transmission-Based Precautions. Other residents should remain in their room to the extent possible, except for medically necessary purposes. Have all residents who leave their rooms, including those who must regularly leave the facility for medically necessary purposes (e.g., residents receiving [MEDICAL TREATMENT]) wear a facemask or cloth face covering if tolerated when outside of their room, including for procedures outside of the facility. On 7/27/20 at 9:32 AM, Resident #1 who had been ordered to remain in isolation, was observed in the 1st floor hallway eating breakfast across from the dining area. Other residents were observed on the unit at this time. Resident #1 was not wearing a mask and was seated in the hallway near Licensed Practical Nurse (LPN) #7. At 9:45 AM a tour of the 1st floor alongside the Director of Nursing (DON) revealed Resident #1 was still eating in the hallway outside their room and without a face covering. Interview with the DON at this time confirmed that the DON expected Resident #1 to be in their room under isolation. Interview with LPN #7 confirmed that they knew Resident #1 was on isolation precautions but wanted the resident in their line of sight during breakfast due to the resident's fall risk. On 7/28/20 at 10:16 AM Resident #6 and #7's door was observed open and Resident #6 was sitting in the open doorway with their feet in the hall. Resident's #6 and 7 were placed on isolation precautions starting 7/24/20. Resident #11, while ambulating down the hall with the assistance of Physical Therapy (PT) Staff #10, paused at the doorway approximately 2-3 feet from Resident #6's face and had a roughly 1 min conversation with Resident #6 before continuing down the hallway. PT Staff #10 was interviewed at 10:32 AM and asked if they were aware of any residents on the unit on isolation precautions. Staff #10 identified Resident #1, Resident #12 and Resident #13 but failed to identify Residents #6 and #7. Staff #10 informed surveyors that they were made aware of residents currently on isolation precautions by the nurse on the unit. Further observation of the unit at this time revealed Resident #1's door was open approximately 2 feet despite being on isolation observation. On 7/29/20 at 10:07 AM the door to Resident #6 and 7's room was observed completely open. Resident's #6 and #7 were still on isolation protocol for potential exposure to Covid-19 at this time. Interview with the DON at 11:45 AM confirmed that they expected resident doors to be closed as part of the isolation observation precautions. The facility has a dedicated Covid-19 unit with multiple open rooms available for residents to be isolated and observed that is not being utilized. In a 7/23/20 interview at 9:45 AM, Quality Nurse #3 reported the unit is not utilized due to staffing shortage. (4) The facility failed to ensure that symptomatic staff did not and could not work during the declared health emergency. State Surveyors were told by the Quality Nurse #3 and Administrator upon entering the facility on 7/22/20 that the facility had no positive COVID-19 cases in residents or staff but this was not accurate. Additionally, the Quality Nurse informed surveyors at 8:58 AM on 7/28/20 that they did not have line listings for staff symptoms because no staff have displayed symptoms of COVID-19 or tested positive for COVID-19. On 7/28/2020 at 10:00 AM, in an interview with Dietary Staff #8, surveyors learned that a member of the dietary team, Staff #9, had tested positive for COVID-19. Further interview with the Food Service Manager (FSM, Staff #11) at 12:20 PM confirmed that Staff #9 had tested positive for COVID-19 on 7/13/2020 and had informed the FSM on 7/14/20 who immediately informed the facility's Quality Nurse #3 the same day. Further interview with Dietary Staff #8 on 7/28/20 at 10:35 AM revealed that Staff #9 had come to work the morning of 7/12/20 and complained of having a persistent cough. Dietary Staff #8 advised Staff #9 to speak with one of the nurses on the unit. According to Dietary Staff #8, Staff #9 spoke with two nurses on the Terrace unit, the first nurse referred Staff #9 to the second nurse who told Staff #9 they can remain at work if they wear a mask. Dietary staff #8 was not able to identify which nurses gave Staff #9 these instructions. Staff #9 returned to the kitchen and completed their shift for the day. On the following day, 7/13/20, Staff #9 did not report for work and was privately tested for COVID-19. Staff #9 received the COVID-19 positive result on 7/14/20. Coughing is a symptom of COVID-19 identified by the Centers for Disease Control and Prevention guidance published 5/13/20. The facility's COVID 19 Pandemic Emergency Procedure provided to surveyors states to Reinforce sick leave policies and remind Health Care Personnel (HCP) not to report to work when ill. as well as If they (HCP) are ill, have them keep their cloth face covering or facemask on and leave the workplace. Cross reference F 885. (5) The facility failed to report the known Staff case of COVID-19 as required. On 4/29/20 the Maryland Department of Health (MDH) published the Amended Directive and Order Regarding Nursing Home Matters which provided in addition to all current reporting requirements to state and local health departments, all facilities shall report the following information to the Chesapeake Regional Information System for Our Patients (CRISP). On a daily basis, each facility report should include at least the following: i. The census of occupied beds; ii. Number of residents with positive COVID-19 test results; iii. Number of residents with suspected COVID-19; iv. Number of residents with negative COVID-19 test results; v. Number of deaths, by COVID-19 status; vi. Number of staff with positive COVID-19 test results; vii. Number of residents with severe respiratory infection or COVID-19 resulting in hospitalization ; viii. Number of staff with severe respiratory infection or COVID-19 resulting in hospitalization ; ix. Number of residents or staff with new-onset respiratory symptoms that occur within 72 hours of another resident or staff developing respiratory symptoms; and x. Any other information required. On 6/19/20 and 7/24/20 in updates to Amended Directive and Order Regarding Nursing Home Matter, these same reporting requirements continued. In addition to the report to the surveyors that there had been no positive COVID cases in the building, review of reporting data revealed that the facility failed to report the new onset of symptoms for Staff #9 and failed to report the positive COVID-19 test for Staff #9 as required. (6) The facility failed to ensure communication to staff of critical isolation precautions information. On 7/22/2020, surveyors conducted a tour of the facility which included all units, donning/doffing rooms, and nurse's stations. The facility did not have any signs in place showing staff what PPE to use and how to properly Don/doff (put on and take off) their PPE. On 7/28/2020 from 9:00 AM to 9:50 AM further observation of staff don/doff rooms on the Terrace, 1st floor, 2nd floor and 3rd floor confirmed that no signage was in place. (7) The facility failed to develop a system to conduct surveillance monitoring of staff infection control practices to determine effectiveness and need for quality improvement training During an interview on 7/22/20 at approximately 2:00 PM the surveyor asked Quality Nurse #3 who the acting Infection Preventionist was as well as to explain how they audits infection control practices of the staff such as hand hygiene, donning and doffing of personal protective equipment (PPE) and other infection control and prevention practices. Quality Nurse #3 indicated that they watched the staff when they were on the units and if they were not doing something properly, they would immediately be educated by Quality Nurse #3. In an interview on 7/28/20 at 11:00 AM Quality Nurse #3 indicated that the facility did not conduct routine audits of staff practices. Quality Nurse #3 was asked how they monitored trends and educational needs for quality improvement planning and follow up. Quality Nurse #3 then presented the surveyor with a form labeled High Reliability Review Infection Prevention and Control Strategies which was divided into 3 shifts and provided space to record guided observations of the staff infection control practices related to COVID-19. However, when asked how they use this tool, Quality Nurse #3 indicated that they do not use the form but the charge nurses can fill it out and it is then sent to corporate. She was asked if she reviews the completed forms for the quality assessment and performance improvement (QAPI) purposes in order to identify the facility needs for further staff training. Quality Nurse #3 indicated they did not; she indicated that it is just sent to corporate. (8) Facility staff were reusing disposable gowns in an unsafe manner. The CDC guidelines allowing extended use of gowns which was not accepted practice but rather was an allowable exception providers might need to utilize if they experienced a sudden surge and were unable to obtain gowns through any other means. The guidance was published on 3/17/20 and provided that surge capacity refers to the ability to manage a sudden, unexpected increase in patient volume that would otherwise severely challenge or exceed the present capacity of a facility. While there are no widely accepted measurements or triggers to distinguish surge capacity from daily patient care capacity, surge capacity is a useful framework to approach a decreased supply of isolation gowns during the COVID-19 response. Three general strata have been used to describe surge capacity and can be used to prioritize measures to conserve isolation gown supplies along the continuum of care. The third highest level of surge capacity threatening to outstrip available resources and supplies shortage was defined as crisis capacity. The CDC indicated these described strategies for gowns are not commensurate with standard U.S. standards of care . but may be considered during periods of known solation gown shortages. An initial tour of the facility was conducted on 7/22/20. On the third floor at 8:43 AM the surveyor observed room [ROOM NUMBER] with multiple disposable isolation gowns hanging on hooks around the perimeter of the room. At approximately 9:00 AM, the surveyors observed a room at the end of the hallway on the first floor with disposable isolation gowns hanging on the walls of the room. Staff #14 identified this room as the Snoezelen (sensory) Room and indicated that it was being used as the donning and doffing station. Staff #14 explained that staff remove their

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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** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 3) gown at the end of their shift, hang it on the hook then re-don the same gown the next time they work. Staff #14 further explained that the gowns are discarded if they become soiled or torn. At 10:15 AM during an interview, Staff #4, a unit manager, was asked about the process for staff coming on duty. Staff #4 indicted that staff are screened at the front entrance, temperatures are assessed, staff put on a mask then proceed to the donning & doffing station on their unit and don their gown, gloves and face shield there. Quality Nurse #3 indicated at that time that the facility did not track the PPE usage and that the facility did not have a shortage of PPE. At 12:10 PM Staff #15, a Geriatric Nursing Assistant (GNA) was observed entering the first floor nurses' station. Staff #15 put on a disposable gown and face shield which they picked up from the back of a chair in the nurses' station. Staff #15 was asked to explain the protocol for reusing the PPE and indicated that they put them in the nurses' station when they went to lunch. Staff #15 explained that at the end of the day, the staff remove and store the gowns and face shields in the donning and doffing stations on each unit for reuse the next day. Staff #15 was not sure if the disposable gowns were sanitized in any way. On 7/27/20 at approximately 2:00 PM Staff #2 the Director of Nursing was asked for the PPE burn rate monitoring sheets for the facility (these are sheets which log the amount of PPE that is used in order to determine usage rates and supply needs). Staff #2 indicated that the Health Department is no longer requiring they be sent. Staff #2 indicated that they were last submitted approximately 3 weeks prior and confirmed that the facility was not experiencing a shortage of PPE. The facility was not experiencing and had not implemented crisis strategies. An interview was conducted with the Receiving Clerk, Staff #15, at 3:20 PM on 7/27/20 who confirmed that they were no longer required to submit the burn rate sheets and indicated that the facility had no shortages of PPE. Staff #15 confirmed that the gowns that staff were using were disposable and that the staff were reusing PPE until this past week. On 7/30/20 at approximately 5:00 PM, the surveyor observed room [ROOM NUMBER]; a yellow sign was posted on the door frame outside the room with instructions to see the nurse before entering. A plastic PPE supply cart was in the hallway just outside of the door. Immediately inside of the room on the right was a wardrobe with double doors. The knob on each of the doors had multiple disposable isolation gowns hanging from them. Staff #12, the Regional Director of Clinical Operations, was shown these findings at that time and confirmed that the resident was on isolation precautions for observation due to symptoms associated with COVID-19. When asked to explain the rationale for hanging the gowns in such a manner Staff #12 indicated that staff may be reusing the gowns because of shortages. Staff #12 was made aware at that time that per Staff #2, #3 and #15 there were no shortages of PPE and there was no indication that crisis strategies had been implemented. The facility had a designated COVID-19 unit. No residents were residing on this unit during the survey. On 7/31/20 at 10:07 AM the surveyor observed the vestibule to the entrance of the designated COVID unit. 8 disposable gowns were observed hanging on wall hooks along with 2 face shields. On the wall just inside the unit disposable isolation gowns were observed hanging on wall hooks, a bulletin board and a tree style coat rack. Per the Centers for Disease Control (CDC) COVID-19 Nursing Home & Long-Term Care Facilities guidance - updated June 25, 2020: If extended use of gowns is implemented as part of crisis strategies, the same gown should not be worn when caring for different residents unless it is for the care of residents with confirmed COVID-19 who are cohorted in the same area of the facility and these residents are not known to have any co-infections (e.g., [MEDICAL CONDITION]). Quality Nurse #3 was unable to provide the surveyor with CDC or Health Department guidance which supported and provided guidance for the practice of storing and reusing disposable isolation gowns throughout the survey. The interrelated failures in implementing an effective infection prevention control program left all residents, staff and visitors at increased risk for harm and death associated with COVID-19 exposure during the declared health emergency.
F 0885 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	Based on staff interview and document review it was determined that the facility failed to inform all residents, their representatives, and families by 5 PM the next calendar day following the occurrence of a confirmed COVID-19 infection. This was evident for all resident representatives/families of residents in the facility. The findings include: On 7/28/2020 at 10:00 AM in an interview with Dietary Staff #8, surveyors learned that a member of the dietary team (Staff #9) had tested positive for COVID-19. Further interview with the Food Service Manager (FSM, Staff #11) confirmed that Staff #9 had tested positive for COVID-19 on 7/13/2020 and had informed the FSM on 7/14/20 who immediately informed the facility's Quality Nurse #3 the same day. State Surveyors were told by the Quality Nurse and Administrator upon entering the facility on 7/22/20 at 8:15 AM that the facility had no positive COVID-19 cases in residents or staff. Additionally, the Quality Nurse informed surveyors at 8:58 AM on 7/28/20 that they did not have line listings for staff symptoms because no staff have displayed symptoms of COVID-19 or tested positive for COVID-19. An interview with the Administrator and the Regional Director of Clinical Operations on 7/28/20 at 2:27 PM revealed that the Administrator did know that Staff #9 tested positive for COVID-19 and that the facility sent letters to resident families and representatives immediately after learning of the test result on 7/14/20. On 7/29/20 at 10:20 AM the Administrator provided a copy of the letter mailed to resident families and representatives that was dated 7/15/20. Interview with the Administrator at this time confirmed that the facility mailed the letters on 7/15/20 and therefore did not inform all resident representative and families by 5 PM the next calendar day following the occurrence of a single confirmed COVID-19 infection. Cross reference F 880 (3).