

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 215327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/29/2020
NAME OF PROVIDER OF SUPPLIER PEAK HEALTHCARE AT SLIGO CREEK		STREET ADDRESS, CITY, STATE, ZIP 7525 CARROLL AVENUE TAKOMA PARK, MD 20912	
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 0885 Level of harm - Minimal harm or potential for actual harm Residents Affected - Some	<p>Based on surveyor review of administrative records and interview with the facility staff, it was determined that the facility failed consistently inform residents, their representatives, or the families of resident's residing in the facility of a single confirmed infection of Coronavirus Disease 2019 (COVID-19) by 5:00 PM on the calendar day following the occurrence of the infection. This finding was identified during the focused infection control survey. The findings include: On 07-27-2020 at 3:30 PM surveyor interview with the facility's Administrator and the Director of Nursing revealed that designated staff members had the responsibility to make phone contacts with residents' responsible parties and or families on the status of the COVID-19 outbreak in the facility. These staff members also met with residents face to face weekly to inform them of the COVID-19 outbreak status and to allow residents to voice any concerns. Most of these interactions were documented in the residents' electronic medical records. On 07-28-2020 surveyor review of the facility's administrative records revealed no documented evidence that a consistent system was in place to contact residents, their representative and/or families by 5:00 PM the next calendar day following the occurrence of a single confirmed infection of COVID-19 of residents or staff whose tests were completed on 05-22-2020, 05-23-2020, 05-30-2020, 06-07-2020, 06-10-2020 and 06-13-2020. On 07-29-2020 at 5:40 PM surveyor interview with the facility's Administrator and the Director of Nursing revealed no additional information.</p>		

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.