STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215321	A. BUILDING _____ B. WING _____	07/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JULIA MANOR NURSING AND REHABILITATION CENTER	333 MILL STREET HAGERSTOWN, MD 21740

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 when 1) the facility failed to ensure that separate areas were maintained for newly admitted residents with unknown COVID-19 status, and residents with COVID-19 negative status; 2) the facility failed to ensure that staff were cohorted to specific residents or units; 3) the facility failed to implement effective and compliant systems or procedures to ensure that staff understood when and how to sufficiently follow isolation precautions; 4) the facility failed to ensure that staff practiced safe hand hygiene practices; and 5) the facility failed to ensure sufficient availability and use of personal protective equipment (PPE). With insufficient barriers for infectious spread in structure, in policy, and in practice, staff worked with and between units and between residents with unknown COVID-19 status and residents with COVID negative status. The interrelated failures were evident in policy and were evident throughout the facility. 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. In the State Operations Manual, Appendix PP 11/22/2017, the Centers for 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).40 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. 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. On 7/28/2020 at 2:15 PM, the surveyor toured and observed the second floor nursing unit. During this tour, the second floor Unit Manager stated that the west hallway of this unit was the designated observation unit. The right hallway was designated as the unit for hospital admissions (observation unit). On 7/28/2020 at 2:17 PM, the surveyor observed that the double doors between the observation unit and the neighboring unit were not closed. When asked if the doors were supposed to be closed, Staff #16 said no, they were always kept open. Adding to the failure to establish any demarcation/ separation between the observation unit and the rest of the building, on 7/28/2020 at 2:17 PM, the surveyor observed that the facility had not posted any signage at the entry to the observation unit indicating staff should follow transmission-based (both contact and droplet level) precautions upon entry to that unit/area. The surveyor observed that there were no signs that indicated that the west wing was an isolation unit and there were no isolation precautions signs post at any of the resident doorways. On 7/28/2020 at 2:22 PM, a joint interview was conducted with the Nursing Home Administrator (NHA), Staff Educator (SE) and the Infection Preventionist (IP). They were asked why there were no signs posted on the west wing (observation unit) related to isolation and were asked what the process was for precautions on the observation unit. The IP stated, the criteria for new admissions is to have a negative COVID test and then residents are screened three times a day and are screened like the staff are when they come in the building with temperature, hand washing and review of symptoms. Another interview was conducted with the NHA, SE and IP on 7/28/2020 at 3:36 PM. The surveyor asked again about the missing isolation signage (signage that was not observed) outside of resident rooms or anywhere on the observation unit. They again reported that their criteria to the unit was a negative COVID test and then residents are screened 3 times a day for symptoms and temperature. Staff #16 (LPN unit manager) corroborated the belief that isolation precautions were not necessary on the observation unit. On 7/28/2020 at 2:45 PM, Staff #16 indicated that residents on the observation unit were negative and did not require isolation precautions. When asked what was done for new admissions on the observation unit, the response was, we monitor for 14 days for symptoms. They get tested prior to coming here. They are negative when they are admitted . If they were positive, they would go on isolation. We just monitor and once their 14 days are up, we move (them) to another unit. The observation unit was open to and was not sufficiently separated from the rest of the facility; and no signage was evident to alert residents, staff or visitors of the separate observation area/unit. 2. With residents on the second floor unit who were negative for COVID-19 and residents on the observation unit (also on the second floor) who had unknown COVID-19 status, staff were also not cohorted to specific residents or units. 2.1 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. Nonetheless, staff were assigned to work with residents with unknown status and with residents who were COVD-19 negative. On 7/28/2020 at 2:40 PM, Staff #15 (GNA) was observed walking from the center hallway to the observation unit wearing a mask and cloth gown. Staff #15 walked into room [ROOM NUMBER] on the observation unit and walked back out of the room. Staff #15 did not change her gown and did not take any other special precautions. Staff #15 stated that she was assigned to that hall and she had 2 residents on the other hall also. Staff #15 stated, they typically keep the same staff, but since the census was down on the isolation hall, I picked up 2 rooms on the other hall. On 7/28/2020 at 2:45 PM, Staff #16 (unit manager) was then asked if room assignments are split and she said yes, according to the census numbers. The nurse just has the hall but the GNA will be split. The nurse assigned to the hall was assigned to just the residents who were on observation and the GNA was covering on the observation unit and two residents on another hallway entirely. 2.2 In their 4/2/20 COVID-19 Long-Term Care Facility Guidance CMS added, that staff as much as possible should not work across units or floors. In interview on 7/29/2020 at 9:15 AM, Staff #12 (LPN) indicated that she floated on all 3 halls (wings) on the second floor unit. Staff #12 stated, yesterday I was on the east hall and today I am on the west hall. 3. While staff worked across the poorly defined units with and between residents of both negative and unknown status; the facility also failed to implement effective and compliant systems and procedures to ensure that staff understood when and how to sufficiently follow isolation precautions. On 7/21/2020, the Maryland Department of Health (MDH) issued updated guidance

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** - Many	(continued... from page 1) entitled Preparing for and Responding to COVID-19 in Nursing Homes and Assisted Living Facilities. The MDH provided that residents in the observation unit should be placed in isolation using contact and droplet precautions with eye protection. As noted in example #1 above, both the Infection Preventionist and the unit manager for the observation unit were unaware that contact and droplet precautions were necessary on the observation unit. The IP provided the surveyor with a copy of COVID-19 guidance regarding accepting and transferring residents from their corporate office on 4/15/2020 which the surveyor reviewed on 7/28/2020 at 4:15 PM. The policy stated that new and returning patients/residents that tested negative during a recent acute care stay, can be transferred to a long-term care facility after d/c (discharge) from the hospital. The following must be implemented: 1. the patients/resident should be placed on a 14-day quarantine on admission from the hospital 2. transmission based precautions for at least 7 days from the date of the negative COVID-19 test. 3. or at least 3 days have passed since the resident has had a fever without the use of fever reducing medications and does not exhibit any signs of respiratory symptoms. For the patients/residents with no clinical concerns for COVID-19: All hospitalized patients/residents should be assessed for COVID-19 prior to transfer to a long-term care facility. If a test is not indicated per CDC testing criteria, and the patient/resident has no clinical concerns for COVID-19. The following must be implemented: 1. The resident should be placed on a 14-day quarantine on admission from the hospital 2. Based on the facilities status (resp illness present) the resident screening tool should be completed daily for non-respiratory illness facilities, and twice a day for facilities with respiratory illness on all patients/residents. In addition to the practice concerns, the facility policy also failed to meet minimum standards. It is unsafe and violates the standards to end transmission-based precautions 7 days after a negative test. On 4/30/2020, the Centers for Disease Control and Prevention (CDC) published guidance entitled Responding to Coronavirus (COVID-19 in Nursing Homes. This guidance provided that a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. Corroborating the concerns in policy and in practice, in interview on 7/29/2020 at 9:43 AM, the Director of Nursing (DON) reported that newly admitted residents are not necessarily on isolation. They are coming in after symptoms are checked, so they don't require isolation. They all had a negative COVID test prior to being admitted . Consistent with the reports that isolation precautions were not necessary on the observation unit, the facility posted no isolation precautions on the observation unit, and observation on 7/28/2020 at 2:17 PM revealed there were no bins with isolation supplies available to staff working with the residents on the unit. 4. Without establishing separation between the units between the residents or between the staff, and with inadequate isolation precautions policies and practices evident, staff also failed to practice hand hygiene appropriately and failed to safely use PPE. These system failures regarding hand hygiene practices and use of PPE, when combined with the structural failures describe above, increased the risk for spread of COVID-19 to any and all staff, residents, and visitors throughout the building. 4.1 Hand Hygiene The surveyor made multiple observations where facility staff members were not performing hand hygiene as necessary. 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. On the observation unit, on 7/29/2020 at 9:20 AM, Staff #11 was observed taking the bed linen off the bed by the window in room [ROOM NUMBER] with her bare hands. She then walked out of the room and into the room next door, room [ROOM NUMBER]. Staff #11 went over to the resident in the bed by the window and walked around the bed to pick up a package off the floor. Staff #11 placed the package next to the resident. Staff #11 did not sanitize her hands after coming out of room [ROOM NUMBER] and before going into room [ROOM NUMBER]. Review of training sign-in sheets revealed that Staff #11 had received education on infection control on 4/23/2020. An interview of Staff #13 was conducted on 7/28/2020 at 2:35 PM, as she came out of a resident's room on the observation unit. When exiting to the hallway, Staff #13 saw the surveyor and stated, Oh, I have to wash my hands and went back into the resident's room to wash her hands. Staff #13 came back out of the resident's room and stated that the residents on the unit were on observation due to being new admissions and they were monitored for COVID symptoms. Staff #13 said they do COVID monitoring. Staff #13 was asked what type of precautions that the resident was on in the room that she had just exited. She stated that the resident was on isolation. Staff #13 was asked what precautions you would take if a resident was on isolation, and the response was, isolation gown would be worn, a yellow gown. Staff #13 was not wearing a mask or gown that met minimum standards, but rather was wearing a cloth mask and a cloth gown. Staff #13 was asked why she did not wear an isolation gown and she said, Because the resident is on observation. Staff #13 wore the same gown and mask when entering rooms on the observation unit. On 7/28/2020 at 1:10 PM, on the third floor unit, Staff #9 was observed not sanitizing her hands after touching contaminated items. With no gloves, Staff #9 was observed going into room [ROOM NUMBER] to the bed by the window and touching several objects. Staff #9 then walked over to the resident in the bed nearest to the door. Staff #9 picked up a Styrofoam cup from an over-the-bed tray table and moved the cup, touched the resident in the bed and then left the room without sanitizing her hands. Staff #9 then walked down the hallway to the next room. There was a tray table sitting in the hall that GNA #9 touched before going into the next resident room (#321). GNA #9 touched the resident in the bed nearest the doorway and then looked up and saw the surveyor in the hall and shut the resident's door. The GNA failed to sanitize her hands after touching contaminated items and resident contact. Staff #9 did not don gloves on the way in to either room (and therefore did not remove gloves) and did not perform hand hygiene. It was later confirmed that GNA #9 was trained on 4/29/2020 on infection control/PPE, and on 3/11/2020 for handwashing. 4.2 Masks On 5/8/20, the Centers for Disease Control and Prevention (CDC) published guidance associated with a self-assessment tool entitled, Coronavirus Disease 2019 (COVID-19) Preparedness Checklist for Nursing Homes and other Long-Term Care Settings. The Maryland Office of Health Care Quality required that all long-term care facilities in Maryland review and complete this assessment. Guidance within the assessment indicated that all recommended PPE should be worn during care of residents under observation; this includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. Cloth face coverings are not considered PPE and should not be worn by (healthcare personnel) when PPE is indicated. Multiple staff (#12, #11, #10, #14, #1) wore cloth face coverings that did not meet minimum requirements to ensure staff and resident safety from potential spread from the population of residents with unknown COVID-9 status. During an interview with Staff #12 on the observation unit on 7/29/2020 at 9:15 AM, it was observed that Staff #12's face mask was not worn properly, as it did not fit up to the bridge of the nose. The top of the mask was just below the top of the nostrils. Observation was made on the observation unit on 7/29/2020 at 9:20 AM of Staff #11 wearing a green cloth face covering that was loose and kept sliding down her nose under her nostrils. She said she had COVID boot camp training and learned how to put PPE on and how to take it off. Staff #11 was also observed going in other rooms on the observation unit wearing the same cloth gown and same facial covering, neither of which met minimum standards. Staff #11 acknowledged that she was having a hard time keeping the mask from sliding down the front of her face. Observation was made on the second floor nursing unit, on 7/28/2020 at 2:25 PM, of Staff #10 wearing a facial mask that failed to cover the entire nose, revealing the nostrils. Staff #10 was asked if she received training on infection control and the proper use of PPE. Staff #10 said she did have training and the surveyor corroborated that with review of training sign-in sheets, dated 4/30/2020, for an in-service on infection control, handwashing, and PPE. On 7/28/2020 at 2:35 PM, Staff #14 was also observed not wearing a mask but rather wearing a noncompliant cloth facial covering. Staff #14 was on the second floor nursing unit, walking down the east wing hallway from the far end of the hall and was wearing a red cloth mask down below his nose. As soon as Staff #14 saw the surveyor, he pulled the mask up over his nose. Staff #14 was asked if he had received education on PPE, COVID, infection control and handwashing and he said that he did. The surveyor reviewed education sign-in sheets that revealed he was trained on PPE with competency validation, donning and doffing and standard and transmission based precautions on 4/29/2020. Observation was made on the third floor nursing unit, on 7/28/2020 at 1:10 PM, of Staff #1 wearing a face mask that failed to cover the entire nose as the top of Staff #1's nostrils were exposed. 4.3 Staff were donning cloth gowns at the start of their shifts and wearing the same gown between residents and between units throughout their shift. This included observations of staff working with residents with unknown COVID status and then working in the same gown with COVID-negative status residents. In interview with the NHA, SE, and IP on 7/28/2020 at 3:36 PM, the surveyor asked about the staff members wearing the same gown for all residents. The facility leadership stated that the gowns were changed if they became contaminated or soiled after coming out of a quarantine room, only then would staff need to change the gowns. In interview on 7/29/2020 at 9:43 AM, the DON reported that the facility was following extended wear PPE guidelines for all (and she added that if a

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 2) resident) presented with symptoms, they would be placed on isolation with single use items, true isolation. The DON stated, we don't have an oversupply of PPE, we have an appropriate supply for what we need at the moment. The DON provided the surveyor a copy of the CDC Coronavirus Optimizing supply of PPE and other equipment during shortages and reported this was the guidance that the facility followed for the facility-wide gown practice (where staff wear the same gown throughout their shift and throughout the building). The CDC guidelines allowing extended use of gowns and reuse of cloth gowns are not accepted practice but rather were an allowable exception providers might need to utilize if they experienced a sudden surge and were unable to obtain gowns through any other means. The guidance was published on 3/17/20 and provided that surge capacity refers to the ability to manage a sudden, unexpected increase in patient volume that would otherwise severely challenge or exceed the present capacity of a facility. While there are no widely accepted measurements or triggers to distinguish surge capacity from daily patient care capacity, surge capacity is a useful framework to approach a decreased supply of isolation gowns during the COVID-19 response. Three general strata have been used to describe surge capacity and can be used to prioritize measures to conserve isolation gown supplies along the continuum of care. The third highest level of surge capacity threatening to outstrip available resources and supplies shortage was defined as crisis capacity. The CDC indicated that these described strategies for gowns are not commensurate with standard U.S. standards of care . but may be considered during periods of known solation gown shortages. On 7/29/2020 at 10:16 AM, the DON provided the most recent calculations for the PPE on hand and it was documented that the facility had 1,895 gowns (of which 200 were cloth gowns), 650 N95 masks and 6,370 surgical masks. The surveyor asked the DON if they were experiencing a shortage and she stated why would we use up single use gowns when we don't have COVID in the Building because if we get COVID then we wouldn't have enough gowns and she added that if people were on isolation then they would use single use gowns. Thus, in addition to inappropriate use and reuse of cloth gowns, as did the IP and the unit manager on the observation unit, the DON further corroborated the facility was not placing newly admitted residents into the required contact and droplet isolation precautions. Specific staff observations regarding the cloth gowns included: Observation was made, on 7/29/2020 at 9:20 AM, of Staff #11 wearing a cloth gown and a green cloth mask that was loose and kept sliding down her nose under her nostrils. She was asked if she changed her gown after coming out of the rooms on the observation unit, and she said she wears the same gown and same goggles. She said she had received COVID boot camp training and learned how to put PPE on and how to take it off. Staff #11 was observed going in other rooms on the observation unit wearing the same cloth gown and same facial mask. On 7/29/2020 at 9:30 AM, Staff #11 was observed leaving the observation unit with a gown she had worn during resident care, exiting the observation unit and taking an elevator to exit the floor. With multiple residents on the observation unit with unknown COVID-19 status, the failure to both change and to remove the gown when exiting the unit increased the risk for spread of COVID-19 from the observation unit and throughout the nursing home. An interview of Staff #13 was conducted on 7/28/2020 at 2:35 PM as she came out of a resident's room on the observation unit. Staff #13 was asked what type of precautions that the resident was on in the room that she just exited. She stated the resident was on isolation. Staff #13 was asked what precautions you would take if a resident was on isolation, and the response was, isolation gown would be worn, a yellow gown. Staff #13 was observed wearing a cloth mask and a cloth gown. Staff #13 was asked why she did not wear an isolation gown and she said, Because the resident is on observation. Observation was made of Staff #15 (GNA) on 7/28/2020 at 2:40 PM walking from the north hallway to the west hallway (new admission observation unit) wearing a mask and cloth gown on the second floor. Staff #15 walked into room [ROOM NUMBER] and walked back out. Staff #15 did not change her gown and did not take any other special precautions. Staff #15 was asked what type of precautions were taken with residents on the observation unit and she stated, I just practice standard precautions for everyone. Interview of Staff #18 on 7/29/2020 at 9:05 AM on the second floor observation unit revealed she wears a cloth gown in all rooms. When asked about the precautions taken on the unit, Staff #18 stated, They don't have paper gowns yet, so we just wear the same gown. They usually have a box on the door with paper gowns. I just wear my gown, gloves and a cloth mask. Staff #18 stated, When on isolation, before entering the room, you wear goggles, gloves, booties, gown and take off before coming out. The surveyor observed that there were no isolation bins or boxes on the door with isolation gowns. Interview of Staff #12 (LPN) on 7/20/2020 at 9:15 AM, revealed that she floated on all 3 halls (wings) on the unit. Staff #12 stated, yesterday I was on the east hall and today I am on the west hall. When asked about wearing the cloth gown, Staff #12 stated, We wear the same gown. We are the observation unit, just standard precautions, PPE, contact and droplet precautions. The residents get tested before they come. Staff #12 stated, Droplet is glasses, mask, gown, gloves. I just wear my eyeglasses. I don't wear goggles. When asked if she had been trained on isolation precautions, she stated yes. With residents in the building who had unknown COVID status, the facility failed to maintain a dedicated observation unit with isolation precautions, failed to cohort staff to specific units, assigned staff to work with residents with unknown and with negative COVID-19 status during the same shift, assigned staff to different units on different shifts, and failed to ensure that staff wore masks sufficient to prevention transmission of COVD-19, failed to ensure that staff wore appropriate gowns and in fact, sanctioned that staff wore gowns that were noncompliant throughout the facility, failed to ensure that facial coverings and gowns that were worn while working with resident with unknown COVD-19 status did not leave the resident rooms, failed to ensure that staff wore gloves when necessary, and failed to ensure that staff washed their hands when required. The combined effect of all these noncompliant practices, left all residents, staff and visitors at increased risk for harm and death during the known and declared health pandemic.