STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395142	A. BUILDING _____ B. WING _____	**06/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GARDENS AT BLUE RIDGE, THE	**3625 NORTH PROGRESS AVE HARRISBURG, PA 17110**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review and staff interview, it was determined that the facility failed to ensure infection control policies and procedures were implemented to prevent the potential spread of infectious disease for one of three units observed (Unit 1) and the facility failed to notify [MEDICAL TREATMENT] centers of Residents who were tested for COVID-19 for two of three [MEDICAL TREATMENT] Residents reviewed (Residents 4 and 5). Findings Include: Review of Resident 4's clinical record revealed [DIAGNOSES REDACTED]. Further review of Resident 4's clinical record revealed that Resident 4 receives [MEDICAL TREATMENT] treatments at an outside [MEDICAL TREATMENT] clinic three times a week. Review of Resident 4's nursing progress note dated May 27, 2020, revealed Resident 4 presents with harsh non productive cough. New order was received to swab for COVID-19. Review of nursing note dated May 28, 2020, revealed that the COVID-19 test was done and sent to the lab. On May 29, 2020, a nursing note stated that Resident 4 went to [MEDICAL TREATMENT]. There is no documented evidence that [MEDICAL TREATMENT] was made aware that Resident 4 was swabbed for COVID-19 and results were pending. Review of nursing progress note dated May 31, 2020, revealed that Resident 4's test was positive for COVID-19. Message left for [MEDICAL TREATMENT] to return call. Transportation updated to contact [MEDICAL TREATMENT] for new chair time at isolation clinic. Review of Resident 4's [MEDICAL TREATMENT] communication forms dated May 20 and May 22, 2020, revealed written communication to the [MEDICAL TREATMENT] center that Resident 4's neighboring room was positive for COVID-19. Review of Resident 4's [MEDICAL TREATMENT] communication forms dated May 27, May 29, and June 1 revealed no written communication that Resident 4 had been tested for COVID-19 and no written communication that the test came back positive. During an interview with Employee 1 from the [MEDICAL TREATMENT] clinic, on June 25, 2020, at 9:42 AM, Employee 1 stated that Resident 4 arrived to the [MEDICAL TREATMENT] center approximately one hour prior to treatment and waited in the lobby until treatment began. About 30 minutes into Resident 4's [MEDICAL TREATMENT] treatment, a nurse from the facility called to inform [MEDICAL TREATMENT] that they were sending a patient our way that tested positive for COVID (Resident 4). The staff member from [MEDICAL TREATMENT] stated that no communication was received from the nursing facility that the Resident was suspected of having [MEDICAL CONDITION]. Review of Resident 5's clinical record revealed [DIAGNOSES REDACTED]. Further review of Resident 5's clinical record revealed that Resident 5 receives [MEDICAL TREATMENT] treatments at an outside [MEDICAL TREATMENT] clinic three times a week. Review of Resident 5's nursing progress notes revealed that on June 2, 2020, Resident 5 was swabbed for COVID-19. On June 3, 2020, Resident went to [MEDICAL TREATMENT]. There is no documented evidence in the progress notes that [MEDICAL TREATMENT] was made aware that Resident 5 was swabbed for COVID-19. On June 4, 2020, a progress note states that [MEDICAL TREATMENT] was called and made aware that Resident 5's COVID-19 test was negative. Review of Resident 5's [MEDICAL TREATMENT] communication form dated June 3, 2020, revealed no documentation on the form to notify [MEDICAL TREATMENT] that Resident 5 was tested for COVID-19. During an interview with an employee from the [MEDICAL TREATMENT] clinic, Employee 2, on June 25, 2020, at 1:05 PM Employee 2 stated that the [MEDICAL TREATMENT] clinic was not made aware that Resident 5 was tested for COVID-19 which could have resulted in possible exposure to other patients and staff at the [MEDICAL TREATMENT] clinic, if the test would have been positive. During a staff interview with the Assistant Director of Nursing (ADON) on June 16, 2020, at approximately 10:15 AM she stated that if a Resident is tested for COVID-19, they would be presumed positive and it should be written on the [MEDICAL TREATMENT] communication form. She also stated that if a Resident tests positive for COVID-19, it should be written on the communication form and the [MEDICAL TREATMENT] center should be called. A tour of the facility with the Director of Nursing (DON) on June 16, 2020, at approximately 10:00 AM revealed designated Green Zones and Red Zones. The Red Zones are the designated COVID-19 units for the Residents who have tested positive for COVID-19. The DON stated on June 16, 2020, at approximately 9:45 AM that when staff are working in the Red Zone they are required to wear a gown, mask, face shield, and gloves. He stated that when going from room to room, staff can wear the same gown, mask and face shield, unless soiled, but they are required to change gloves and perform hand hygiene after Resident contact. Observation of unit 1, a designated Red Zone during beverage pass on June 16, 2020, at 12:15 PM revealed Nurse Aide (NA) 2 exiting Resident 7's room, wearing a gown, mask, face shield and gloves, and without removing her gloves or doing hand hygiene, entering Resident 8's room. She was observed speaking with Resident 8 and touching Resident 8's walker with her gloved hand. NA 2 exited Resident 8's room, did not remove her gloves or perform hand hygiene, went to the beverage cart and poured a glass of tea and again entered Resident 8's room. NA 2 was observed moving Resident 8's bedside table and unwrapping her silverware in preparation for lunch. NA 2 then exited Resident 8's room, did not remove gloves or perform hand hygiene, and went to the beverage cart. NA 2 then entered Resident 9's room to deliver a beverage, exited Resident 9's room and entered Resident 10's room. NA 2 then came back out into the hallway to the drink cart, poured a glass of iced tea and took the glass into Resident 10's room. NA 2 touched Resident 10's bedside table then came out of the room. NA 2 did not remove gloves or perform hand hygiene. NA 2 then entered Resident 11's room, delivered a drink and then exited the room. At that time, at approximately 12:20 PM, the Director of Nursing was walking by and immediately stopped NA 2, had her remove her gloves, wash her hands and he did on the spot education with NA 2. On June 16, 2020, at approximately 1:15 PM, the Nursing Home Administrator was made aware of the above observations. 28 Pa. Code 211.12(d)(1) Nursing services.

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.