STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215106	A. BUILDING _____ B. WING _____	05/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SAGEPOINT NURSING AND REHABILITATION CENTER	10200 LA PLATA ROAD LA PLATA, MD 20646

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview it was determined that the facility failed to develop and implement a comprehensive, resident-centered care plan for residents who were given a medication that is known to have toxic effects. This was evident for 1 (#1) of 9 residents that had medical record reviews. The findings include: A record review on 4/22/2020 at 9:00 AM for Resident #1 revealed that the resident had [DIAGNOSES REDACTED]. [MEDICAL CONDITION] is a heart condition that affects adequate blood flow from the heart due to irregular heartbeat. A progress note dated 4/22/2020 stated the resident was COVID-19 positive and was started on an anti[DIAGNOSES REDACTED]l medication. Review of Resident #1's comprehensive care plan revealed that on 4/21/2020, a COVID-19 care plan was initiated with a goal: Will exhibit relief from symptoms of COVID-19 in the next 30 days. The interventions included monitoring for symptoms, oxygen therapy, psychosocial issues, and isolation. However, facility staff failed to initiate monitoring for toxic effects of the anti[DIAGNOSES REDACTED]l medication the resident had been started on. An interview with Licensed Practice Nurse (LPN) #23 on 5/1/2020 at 11:45 AM, revealed that staff had initiated monitoring of COVID-19 symptoms for residents who had been COVID-19 positive and started on the anti[DIAGNOSES REDACTED]l medication. When asked if they monitored these residents for toxic effects of the medication, LPN #23 stated that they had not. An interview with the Director of Nursing (DON) on 5/1/2020 at 11:50 AM, revealed that the nursing staff were not initiating monitoring for toxic effects for residents who had been started on the anti[DIAGNOSES REDACTED]l medication. The Administrator was made aware of these concerns on 5/6/2020 at 9:10 AM.
F 0770 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide timely, quality laboratory services/tests to meet the needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** F-770 Based on observation, staff interview, and review of resident medical records, the facility failed to ensure an effective process was implemented to ensure critical lab results were received timely, resulting in a more than 10 day delay in obtaining COVID testing results for Resident #4 who was COVID positive. The system failure increased the risk for the spread of the potentially fatal infectious agent from unidentified positive residents to all other residents in the highly vulnerable nursing home population, as well as to staff and visitors. As a result of these findings, a state of immediate jeopardy was declared on 4/29/2020 at 4:36 PM. The facility submitted an acceptable plan of removal at 11:04 PM on 4/29/2020 and it was accepted by the state agency at 11:20 PM. After removal of the immediacy, the deficient practice remained for the potential for more than minimal harm and at a scope and severity of D. The Findings include: CMS defines cohorting as the practice of grouping residents infected or colonized with the same infectious agent together to confine their care to one area and prevent contact with other susceptible residents. Resident #4 was tested for COVID on 4/6/20. Review on 4/24/20 at 11:33 AM, of the medical record for Resident #4, revealed a 4/6/20 nursing note entered by the Director of Nursing (DON) at 11:07 AM documenting per (Resident's Primary Physician), resident was tested for COVID-19 today. Results pending. During a joint interview on 4/23/20 at 10:30 AM, the Administrator and DON both indicated that the facility had decided to have all residents in the facility tested for COVID-19 on 4/6/20. During a later 4/28/20 interview at 1:03 PM, the DON stated that for some reason Resident #4's results had not been obtained when on 4/20/20 the family asked for test results and we couldn't find them. The DON reported that she then contacted the laboratory and obtained the results on 4/20/20. In a 4/20/20 nursing note entered at 1:30 PM, the DON documented that she updated Resident #4's representative on his/her s COVID positive results. No earlier documentation regarding the test results was found in the medical record. During an interview on 4/29/20 at 6:30 PM, the Administrator described the facility process for obtaining lab results. She indicated that test results were received by nursing staff, and when received, each nurse was responsible for reporting the results to their unit managers, the residents' attending physicians, and to residents' responsible parties. The Administrator acknowledged there was no master list or other process developed to track and ensure that results from all the critical COVID lab tests sent to the lab were reported back to the nursing home timely. During 5/1/20 interview at 9:45 AM, the Administrator indicated that results from the 4/6/20 testing of all of the other residents in the facility were received beginning on either 4/8/20 or 4/9/20 and up to 4/11/20 (the facility provided 4/8 and 4/9 contradictory dates and the Administrator indicated that she would verify the dates but no confirmation was ever provided to the survey team prior to the survey exit). With no system to ensure all COVID test results were obtained timely, the COVID positive result for Resident #4 was missed. Only when family requested the results did staff discover they had not been obtained. Resident #4 remained on the otherwise negative unit during the lengthy delay after he/she had been tested on [DATE] and before staff obtained the test results on 4/20/20. This system failure increased the risk for transmission of the potentially fatal infectious agent to all residents, staff and visitors. As a result of these findings, a state of immediate jeopardy was declared on 4/29/2020 at 4:36 PM and an IJ summary tool was provided to the facility at that time. The facility submitted the first draft of their plan to remove the immediacy at 6:25 PM and it was not accepted. The facility submitted the second draft at 8:26 PM and it was also not accepted. The third draft was submitted at 11:04 PM and it was accepted by the state agency at 11:20 PM. The provisions of the plan to remove the immediacy included the following: Immediate review of all residents tested for COVID-19 to ensure that no other resident's result was not entered into the medical record or communicated with the resident's responsible party. A master list will be maintained by the director of nursing that documents when a resident is tested for COVID-19 and when the result becomes available. The Director of Nursing and the infection Preventionist will be educated by the Administrator regarding this new process. The Unit Managers will be educated by the DON that, upon testing of a resident for COVID-19, they will communicate that test to the DON so that an entry may be made into the master list. All lab test results will go straight to the DON who will enter the result into the master list at that time and communicate the result to the Unit Managers. The DON will review the master list daily to monitor for delays in return of lab reports. The master list will be surrendered to the Quality Assessment Performance Improvement (QAPI) committee by the DON for review and adjustments as needed. This will happen monthly for three months. The Immediate Jeopardy was removed on 5/1/20 at 12:00 PM. Cross Reference Federal Tags F835 and F880, and State CO[DATE] and 1410
F 0835 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** F835 Based on observation, interview with facility staff, and review of Federal guidance, facility policy and resident

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 0835 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) records, it was determined that the facility was not managed in a manner that effectively utilized its resources to maintain the highest practicable well-being of each resident as evidenced by the failure to manage the facility's response to, and minimize the transmission of, the COVID-19 virus during the COVID-19 pandemic. Specifically, the administration failed to ensure the facility was in compliance as evidenced by the failures to: 1) obtain COVID-19 lab results timely for residents, 2) properly cohort residents based on COVID-19 status, and 3) educate, monitor, and evaluate proper use of personal protective equipment (PPE) and hand hygiene. As a result of this noncompliance, at the time the survey began, all residents, staff and visitors had been placed at risk, 92 residents had become positive for COVID-19, and 29 of these residents had died . The findings include: 1. During a telephone interview on [DATE] at 1:00 PM with the Director of Nursing (DON), the DON stated that she was responsible for ensuring that all residents were tested for COVID-19 when the facility performed testing on all residents on [DATE]. The DON confirmed that Resident #4 was tested on [DATE] by nasal swab for COVID-19 but that results of the test were not documented and available in the medical record until [DATE]. The DON was unable to explain why results from the laboratory were not available in the medical record and could not demonstrate any evidence that staff had attempted to obtain the results from the testing laboratory until [DATE]. The DON stated that she obtained the laboratory results for Resident #4 from the testing laboratory on [DATE]. Resident #4's medical record was reviewed on [DATE] at 10:00 AM. The review confirmed the statements of the DON that Resident #4 had been tested for COVID-19 on [DATE] but that no test results were available in the medical record until [DATE]. The facility's COVID-19-focused line listing was reviewed on [DATE] at 11:00 AM. The review revealed that the line listing contained two columns related to COVID testing and status: COVID-19 (positive or negative) and Date of COVID-19 test. Resident #4's entry stated (positive) and (testing date of) ,[DATE]. No column indicated when test results were received by the facility. During a follow up interview with the DON on [DATE] at 11:33 AM, the DON stated that she had received a phone call from one of Resident #4's family members on [DATE]. She reported that, Resident #4's family member requested the resident's COVID-19 test results from testing done on [DATE]. However, when the DON reviewed the medical record, she determined that the resident did not have any test results for that testing recorded anywhere in the resident's medical record. The DON went on to explain that she followed up with the testing laboratory the same day on [DATE] and received results indicating that Resident #4 had been COVID-19 positive since [DATE] - 14 days prior. The DON further stated that results for other residents had arrived back to the facility as soon as either [DATE] or [DATE] (the facility provided contradictory information on these two dates and although asked, never provided clarification). During an interview with the Administrator that took place on [DATE] at 10:25 PM, the Administrator stated that there was no master list of residents to track receipt of the critical lab results for COVID-19. 2. During an interview that took place on [DATE] at 6:50 PM, the Administrator and the Director of Nursing (DON) indicated that there was one positive resident (Resident #3) residing on the 300 Unit, a unit designated for COVID-19 negative residents. When asked if there was room on the positive units for additional residents, they indicated that there was. Concurrent observation of the 300 Unit revealed that only Resident #3's room had a sign posted on the door indicating that the resident was on droplet precautions. There was no trash receptacle for discarding contaminated personal protective equipment just outside or inside of the resident's room door. During an interview that took place on [DATE] at 7:05 PM, the Unit Manager of the 400 Unit stated that there were no COVID-19 positive residents on the 400 Unit. The Administrator and Director of Nursing (DON) were present during the interview and the DON confirmed that there were no positive residents on the unit. Licensed Practical Nurse (LPN) #24 was interviewed directly afterward at 7:06 PM on [DATE]. LPN #24 stated that she was the nurse for the 400 Unit that evening and was caring for 17 patients. When asked if there were any COVID-19 positive residents on the unit, she reported that there were two: Residents #1 and #2. She outlined her process for changing her isolation gown when leaving a positive resident's room. When asked if she had worked exclusively on negative units, she responded that she worked on the 200 Unit, which was being maintained as a COVID-19 positive unit as recently as [DATE]. And when asked what steps she took to care for residents under investigation for COVID-19 and awaiting test results, she stated, I will take extra precautions with them. During an observation of the 400 Unit that took place on [DATE] at 7:10 PM, Resident #1's door was noted to be open. The resident was seen resting in his/her bed, and the resident was noted not to be wearing a mask. There was no donning station with personal protective equipment (PPE) supplies outside the room. Later during the same observation at 7:11 PM on [DATE], Resident #2's door was noted to be open and the resident was also seen in bed not wearing a mask. A staff member was actively placing a droplet precaution sign on the door at the time of the observation. The staff member walked away without closing the resident's door. During an interview with the Director of Nursing that took place on [DATE] at 9:45 AM, the Director of Nursing indicated that residents who tested positive for COVID-19 were allowed to remain on negative units if they or their responsible parties refused to allow them to be transferred to a positive unit. The Centers for Medicare & Medicaid Services document entitled, COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers with a retroactive effective date of [DATE] was reviewed on [DATE] at 12:00 PM. The review revealed that CMS had waived the requirements in 42 CFR 483.10(e)(5), (6), and (7) solely for the purposes of grouping or co-horting residents with respiratory illness symptoms and/or residents with a confirmed [DIAGNOSES REDACTED]. This action waives the facility's requirements to, provide notice and rationale for changing a resident's room and to provide for a resident's refusal of a transfer to another room in the facility. During an interview with the DON on [DATE] at 11:33 AM, the DON reported that she was not aware of the above CMS waivers. When asked who was responsible in the facility for receiving, reviewing, and disseminating guidance from the CDC, CMS, and the state health department, she responded by stating that she was the designated person. She also said that doing so was difficult and a group effort, and reported that the Administrator and the Chief Nurse for the Assisted Living department helped to complete this task. 3a. During an observation of the facility that took place on [DATE] at 6:30 PM, the Administrator and Director of Nursing (DON) were noted to wear the same pair of gloves while entering and exiting both positive and negative units. When entering and exiting different units, the DON obtained alcohol-based hand sanitizer from a pocket and would dispense the product directly onto her gloves and the gloves of anyone else entering and exiting the unit. When asked what guidance this practice of sanitizing but not changing gloves was based on, the DON stated that it was recommended to them by a physician from Health and Human Services who had visited the facility as part of a team to advise the facility on their infection control practices. During an observation that took place on [DATE] at 8:40 AM, registered nurse (RN) #22 was seen entering room [ROOM NUMBER] with medications and then kneeling on the floor next to the bed to administer them to the resident in bed A. She then came out of the room carrying a medication container, set it on the medication cart, and then removed her gloves and donned a new pair from her pocket. Then she applied alcohol-based hand sanitizer to the new pair of gloves. She was interviewed at that time and confirmed this process. Later at 8:45 AM on [DATE], Social Worker (SW) #13 and Geriatric Nursing Assistant (GNA) #18 were seen picking up trays on the 300 Unit. SW #13 took a tray from room [ROOM NUMBER], placed it on the tray cart, and then sanitized the gloves that she was wearing. SW #13 was interviewed and stated that she was not told to conserve gloves and was not told to sanitize them between residents. GNA #18 was interviewed at the same time and stated that she changed her gloves between residents, sanitizing her hands before putting on the new pair. During a follow up interview with the DON that took place on [DATE] at 9:10 AM, the DON indicated that the practice of sanitizing gloves had not yet become part of the facility's policy, nor had any staff received formal training on the practice. The DON also stated that the facility had ample supplies of gloves. Available guidance from CMS, the CDC, and the state health department were reviewed throughout the survey. No guidance could be found that recommended the reuse and sanitization of gloves by health care professionals. 3b. During an observation of the 200 Unit (designated COVID-19 positive) that took place on [DATE] at 7:45 PM, the Administrator and Director of Nursing (DON) were noted to enter the unit without donning any additional PPE. While on the unit, the Administrator and DON were noted to be in close proximity (within 5 feet) of staff who were going in and out of the hallway with wandering COVID-19 positive residents, as well as other staff who were providing direct patient care to COVID-19 positive residents. During an observation of the 100 Unit (designated COVID-19 positive) that took place later at 7:50 PM, the DON was again noted to not change any PPE, including her gloves. During an observation of the 200 Unit that took place on [DATE] at 9:00 AM, Floor Technician #14 was observed touching contact surfaces without gloves. This was observed in the presence of the Chief Nurse of the Assisted Living Department, who had not intervened to address the employee's noncompliant use of PPE. In CDC Guidance, Recommendations for Use of Personal Protective Equipment When Caring for Patients with Confirmed or Suspected COVID-19 that was released on [DATE], the guidance indicates that if the facility has established a designated unit for cohorting COVID-19 positive residents, then staff are to follow droplet precautions for the entire unit and don and doff prior to entering and exiting the unit accordingly. The CDC guidance was not being followed by Administrative staff who were responsible to monitor and evaluate infection control practices of all staff. c.

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F 0835 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 2) Audits of the facility staff's use of personal protective equipment (PPE) was requested from the Director of Nursing on [DATE] at 9:00 AM, from the Administrator on [DATE] at 9:40 AM, and from the Infection Preventionist on [DATE] at 10:30 AM. Audits were described as anything that demonstrated that administrative or managerial staff actively observed and reviewed the way front-line staff were utilizing PPE to ensure that staff were following the procedures they were trained to follow. No evidence of audits were provided to the survey team as of the end of the survey. Cross Reference Federal Tags F770 and F880 and CO[DATE] and 1410
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** F880 Based on observation, staff interview, review of documentation including medical records and State and Federal guidance, the facility failed to develop and implement an effective infection prevention and control program and contain a COVID-19 outbreak as evidenced by the following interrelated system failures. The facility failed to 1) sufficiently establish doffing stations and ensure staff followed isolation precautions; 2) ensure effective systems to separate COVID negative and COVID positive residents as much as possible during an infectious outbreak; 3) ensure that staff followed accepted standards of practice for hand hygiene during the declared health emergency; 4) ensure that staff utilized personal protective equipment in a manner that met minimum standards and minimized risk for infectious spread; and 5) develop and implement an effective system to both obtain and clinically respond timely to critical laboratory results. As a result of this noncompliance, at the time the survey began, all residents, staff and visitors had been placed at risk, 92 residents had become positive for COVID-19, and 29 of these residents had died . As a result of these findings, an immediate jeopardy was declared on [DATE] at 9:40 AM. The facility submitted a plan of removal at 6:27 PM and it was accepted by the State Agency at 6:45 PM. After removal of the immediacy, the deficiency remained at a potential for more than minimal harm and at a scope and severity of E. The findings Include: On [DATE], the Maryland Secretary of Health issued a Directive and Order Regarding Nursing Home Matters Pursuant to Executive Order No. [DATE]-01 I. The order stated: Staff Assignments: Nursing homes shall immediately implement, to the best of their ability, the following personnel practices: - Establish a cohort of staff who are assigned to care for known or suspected COVID-19 residents. - Designate a room, unit, or floor of the nursing home as a separate observation area where newly admitted and readmitted residents are kept for 14 days on contact and droplet precautions while being observed every shift for signs and symptoms of COVID-19. - Designate a room, unit, or floor of the nursing home to care for residents with known or suspected COVID-19 A person under investigation (PUI) for COVID-19 per the Centers for Disease Control and Prevention (CDC) Guidance originally posted on [DATE], Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings, is to be kept in isolation in the same manner as a resident who is positive for COVID-19. The document also indicates that, when caring for residents suspected of COVID-19, staff should follow standard precautions, wear an N95 respirator, a face shield or goggles, gloves, and an isolation gown. Staff are to dispose of their isolation gown and gloves prior to leaving the resident's room. To complete this disposal, a doffing station including a trash can must be placed inside the resident's room directly next to the door. In order to alert staff of a resident who requires isolation precautions for known or suspected COVID-19, the CDC has provided signage to be placed outside of a resident's room. CMS defines cohorting as the practice of grouping residents infected or colonized with the same infectious agent together to confine their care to one area and prevent contact with susceptible residents. 1.0 The facility failed to sufficiently establish doffing stations and ensure staff followed isolation precautions 1.1 COVID positive test results had been obtained for multiple residents on or before [DATE] and the facility designated that Units 100 and 200 would be dedicated for COVID positive residents and Units 300 and 400 would be dedicated for COVID negative residents. Resident #2 resided on a unit the facility had designated as COVID negative. Review of the medical record on [DATE] at 4:45 PM, revealed that Resident #2 became symptomatic [DATE] with a fever, and then developed a cough and shortness of breath on [DATE]. Further medical record review revealed that, on [DATE], Resident #2 was tested for COVID-19 and results when obtained on [DATE], were positive. Only when the positive test result was obtained, were isolation precautions initiated. Although a known outbreak was evolving in the building, for 7 days Resident #2 was symptomatic but remained on the unit designated for COVID positive residents without isolation precautions. During tour on [DATE] at 7:11 PM, the surveyor observed staff hanging the isolation precaution sign on Resident #2's door. Additionally, the surveyor observed that Resident #2's room door was open, Resident #2 was not wearing a mask, and no station was set up for staff to take off personal protective equipment. 1.2 Medical record review revealed that Resident #1 was symptomatic. Observation on [DATE] at 7:10 PM, revealed that a precaution sign was hung at his/her doorway, but the door to the room was left open, the resident was not wearing a mask, and no station had been set up for staff to safely take off personal protective equipment. 2.0 The facility failed to ensure effective systems to separate COVID negative and COVID positive residents as much as possible during an infectious outbreak. The Centers for Medicare & Medicaid Services (CMS) issued COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers with an effective date of [DATE]. The waivers were reviewed during survey on [DATE] at 12:00 PM. CMS had waived the requirements in 42 CFR 483.10(e)(5), (6), and (7) solely for the purposes of grouping or cohorting residents with respiratory illness symptoms and/or residents with a confirmed [DIAGNOSES REDACTED]. This action waived the facility's requirements to, provide notice and rationale for changing a resident's room and to provide for a resident's refusal of a transfer to another room in the facility. Consistent with the above noted Federal waiver, on [DATE] the State of Maryland Secretary of Health issued a Directive and Order Regarding Nursing Home Matters. This State Order required that Maryland nursing homes immediately implement, to the best of their ability, the following personnel practices: o Establish a cohort of staff who are assigned to care for known or suspected COVID-19 residents. o Designate a room, unit, or floor of the nursing home as a separate observation area where newly admitted and readmitted residents are kept for 14 days on contact and droplet precautions while being observed every shift for signs and symptoms of COVID-19. o Designate a room, unit, or floor of the nursing home to care for residents with known or suspected COVID-19. 2.1 Upon entry into the facility on [DATE] at 6:40 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) were interviewed about cohorting of residents. They reported that they had established separate units for residents that were positive for COVID-19, and for residents that were negative for COVID-19. Units 300 and 400 were designated as negative units. However, observations during the survey revealed that resident cohorting was not consistently implemented. Observations of the 300 and 400 Units on [DATE] at 6:45 PM, revealed that there were COVID-19 positive residents that were allowed to remain on these otherwise negative units. 2.2 In a [DATE] interview at 7:00 PM, the nursing home Administrator indicated that the facility's 400 Unit had no residents that were COVID-19 positive. However, this was not accurate as in interview on [DATE] at 7:06 PM, licensed practical nurse (LPN) #6 indicated that there were two COVID positive residents (Resident #1 and Resident #2) on the otherwise negative unit. 2.3 Two days later, in [DATE] interview at 8:25 AM, the Unit 400 Unit Manager indicated there was still one COVID-19 positive resident (Resident #1) on the otherwise negative unit. Review of the medical record revealed that Resident #1 had tested positive on [DATE]. The Unit Manager stated that Resident #1's remained on the unit as family did not want him/her moved. In interview on [DATE], the DON corroborated that Resident #1's family and resident refused to allow moving the resident from his/her room. The DON added that staff was continuing to encourage family to support the room change. Later, on [DATE], after the two-day delay, Resident #1 was moved off the Covid-19 negative unit. In a [DATE] interview with the DON, she indicated she was not aware of the CMS waivers in place during the health emergency. However, the facility Nursing Home Administrator (NHA) was aware of the CMS blanket waivers. On [DATE], the NHA submitted a request to the State Survey Agency to utilize the facility's closed adult medical daycare center space for cohorting residents. Thus, despite the CMS waiver supporting moving COVID-19 positive residents to isolate them away from negative residents, and despite the State Directive mandating these actions, the facility failed to timely move Resident #1 who was positive for COVID-19; and instead elected to delay the move off of the otherwise negative unit for two days after confirmed [DIAGNOSES REDACTED]. 2.4 On the second negative unit, another resident was not isolated and was also not moved timely as required under the State Directive. In an interview on [DATE] at 11:10 AM, the DON indicated that after a lengthy delay she obtained results for COVID testing for Resident #4 on [DATE] and the results were positive. Three days later, with the known positive [DIAGNOSES REDACTED].#4 was still on this otherwise negative unit. In addition to not being moved off the negative unit, at 8:30 AM on [DATE], the Surveyor observed that Resident #4 was being fed by Geriatric Nursing Assistant (GNA) #18 in the communal dining area on the negative unit. Furthermore, Resident #5 who was COVID negative was observed at the other end of the same table during the same meal. When asked, the GNA stated that the two residents (#4 and #5) ate meals in the dining room daily. 2.5 On [DATE], more than two weeks after the [DATE] testing, the facility still had not developed a working plan on how to manage resident cohorting for

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 3) residents who had tested positive and then recovered and cleared to negative status. In a [DATE] interview, the DON stated that they had not yet developed a plan but were working on developing one. 3.0 The facility failed to ensure that staff followed accepted standards of practice for hand hygiene during the declared health emergency. Surveyors made multiple observations where facility staff members were not performing hand hygiene, as necessary. For example: 3.1 On [DATE] at 8:40 AM, registered nurse (RN) #22 was observed going into a resident room on the 300 Unit with medications. RN #22 was observed kneeling on the floor while administering medications to the resident in bed A. RN #22 exited the resident room carrying a medication container and sat the container onto the medication cart. RN #22 then removed the gloves she was wearing and pulled out a new pair and applied them without washing her hands. RN #22 then sanitized the new gloves with hand sanitizer. 3.2 On [DATE] at 8:45 AM, surveyors observed two staff picking up trays on the 300 unit. A facility Social Worker was observed entering a resident room, picking up a tray and placing it on the cart. The Social Worker then did not wash her hands but sanitized the same gloves and then entered the next room. During an interview, she stated she was not told to conserve gloves and was not told to sanitize them between residents. Following a different process, geriatric nursing assistant (GNA) #18 reported that she changed gloves and sanitized her hands before going to the next resident to pick up the tray. 3.3 Surveyors observed LPN #12 touching contact surfaces without gloves on [DATE] at 7:30 PM. 3.4 Surveyors observed a facility Floor Tech touching contact surfaces without gloves on [DATE] at 9:00 AM. 3.5 During the 6:35 PM tour on [DATE], the surveyors observed that on entry to the 200 unit (a unit designated as COVID positive) neither the Administrator nor the Director of Nursing (DON) put on protective gowns and they were both observed in close proximity (within 3 - 5 feet) to staff working with residents and with residents that were in the main hallway. 3.6 During the 6:35 PM tour on [DATE], the surveyors observed that on entry to the 100 Unit (a unit with positive residents) the Director of Nursing (DON) did not put on a protective gown and gloves. 4.0 The facility failed to ensure that staff utilized personal protective equipment in a manner that met minimum standards and minimized risk for infectious spread. In CDC Guidance, Recommendations for Use of Personal Protective Equipment When Caring for Patients with Confirmed or Suspected COVID-19 that was released on [DATE], the guidance indicates that if the facility has established a designated unit for cohorting COVID-19 positive residents, then staff are to follow droplet precautions for the entire unit and don and doff prior to entering and exiting the unit accordingly. Surveyors made multiple observations where facility staff were not following isolation precautions. 4.1 Observations from [DATE], [DATE], and [DATE] revealed that there was no donning or doffing station located at the entrances to either the 100 or 200 unit, both of which were designated COVID-19 positive units. During a [DATE] observation at 11:45 AM on the COVID positive 200 unit, the DON and other nursing staff at the nurses' station identified that a box on the floor of the nursing station that contained multiple forms of personal protective equipment (PPE) was the unit's donning station. It was noted that there was no trash receptacle designated for doffing. On the other positive unit, on [DATE] at 11:50 AM the surveyor observed a donning and doffing station was located on an over-the-bed table (table on wheels that can be placed over a table for resident access) at the nursing station. However, there was no trash receptacle located nearby for doffing of PPE. Doffing at the nursing station would require staff to walk through the unit with contaminated protective equipment after exiting any resident room. 4.2 On [DATE] at 9:00 AM, the surveyor observed GNA #20 in the 200 hallway and she removed her isolation gown to leave the unit. She stood at the exit doors and removed her gown, rolled it up and tucked it under her right arm against her uniform to carry it to the nursing station to throw it in the trash. The nursing station was centrally located on the unit at an intersection of 3 hallways and it was approximately 30 - 50 feet from the exit where GNA #20 removed her gown. Again, the trash at the nursing station was not designated for doffing of contaminated protective equipment. Further, there were no trash receptacles located near the exit door for staff to safely doff their isolation gowns and in this specific example any pathogens transferred from the gown could then be carried off this unit on the GNA clothing. 4.3 On [DATE] at 7:35 PM, licensed practical nurse (LPN) #12 was observed opening a door when exiting a room on a COVID positive unit, closed the door, and then went up the hall to the nursing station. LPN #12 was then observed touching the computer without changing gloves or sanitizing her hands. As was true with staff rolling up a gown and carrying it across the unit, these staff actions also carried any pathogen from the last resident room into the common area of the unit when touching the computer in the common area. 4.4 With two independent observations of staff breaking infection prevention and control standards in a manner that failed to maintain a clean environment in the common areas of the unit, during [DATE] tour, at 6:35 PM the surveyors observed that on entry to the COVID positive 200 unit neither the Administrator nor the Director of Nursing (DON) put on protective gowns. Further, without protective gowns, both the Administrator and DON were then observed on the unit in close proximity (within 3 - 5 feet) to two COVID-19 positive residents who were not wearing masks. 4.5 In another observation during the 6:45 PM tour on [DATE], on entry to the 100 Unit (a unit with positive residents), the Director of Nursing (DON) did not put on a protective gown and gloves. 5.0 The facility failed to develop and implement an effective system to both obtain and clinically respond timely to critical laboratory results resulting in delays implementing isolation precautions and delays in cohorting positive residents off negative units. Resident #4 was tested for COVID on [DATE]. Review of the medical record on [DATE] at 11:33 AM, revealed a [DATE] nursing note entered by the Director of Nursing (DON) at 11:07 AM. This nursing note indicated Per (Resident's Primary Physician), resident (#4) was tested for COVID-19 today. Results pending. During a joint interview on [DATE] at 10:30 AM, the Administrator and DON both indicated that the facility had decided to have all residents in the facility tested for COVID-19 on [DATE]. During a later [DATE] interview at 1:03 PM, the DON stated that for some reason Resident #4's results had not been obtained and when on [DATE] the family asked for test results and we couldn't find them. The DON reported that she then contacted the laboratory and obtained the positive test result on [DATE]. In a [DATE] nursing note entered at 1:30 PM, the DON documented that she updated Resident #4's representative on his/her s COVID positive results. No earlier documentation regarding the test results was found in the medical record. During an interview on [DATE] at 6:30 PM, the Administrator described the facility process for obtaining lab results. She indicated that test results were received by nursing staff, and when received, each nurse was then responsible for reporting the results to their unit managers, the residents' attending physicians, and to residents' responsible parties. The Administrator acknowledged there was no master list or other process developed to track and ensure that results from all the critical COVID lab tests sent to the lab were reported back to the nursing home timely. During [DATE] interview at 9:45 AM, the Administrator indicated that results from the [DATE] testing of all residents in the facility were received beginning on [DATE] and up to [DATE]. The Administrator indicated that she would verify those dates, however final confirmation of those dates was never provided to the survey team. With no system to ensure all COVID test results were obtained timely, the COVID positive result for resident #4 was missed. Only when family requested the results did staff discover they had not been obtained. Resident #4 remained on the otherwise negative unit during the lengthy delay after he/she had been tested [DATE] and before staff obtained the test results on [DATE]. This system failure increased the risk for transmission of the potentially fatal infectious agent to all residents, staff and visitors. As a result of these findings, a state of immediate jeopardy (IJ) was declared on [DATE] at 9:40 AM and an IJ summary tool was provided to the facility at that time. The facility submitted the first draft of their plan to remove the immediacy at 1:00 PM and it was not accepted. The facility submitted 3 additional drafts that were not accepted. The fifth draft was submitted at 6:27 PM and it was accepted by the state agency at 6:45 PM. The provisions of the plan to remove the immediacy included the following: 1. Any resident noted to be on the COVID negative unit that has not met criteria for symptom-based recovery would be moved to a COVID positive neighborhood. The facility has just completed universal testing again, now per Governor Hogan's directives, the testing was completed yesterday [DATE]. The facility has maintained CDC guidance and will move residents to appropriate neighborhoods based on the latest universal testing results. For individuals under investigation (PUI) residents' doors will remain closed and signage placed outside the room. A resident has been identified and has been moved from a private isolation room to a COVID neighborhood. 2. A review of current residents diagnosed as positive for severe acute respiratory syndrome COVID-19 will be completed and compared with the daily room and board census as completed by the Director of Nursing. Any residents noted as necessary for a room change to a COVID positive neighborhood will be moved. Room changes regarding necessary moves is communicated via email and or verbally from the Director of Nursing to Unit Managers. If the facility cannot move a COVID positive patient to a COVID positive neighborhood for lack of bed availability the facility will work with local agencies to determine an alternate location. 3. The facility will review the state required line listing daily against the facility census for assurance room placements are per CDC guidance, this will be completed by the Director of Nursing. The facility will re-educate staff on the process of proper precautions and signage for (Persons Under Investigation for possible COVID-19 exposure or infection or PUIs), including hand sanitizing gloves and washing hands in between gloves changes and donning and doffing PPE, this will be completed by the Infection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215106	A. BUILDING _____ B. WING _____	**05/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SAGEPOINT NURSING AND REHABILITATION CENTER	**10200 LA PLATA ROAD LA PLATA, MD 20646**

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 -** Many	(continued... from page 4) Preventionist. Staff noted in the statement of deficiency will be given additional education beyond the standard process to assist them in understanding the importance of following the CDC guidance. Audits will be completed by the Infection Preventionist daily and during off shifts. In addition, the Unit Managers will be tasked with completing additional audits in support of the infection preventionist. 4. This line listing and bed census review will be sent to the facility Medical Director weekly for confirmation and review. These weekly and daily reviews will then be shared with the Quality Assurance Performance Improvement Committee (QAPIC). Facility will complete routine monitoring of staff PPE practices, donning and doffing per CDC adherence. The aforementioned Infection Preventionist audits will equally be surrendered to QAPIC. The facility will review the monitoring of PPE, hand washing, donning and doffing techniques for any additional education necessary for staff and complete QAPIC reviews. This will continue to inform and allow the QAPIC to make any necessary recommendations. The Immediate Jeopardy was removed on [DATE] at 9:10 AM after confirmation of the completion of the facility's plan of removal by the surveyor who was on site at the facility. Cross Reference Federal Tags F-835 and F-770, and CO[DATE], 1410 and 2940