STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085029	A. BUILDING _____ B. WING _____	**07/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HARRISON SENIOR LIVING OF GEORGETOWN, LLC	**110 W. NORTH STREET GEORGETOWN, DE 19947**

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.** Based on observation, record review, interview and review of other facility documentation it was determined that the facility failed to maintain an infection control program to help prevent the transmission of COVID-19. The facility failed to adhere to transmission-based precautions by not donning proper PPE when entering the PUI (persons under investigation for suspected COVID-19) and/or confirmed COVID-19 areas and by not doffing contaminated PPE when exiting the confirmed COVID-19 and/or PUI areas. The facility failed to store used PPE for extended use in a safe manner on two (Rehab and Sussex) out of three nursing units. The facility failed to store and/or transport linens, disposable briefs and other resident care items in a sanitary manner on one (Sussex) out of three nursing units. The facility failed to ensure infection control policies reflected management of residents within dedicated PUI and/or COVID-19 areas, including guidelines for when to change PPE. Findings include: Use of PPE 3/20/20 - The facility document entitled 'Suspected Resident with Respiratory Illness Consistent with COVID-19' included . Place a mask on the resident if moved out of room for any reason . Ensure staff adheres to strict Standard, Contact and Droplet precautions . 4/15/2020 (last reviewed) - CDC's 'Preparing for COVID-19: Long-term Care Facilities, Nursing Homes' included . health care providers who enter the room of a patient with known or suspected COVID-19 should adhere to standard precautions and use a respirator (or facemask if a respirator is not available), gown, gloves and eye protection. 5/18/2020 (last reviewed) - CDC guidance for strategies to optimize PPE included .Consideration can be made to extend the use of isolation gowns (disposable or cloth) such that the same gown is worn by the same HCP (health care provider) when interacting with more than one patient known to be infected with the same infectious disease when these patients housed in the same location (i.e., COVID-19 patients residing in an isolation cohort) . The same disposable gown and gloves used to care for COVID-19 residents should not be worn to provide care for PUI residents. A new disposable gown and gloves should be worn. 7/7/2020 (11:24 PM) - A random observation revealed, four rooms at the end of the Sussex unit's hallway exiting near the employee entrance were currently designated for confirmed and suspected COVID-19 residents. Temporary plastic walls with zippered access separated the two rooms closest to the locked exit door (confirmed COVID-19) from the next two rooms (suspected COVID-19 or PUI). The two PUI rooms were separated from the next four rooms (currently for recovered residents, but previously used as PUI rooms) with a temporary plastic wall. 1. 7/7/2020 - Observation on the PUI and COVID-19 areas revealed that E10 (CNA) failed to doff (remove) contaminated PPE on six occasions over 35 minutes:: - 3:05 PM: E10, donned in full PPE, walked from the COVID-19 area to PUI without changing the disposable plastic gown and single-use /gloves. E10 closed the temporary wall zipper, contaminating both gloves and proceeded onto the Sussex unit housing recovered residents in same disposable gown and contaminated gloves. E10 returned, opened the zippered wall and entered the COVID-19 area. - 3:11 PM: Wearing the same contaminated disposable plastic gown and single-use gloves, E10 walked from the COVID-19 area to PUI without changing the gown/gloves and went onto the Sussex unit, walking past the nursing station toward the storage area . E10 returned with pile of towels and briefs under each arm, holding the items against the isolation gown, contaminating them. E10 placed these contaminated items on a wheeled supply cart housed in the COVID-19 area. - 3:15 PM: E10 again walked from the COVID-19 area to the PUI area without changing the disposable plastic gown/gloves and entered the Sussex unit to the medication cart to get R8's hearing aids form nurse. E10 returned to COVID-19 area and gave the hearing aids to R8. - 3:19 PM : E10, wearing same contaminated disposable plastic gown, but had removed the gloves, entered PUI room with R4 and R5. - 3:21 PM: E10 exited the PUI area and walked past the zippered curtain outside the four rooms designated for recovered residents. Two unknown staff moved R6's bed with air mattress into room S36 (should have been S38 on the PUI side of the temporary wall). An interview revealed that E10 was unclear which rooms were designated for PUI residents. An unknown staff member carried R6's air mattress to S38. - 3:31 PM: E10 held R6's legs up wearing the same disposable plastic gown and new gloves (which were now contaminated) while other staff pushed the wheelchair to PUI room S38. - 3:32 PM: Wearing the contaminated disposable plastic gown and contaminated gloves, E10 walked onto the Sussex unit to get a mechanical lift from near station and joined the second staff member in room S38 to assist R6 into bed. - 3:40 PM: E10 went to the Sussex storage area wearing the same contaminated disposable plastic gown and gloves to obtain a package of disposable wipes for R6 from the storage area. 7/7/2020 (10:13 AM) - During an interview, E1 (NHA) explained that the infection control policies were in the process of being changed by the corporate infection control consultant and that the facility recently conducted a COVID-19 QAPI meeting. 7/8/2020 (1:55 PM) - During an interview, E2 (ADON) and E3 (MDS Coordinator) confirmed that gowns/gloves should be removed/changed when exiting the COVID-19 area and changed again when exiting the PUI area. 2. 7/7/2020 (3:30 PM) - During a random observation, E13 (LPN), wearing a mask (no gown, no eye protection) walked from the Sussex unit through the PUI area and onto the COVID-19 area and exited the back door with bare hands and the bookbag on her shoulder touching the contaminated temporary walls. 3. 7/7/2020 (3:08 PM) - E11 (LPN) was seen, during a random observation, entering the locked door onto the COVID-19 unit only wearing a mask (no gown, no eye protection). E11 touched the plastic walls with bare hands while passing.onto the PUI area and while passing through the temporary wall leaving the PUI area. E11 walked onto the Sussex to work the evening shift. 7/8/2020 (11:52 AM) - An interview with E5 (staff member manning the employee screening station outside the entry to the COVID-19 area) revealed that staff should not enter through the COVID-19 area, but should go around to get onto the Sussex unit. 4. Review of R6's clinical record, facility map and COVID-19 surveillance data revealed: 6/10/2020 - R6 was cleared from confirmed COVID-19 with two negative swabs and resided on the secured Sussex unit as a recovered resident. 7/7/2020 - Physicians' orders included oxygen by nasal cannula and an antibiotic for confirmed pneumonia along with contact and droplet precautions with transfer to the PUI area. 7/7/2020 (approximately 3:10 PM) - During a random observation, R6 arrived to the PUI area in a wheelchair, without a face mask. R6 was originally in room S4 and during the transfer was pushed past the nursing station, rooms S6, S30, S31, S32 and S34. R6 was verbal, expressing the desire to lay down and did not indicate she was short of breath. Residents with suspected COVID-19 should wear a mask when outside of their room unless unable to tolerate. 7/8/2020 (approximately 12:10 PM) - An interview with E15 (Medical Director) revealed R6 was moved to the PUI area and testing for COVID-19 was to play it safe even though pneumonia was identified. 5. 7/8/2020 - Observations and interviews on the PUI / COVID-19 areas revealed: - 9:33 AM: E12 (CNA) was in the PUI area wearing a disposable plastic gown and mask and stated she had already bathed and washed hair of all three COVID-19 residents and bathed the one PUI resident this morning. E12 was not wearing eye protection. - 9:48 AM: E12 entered R7's COVID-19 room without eye protection to take R7's lunch order. E12 entered the PUI side without changing her disposable gown. - 9:49 AM: E14 (RN) handed a new face shield and passed it to E12 under the closed zippered curtain separating the PUI area from the recovered residents - 9:50 AM: E12 stated she was in the isolation area full time when COVID-19 was at it's peak. E12 explained that she changes before she goes out there (pointing to Sussex unit). E12 added that when staff are assigned to the Sussex unit, they should go around and enter from the other side and not cut through here. - 10:00 AM: E12 confirmed she did not wear a face shield when bathing residents since she could not find her face shield after being away on leave. 6. 7/8/2020 (11:50 AM) - During a random observation: E16 (Maintenance)

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** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) entered the facility through the employee entrance without mask and pulled up his t-shirt and partially covered his nose. E5 (staff member manning the employee entrance screening station) advised E16 that he cannot enter the building without a mask. E16 continued to walk down the hall toward the break room and then returned a short while later wearing a mask. E5 was not sure why E16 did not have a mask since she is handing out masks out there (outside employee entrance). 7/8/2020 (12:34 PM) - During an interview E1 (NHA) confirmed that E16 should have been wearing a mask and that education had already been completed. Storage of PPE 4/6/2020 - Facility policy entitled PPE Reuse documented that masks and N95 respirators may be worn continuously until visibly soiled or moist from respirations. . can be stored between uses in a clean, sealable paper bag or breathable container . gowns can be reused if they are not visibly soiled . Hang the gown in an open area and avoid having the gown come in contact with other garments. 7. Observations during the the first day of survey (7/7/2020) found numerous PPE inappropriately stored on Rehab and Sussex units as well as the PUI/COVID-19 areas: - 10:46 AM: Outside room R8 (quarantine) : 2 masks, each in paper bag, then placed inside plastic bags; 6 used disposable gowns in plastic bags. - 10:53 AM: Outside room R11 (quarantine) 2 masks in paper bag placed in a plastic bag with used disposable gown; 3 additional used disposable gowns in plastic bags. - 11:25 AM: Outside room S35 (PUI) 2 masks in plastic bags and 6 used disposable gowns (including 1 draped over the handrail) in contact with other used gowns. - 11:32 AM: Outside S40 (COVID-19) 2 masks, each in a paper bag, then placed inside plastic bags; 1 mask hanging uncovered with a face shield; 7 used disposaable gowns hanging with each touching another used gown and/or the dirty linen/trash cart (including a plastic gown dated 7/2/2020). - 11:40 AM: Outside COVID-19 unit in area used for donning/doffing PPE: 2 masks, each in a paper bag, then placed inside plastic bags. - 1:11 PM: Outside room R4 (quarantine), two disposable gowns draped over the handrail, one used gown hanging on the resident entry door with a tie from the gown touching the wastebasket propping the resident door open and directly next to a stack of clean gowns draped over the PPE box on the door. - 1:13 PM: Unused plastic gowns piled on a chair near computer terminal between rooms R10 and R12. - 1:17 PM: Unused plastic gowns piled on top of the Sussex unit's nursing station shelves containing resident charts. The gowns were touching the wall, gold plastic basin on the shelf, and was hanging over the front edge of the shelf. - 1:25 PM: Room near employee entrance used for storing staff masks and face shields with 73 face shields in plastic bags (1 stuck to the inside of the plastic bag as if it was wet when put away); 12 used disposable gowns in plastic bags; 1 mask in a paper bag then placed inside a plastic bag; 3 surgical masks inside plastic bags and 1 pair goggles inside a plastic bag. - 1:31 PM: Employee hallway with 2 used disposable gowns stored in plastic bags. - 2:49 PM: Outside S37 (COVID-19) with 8 disposable gowns hanging with each touching another used gown and/or linen/supply cart. 7/7/2020 (1:12 PM) - During an interview E7 (CNA) stated she did not know why all the gowns were hung outside room S4. Adding that's how we used to do it when gowns were scarce. 7/7/2020 (3:31 PM) - During a random observation, E6 (LPN) opened bag of isolation plastic gowns which were all folded together. E6 tried to roll them up and stuff back into the plastic bag. 7/8/2020 (12:34 PM) - During an interview E1 (NHA) confirmed that the facility currently had a good stock of PPE. 7/8/2020 (1:57 PM) - During an interview, E2 (ADON) and E3 (MDS Coordinator) confirmed that masks should not be stored in plastic bags. E2 and E3 were informed of the placement of new plastic gowns since they were packaged all folded together and the need for a uniform process for storing the new gowns. 7/7/2020 (2:40 PM) - During an interview, E17 (CNA) explained that she gets a new gown every day and the masks are changed every couple weeks unless dirty or damaged. Storage of Supplies 8. Observations on 7/7/2020 revealed multiple wheeled carts containing linens, disposable briefs and other resident supplies were uncovered and unattended in the hallway: - 1:16 PM: Outside room S3. - 1:17 PM: Outside room S27. - 1:18 PM: Outside room S12. - 2:49 PM: Outside S37 (COVID-19) and shared with PUI residents. 7/8/2020 (approximately 1:59 PM) - During an interview, E2 (ADON) and E3 (MDS Coordinator) confirmed that the carts should be covered. E2 and E3 were also informed that the cart location in the COVID-19 area is shared with PUI residents. Findings were reviewed with E1 (NHA), E2 (ADON), E3 (MDS Coordinator and E4 (MDS Nurse) on 7/8.2020 during the exit conference beginning at approximately 2:10 PM.