STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215083	A. BUILDING _____ B. WING _____	**09/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CAROLINE CENTER FOR REHABILITATION AND HEALTHCARE	**520 KERR AVENUE DENTON, MD 21629**

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 observations, medical record review and interviews, it was determined that the facility failed to ensure that facility staff utilized effective infection control practices to prevent the spread of COVID-19. This was evidenced by: 1) improperly disposed used personal protective equipment (PPE) on the COVID-19 unit ; 2) the facility's failure to perform appropriate screening of visitors upon entrance; and 3) the facility's failure to accurately track and monitor the listing of residents and staff with positive and negative COVID-19 tests. This was evident for 1 of 3 trash bins at the COVID-19 unit's nursing station, for 2 of the 3 days surveyors entered the facility, and tracking of residents and staff with positive and negative COVID-19 tests from 8-27-2020 to 9-9-2020. The findings include: 1. On 9-8-2020 at 11:57 AM, during a tour of the facility's COVID-19 unit, the nursing station area had 3 trash cans for disposal of non medical waste. The trash bin by the first documentation computer had a used isolation gown over flowing the trash can, making it impossible to use the computer without touching against the discarded gown. On top of the used isolation gown, used gloves were observed to be precariously discarded by the edge of the trash can. This deficient practice of improperly discarding used PPE was discussed with the Administrator and the 2 Corporate nurses on 9-9-2020 at 9:30 AM. 2. Centers for Disease Control and Centers for Medicare and Medicaid Services guidance states that facilities should restrict visitors to prevent transmission of COVID-19. For visitors that are permitted, screening questions about recent movements and assessment of illness need to be performed before proceeding past the reception area. On 9-8-2020 at 9:30 AM, surveyors entered the building and Receptionist #17 obtained both of the surveyors temperatures, but did not ask screening questions nor assessment of illness. On 9-9-2020 at 9:00 AM, a first surveyor entered the building and their temperature was obtained and they were screened and assessed by Receptionist #16. On 9-9-2020 at 9:10 AM, the second surveyor entered the building and their temperature was taken, but was not assessed for illness or asked screening questions by Receptionist #16. On 9-9-2020 at 9:30 AM, the deficient screening practice was discussed with the Administrator and 2 Corporate nurses. 3. On 9/8/20 at 9:30 AM during the entrance conference with the Administrator, Corporate Nurse #11, the Infection Preventionist, and the Director of Nursing (DON), the survey team requested any materials that the facility was using to track staff and residents who exhibited signs and symptoms of COVID-19, or who received a positive test result for COVID-19. Such a tool is often referred to as a line listing and is used to track, monitor, and manage residents and staff who have the potential to spread an infectious illness such as COVID-19. Also during the entrance conference, the Administrator or Infection Preventionist stated that the facility's first COVID-19 positive test result among staff occurred from an 8/24/20 test that resulted on 8/27/20 with a positive diagnosis. This was a routine weekly test that the facility had been performing on staff working in the facility. Following that positive result, all residents in the facility were tested for COVID-19 on 8/27/20, and the first positive COVID-19 test among residents occurred on the evening of 8/28/20 around 9:30 PM or 10:00 PM. Prior to leaving the facility at the end of the first day of observation, around 2:00 PM, the survey team had not been provided with the facility's COVID-19 line listing. A second request for the document was made at that time and the facility stated it would be provided to the survey team on the next morning. Upon arrival to the facility on [DATE] at 9:00 AM, the survey team was provided with a series of untitled documents with daily totals of residents and staff who were showing signs and symptoms of COVID-19, as well as totals of positive, negative, and pending lab tests (Tally Sheets). This series of documents had one designated page per day through the dates 8/29/20 to 9/8/20. They did not list any specific residents and they also had been completed by the Director of Nursing (DON) at the Local Health Department (LHD). There were also three sheets entitled Line Listing for Respiratory Illness Outbreaks. One was dated 8/28/20 and listed one resident and no staff. Another, also dated 8/28/20, listed two staff and no residents. The last, dated 9/5/20, listed 10 residents and no staff, and appeared to be completed and signed by the DON of the LHD. The corresponding tally sheet, dated 9/5/20, stated there were 33 positive residents and 19 positive staff. On 9/9/20 at 1:11 PM, When asked about the origin of the documentation, the Infection Preventionist (IP)) stated that all of the above documents had been obtained by requesting them from the LHD. None of the documents had been kept in the facility. The IP stated that the facility maintained a line listing for each unit, that was kept on each unit, so that staff on the units could update them. The survey team requested copies. In a follow up interview that took place on 9/9/20 at 1:47 PM, the IP stated that the line listings that were being kept at the nurses' stations could not be found, except for one blank one. The IP stated that there were no line listing being kept in the facility and that the line listing was being kept by the LHD. However, the IP was able to demonstrate a color-coded list of residents and staff that functioned to track COVID-19 nasal swab tests that were conducted with the results of the tests documented on the color coded document. Another document listed residents who were ordered chest x-rays to monitor for respiratory compromise in COVID-19 positive residents. Another document listed residents receiving antibiotics for pneumonia that developed while positive for COVID-19. Another document tracked temperatures for COVID-19 negative residents. Another was a set of COVID-19 test results maintained in an orderly manner. However, no one document served the function of a line listing by containing all of this information in one organized place. The IP stated that she would talk to the DON at the facility who had been working with the (DON at the LHD) to prepare the line listing to see if the DON may have further answers. The DON at the facility could not provide additional information. The DON of the LHD was interviewed by telephone on 9/9/20 at 2:34 PM. During the interview, the DON of the LHD stated that she had helped prepare some line listings for the facility early on in the outbreak but that she had not maintained up-to-date lists for the facility and did not know if the facility was maintaining their own line listing. She indicated that the facility had asked for all such documents from her yesterday and that they had been provided. The DON of the LHD stated that the Tally Sheets were hers and were designed for her to report outbreak numbers to the state, not to assist in tracking, monitoring, or managing residents at the facility. On 9/10/20 at 10:21 AM, the IP presented the survey team with up-to-date and comprehensive line listing material that the facility had prepared. The information was reviewed by the survey team without further concern.

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.