STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215223	A. BUILDING _____ B. WING _____	08/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHARLESTOWN COMMUNITY INC	709 MAIDEN CHOICE LANE CATONSVILLE, MD 21228

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 -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and documentation review it was determined the facility failed to ensure an effective infection prevention and control program by failing to: 1) ensure that separate areas were maintained for newly admitted residents with unknown COVID-19 status, 2) ensure staff were cohorted to specific residents or units; 3) ensure staff practiced safe hand hygiene practices and wore Personal Protective Equipment (PPE) per Centers for Disease Control (CDC) guidance, 4) ensure residents wore a facial mask when they left their room. With insufficient barriers for infectious spread in structure, staff worked with and between units and between residents with unknown COVID-19 status and residents with COVID negative status. The interrelated, noncompliant practices within the facility infection prevention and control program left all residents, staff and visitors at increased risk for harm and death during a declared health pandemic. The findings include: On 3/5/20 the Governor of the State of Maryland declared that a state of emergency and catastrophic health emergency exists within the entire state of Maryland related to the spread of COVID-19. On 4/29/2020, the State of Maryland Health (MDH) Secretary issued a Directive and Order Regarding Nursing Home Matters pursuant to Executive Order No. 20-04-05-01. This Order required that facilities licensed under Title 19, subtitles 3 and 14 of the Health-General Article and [MEDICAL CONDITION] (nursing homes) shall immediately ensure that they are in full compliance with all U.S. Centers for Disease Control and Prevention (CDC), U.S. Centers for Medicare & Medicaid Services (CMS) and the Maryland Department of Health (MDH) guidance related to COVID-19. In updated Directive and Order Regarding Nursing Home Matters on 6/19/20, and 7/24/20 the MDH continued these same requirements. 1. The facility failed to ensure that separate areas were maintained for newly admitted residents with unknown COVID-19 status and residents with COVID negative status. On 4/5/2020, the State of Maryland Health (MDH) Secretary issued a Directive and Order Regarding Nursing Home Matters pursuant to Executive Order No. 20-04-05-01. The Order required that nursing homes to the best of their ability . 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. In subsequent updates on 4/29/20, 6/19/20, and 7/24/20 this same requirement to maintain a separate observation area continued. 1a. Interview of the Director of Nursing (DON) on 8/6/2020 at 8:35 AM, revealed that there were 2 buildings that housed comprehensive care (CC) residents, the(NAME)Building and the RG Building. The RG Building was located directly behind the(NAME)Building. The DON stated the first floor of the RG building was where the observation unit was located along with a plastic, portioned off section for COVID-19 positive residents. This facility's Observation Unit consisted of residents admitted from an acute care facility and residents admitted for skilled rehabilitation. The second floor unit had mixed residents for rehabilitation and long term care. The(NAME)Building consisted of long term care residents. 1b. On 8/6/2020 at 9:35 AM the surveyor observed the second floor nursing unit in the RG Building. An isolation sign was observed outside of rooms 212, 218 and 219 along with isolation bins which contained PPE. Signs on the doors stated, Isolation, must wear N95 mask, gown, gloves, eye protection. Interview of Registered Nurse (RN) #6 revealed the residents in those rooms were admitted from the hospital and were on isolation. Staff were required to use full PPE when entering those rooms. The doors to the rooms were open. Observation on a second hallway on the second floor revealed rooms [ROOM NUMBERS] had isolation signs hanging outside of those rooms with isolation bins containing PPE. Observation on the third hallway on the second floor revealed rooms [ROOM NUMBERS] with isolation signs and PPE bins. The doors to the rooms were open on both the second and third hallway. 1c. A tour of the RG first floor nursing unit on 8/6/2020 at 10:15 AM revealed 3 hallways. There was 1 hallway behind the plastic wall which was the COVID-19 positive unit and the other 2 hallways were the observation units. The doors were open to both observation unit hallways, which were next to the plastic wall for the COVID-19 unit. Licensed Practical Nurse (LPN) #16 stated on 8/6/2020 at 10:17 AM that there were skilled rehabilitation residents and non-COVID-19 residents on the hallway. She stated, there are a few waiting for another unit bed to go to on either the long term care (LTC) unit or to assisted living (AL). There were isolation bins outside of the rooms where residents were still on isolation. The second hallway to the left of the elevator had the same type of residents. There were 3 residents on isolation, Rooms 103, 107 and 106. The other 5 rooms on the hallway were non-isolation rooms. When asked, Staff #27 stated that it was the skilled unit; 2 new admits and others waiting for transfer or having therapy. The doors to the resident's rooms were open. 1d. On 8/6/2020 at 10:50 AM the facility's policy on COVID-19 information and updates was reviewed. The guidelines stated, residents who are admitted from hospital (all campuses), external admission from hospital or are transferring from IL (independent living) will be placed in strict isolation and wear full PPE (gloves, gowns, protective eye wear) w/N95 respirator. All admissions/readmissions from hospital to CC (continuing care) will be COVID tested within 24 hrs. of admission (this includes internal and external admissions) and placed in strict isolation. The policy continued, all transfers within the CC will No Longer require strict isolation and IL resident transferred to CC will be placed in strict isolation and will be COVID tested between 3-5 days post admission. If resident is negative, strict isolation is lifted. 1e. On 8/6/2020 at 11:30 the DON gave the surveyor a paper titled, amended policy on isolation requirements dated 7/8/2020 update which stated: Residents placed in strict isolation upon admission from hospital will remain so for 14 days, and will then be released from strict isolation, assuming they remain symptom free and have no further exposure to COVID. Please note: if resident is discharged from one service level to another during their strict isolation period, the remainder of that period will be applied to the second service level. For example, if the resident is in skilled nursing for 8 days, and are then discharged to IL, the remaining 6 days of isolation will be completed in their IL apartment. Security will be notified so that a quarantine sign is posted on resident's apartment door. If resident is discharged to AL, MC (memory care), or LTC the resident will be on strict isolation for the remainder of the 14 days and staff will wear full PPE w/N95 to provide care. Residents in strict isolation, and the staff who serve them, will follow all isolation protocols. 1f. On 8/7/2020 at 9:43 AM RN #25, the Assistant Director of Nursing (ADON) was interviewed and stated that the DON works with admissions for deciding where to place residents that are admitted . The ADON stated, we do have some admissions that go to the second floor. The guidance that we understand is if we have the ability to cohort in 1 space, as long as they are in a private area and on strict isolation and cohort the care, then they can be in a private room. The ADON stated, we don't have a dedicated observation unit. 1g. The NHA and ADON were interviewed on 8/7/2020 at 10:25 AM and stated it was (name)'s policy to put new admissions in a private room on isolation. We don't per se have an entire unit where new admissions go. They go in a private room in isolation and staff are cohorted. The NHA confirmed that non-COVID residents were on the same units as residents admitted under isolation orders for 14 days. 2. With residents on the RG second floor unit who were negative for COVID-19 with dispersed newly admitted residents with an unknown COVID-19 status, and on the first floor observation unit where residents who had unknown COVID-19 status were placed, staff were also not cohorted to specific residents or units. 2a. On 7/21/20 the Maryland Department of Health (MDH) issued updated guidance entitled Preparing for and Responding to COVID-19 in Nursing Homes and Assisted Living Facilities. MDH indicated that staff should not float between the observation unit and other units. 2b. In the State Operations Manual, Appendix PP 11/22/2017, the Centers for

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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 -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) Medicare and Medicaid Services (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 (cohorting residents). During outbreaks, healthcare staff may be assigned to a specific cohort of residents to further limit opportunities for transmission (cohorting staff). The terms cohort or cohorting is standardized language used in the practice of infection prevention and control. Nonetheless, staff were assigned to work with residents with unknown COVID-19 status and with residents who were COVID-19 negative. 2c. Observation was made on 8/6/2020 at 9:45 AM of Staff #8 in the hallway outside of room [ROOM NUMBER] on the second floor unit of the RG Building. Staff #8 was asked what her assignment was for the day and if she just took care of the residents on isolation. Geriatric Nursing Assistant (GNA) #8 stated she was assigned 2 residents in isolation rooms [ROOM NUMBERS] and 2 residents in 2 other rooms on that particular hallway and on the other hallway she was assigned 1 resident in isolation room [ROOM NUMBER] and 2 other rooms that were not isolation rooms. GNA #8 stated that she wears full PPE when she goes in the observation rooms because the residents were new admissions from the hospital. The surveyor and GNA #8 walked over to the other hallway and observed the rooms that GNA #8 was responsible for. It was also observed that room [ROOM NUMBER] had an isolation sign hanging outside of the room. The surveyor asked GNA #8 if she normally had a mix of isolation rooms and non-isolation rooms and she answered yes. 3. Without establishing separation between the units, between the residents or between the staff, the staff also failed to practice hand hygiene appropriately and failed to safely use PPE. These system failures regarding hand hygiene practices and the use of PPE, when combined with the failures describe above increased the risk for spread of COVID-19 to all staff, residents, and visitors throughout the building. On 5/8/2020, the Centers for Disease Control and Prevention (CDC) released updated guidance on Hand Hygiene noting that hand hygiene should be performed in the following situations: before resident contact, even if PPE is worn; after contact with the resident; after contact with blood, body fluids, or contaminated surfaces or equipment; before performing aseptic tasks; and after removing PPE. 3a. Observation was made on 8/6/2020 at 9:55 AM on the second floor of the RG Building of GNA #8 walking into room [ROOM NUMBER] (an isolation room). GNA #8 was not wearing a gown or gloves. The resident requested eating utensils. GNA #8 walked out of the room and went down the hall and got utensils and walked back into the room and gave the utensils to the resident. There was a sign on the door that stated you had to wear a gown, gloves, N95 and eye protection when entering the room. GNA #8 did not wear a gown or gloves. An interview was conducted on 8/7/2020 with RN educator #3 at 12:09 PM who revealed GNA #8 was new and just finished orientation last week. Review of in-service sign-in sheets revealed that GNA #8 had PPE, hand hygiene and infection control training on 7/22/2020. 3b. Observation was made on 8/6/2020 at 10:00 AM of GNA #13 on the second floor RG Building nursing unit walk into room [ROOM NUMBER] (which was an isolation room) not wearing full PPE. GNA #13 did not have a gown on even though the sign on the door stated to wear a gown along with other PPE. GNA #13 walked out of the room carrying a large, clear plastic bag with contents in the bottom of the plastic bag with gloved hands. GNA #13 walked across the hall to room [ROOM NUMBER] (non isolation room). GNA #13 went into the room with the plastic bag and sat the bag on the floor. GNA #13 took her gloves off, threw them in the trash and then touched the handles of a wheelchair in the room and wheeled the resident that was in the room into the bathroom. GNA #13 left the resident in the bathroom, walked out of the bathroom and picked up the plastic bag with bare hands and walked into room [ROOM NUMBER], another non-isolation room. GNA #13 came out of room [ROOM NUMBER] with the plastic bag and non-gloved hands, walked down the hall to the soiled utility room, disposed of the plastic bag and then walked back into room [ROOM NUMBER]. GNA #13 did not wash or sanitize her hands. GNA #13 walked back out of room [ROOM NUMBER] and walked down the hall to the clean utility room. GNA #13 was pulled to the side from another staff member and immediately sanitized her hands. GNA #13 walked back to Room # 232 to help the resident out of the bathroom, walked back to the clean utility room at the end of the hall to get a box of gloves and then back into room [ROOM NUMBER]. GNA #13 left and walked into room [ROOM NUMBER], walked out and then walked down to the last room [ROOM NUMBER] (isolation room). GNA #13 was not cohorted to just the isolation rooms as she walked in and out of both types of rooms without changing PPE and without sanitizing her hands. GNA #13 also took a plastic bag from an isolation room and placed the bag in 2 non-isolation rooms while performing other tasks. Review of in-service sign-in sheets on 8/7/2020 at 9:30 AM revealed GNA #13 was educated on Infection Prevention and Care of COVID-19 residents along with social distancing on 5/2/2020. 3c. Observation was made on 8/6/2020 at 10:05 AM on the RG Building second floor unit of a break room for staff which was located across from the elevator, at the top part of the hallway, also across from the nurse's station. There were snack machines, a microwave and a table with chairs. The break room was on the same hallway as resident rooms. The door to the break room was open and all the doors to resident rooms on the hallways were open which included the isolation precaution rooms. Housekeeping Staff #9 was observed with his mask off in the break room while heating up food in the microwave. Staff #9 then then sat down at the table and ate food. Staff #9 was in the break room at least 20 minutes during the observation with his mask off the entire time and the door to the break room was open during the entire observation. During the observation other staff members were seen going in and out of the break room with PPE on. GNA #10 entered the break room and was wearing an eye shield and N95 mask while Staff #9 was not wearing a mask. GNA #10 was working on the second floor nursing unit where the break room was located. 3d. Observation was made on 8/6/2020 at 10:20 AM of Housekeeping Staff #14 in the break room with his mask off while eating at the table. The door remained open. GNA #15 was in the break room with Staff #14 while Staff #14 was unmasked and then went to the charting area in the hallway in between resident rooms. 3e. Observation was made on 8/6/2020 at 10:21 AM of Housekeeping Staff #12 sitting by the window in the second floor dining room with her mask off looking at her cell phone. During interview Staff #12 said that the break room was so small and that was why she was eating in the dining room, which they could do if they were spread apart. At the end of the interview Staff #12 walked into the nourishment area for residents without her mask on and threw trash away. On 8/6/2020 from 10:31 AM to 10:50 AM the Infection Preventionist was informed of all infection control observations. On 8/7/2020 at 1:00 PM the Nursing Home Administrator and ADON were informed of all concerns related to infection control. 4. On 8/6/20 at 12:00 PM, a tour of the(NAME)building's LTC (long term care) nursing units revealed the facility failed to maintain separate areas for newly admitted residents with unknown COVID-19 status and failed to ensure residents wore facial masks when out of their room. 4a. On 8/6/20 at 12:20 PM, during a tour of(NAME)Overlook 2, the 2nd floor nursing unit, observation of room [ROOM NUMBER] revealed the door open with signage posted that indicated the resident (Resident #2) in room [ROOM NUMBER] was on isolation. On 8/6/20 at 12:23 PM, during an interview, GNA #20 stated that Resident #2 was on quarantine isolation because the resident was recently readmitted to the facility following hospitalization . GNA #20 stated he/she was assigned to care for Resident #2 as well as other residents on the LTC unit. On 8/7/20 at approximately 10:00 AM, a review of Resident #2's medical record revealed the resident had an acute hospital stay from 7/28/20 thru 7/31/20 and was readmitted to the(NAME)building, room [ROOM NUMBER], following his/her hospitalization . 4b. On 8/6/20 at 12:30 PM, during a tour of(NAME)Overlook 1, the 1st floor nursing unit, observation of room [ROOM NUMBER] revealed the door was open and there was signage posted that indicated the resident (Resident #3) was on isolation. Across the hall from room [ROOM NUMBER], there was a room occupied by a resident and the door was open. On 8/6/20 at approximately 12:40 PM, during an interview, LPN #24 stated that Resident #3 was on quarantine following his/her readmission to the facility from the hospital. LPN #24 stated that his/her resident care assignment included Resident #3 as well as other residents. On 8/7/20, at approximately 10:15 AM, a review of Resident #3's medical record revealed the resident had an acute hospital stay from 7/19/20 thru 7/24/20 and was readmitted to the(NAME)building, room [ROOM NUMBER] following his/her hospitalization . 5. On 8/6/20 at 12:00 PM, a tour of the(NAME)building's LTC nursing units revealed the facility failed to ensure residents wore facial masks when they were out of their room. 5a. On 8/6/20 at 12:10 PM, during a tour of the 2nd floor nursing unit,(NAME)Overlook 2, an observation was made of Resident #1, who was not wearing a facial mask, self-propelling in a wheelchair in the hall near the dining area. At that time, observation was made of 2 staff members walk past the resident. Each staff member acknowledged the resident with no observed attempt to have the resident wear a facial mask. On 8/6/20 at 12:27 PM, an observation was made of Resident #7, who was not wearing a facial mask, sitting in a wheelchair that was being pushed in the hall of the(NAME)building, 2nd floor nursing unit by RN #26. During an interview, RN #26 stated that residents do not wear masks when they are out of their rooms, that in one of the buildings the residents were required to wear masks but in the(NAME)building, the residents were not required to wear facial masks. On 8/6/20 at 12:30 PM, a tour of the 1st floor nursing unit was conducted. At that time, 5 residents who were not wearing facial masks were observed in the dining area. During an interview, when asked about the residents observed in the dining room, Staff #22 stated the residents were at risk for falls and needed supervision, otherwise they would be in their rooms. Staff #22 stated residents only wore facial masks when they going to an appointment. On 8/7/20 at 10:25 AM, the NHA made aware of the

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 2) above findings.