STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215312	A. BUILDING _____ B. WING _____	**06/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEL AIR HEALTH AND REHABILITATION CENTER	**410 EAST MCPHAIL ROAD BEL AIR, MD 21014**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview with facility staff, 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 the facility 1) failing to isolate readmissions for the entire 14 days 2) failing to isolate residents in a timely manner after obtaining a COVID-19 positive [DIAGNOSES REDACTED]. All residents have the potential to be affected by these deficient practices. The findings include: On 4/5/2020, the Maryland Secretary of Health issued a Directive and Order Regarding Nursing Home Matters Pursuant to Executive Order No. 20-04-05-01 I The order stated: Staff Assignments: Nursing homes shall immediately implement, to the best of their ability, the following personnel practices: - Establish a cohort of staff who are assigned to care for known or suspected COVID-19 residents. - 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. - Designate a room, unit, or floor of the nursing home to care for residents with known or suspected COVID-19 1. The facility staff failed to maintain a resident in a separate observation area for 14 days. Interview with the Administrator and DON (Director of Nursing) on 6/8/20 at 12:30 PM revealed on 3/28/20 the facility created an observation area for readmissions to observe for COVID-19 in rooms 113-122. Review of Resident #5's medical record revealed the Resident readmitted to the facility on [DATE] from the hospital. On readmission to the facility the Resident was placed in the facility's observation area in room [ROOM NUMBER]A. Further review of Resident #5's medical record revealed on 4/8/20 the Resident was moved from the observation area to room [ROOM NUMBER]A, which was 8 days after readmission instead of 14 days. Interview with the Administrator and DON on 6/8/20 at 12:30 PM confirmed the Resident was not held in the observation area for 14 days. 2. The facility staff failed to isolate residents in a timely manner after a COVID-19 diagnosis. A. Review of Resident #7's medical record revealed on 5/7/20 the Resident received a positive COVID-19 [DIAGNOSES REDACTED]. Review of Resident #2's medical record revealed on 5/7/20 the Resident received a negative COVID-19 [DIAGNOSES REDACTED]. Further review of Resident #2's medical record revealed Resident #2 who was COVID-19 negative remained in room [ROOM NUMBER] with a COVID-19 positive resident until 5/8/20. B. Review of Resident #4's medical record revealed on 5/7/20 the Resident received a positive COVID-19 [DIAGNOSES REDACTED]. Review of Resident #3's medical record revealed on 5/7/20 the Resident received a negative COVID-19 [DIAGNOSES REDACTED]. Further review of Resident #3's medical record revealed Resident #3 who was COVID-19 negative remained in room [ROOM NUMBER] with a COVID-19 positive resident until 5/8/20. Interview with the Administrator and DON on 6/8/20 at 12:30 PM confirmed that Resident #2 and #3 were not moved from their rooms in a timely manner when the facility staff was advised their roommates were COVID-19 positive. 3. The facility staff failed to place a resident in a separate observation area on readmission. Review of Resident #1's medical record revealed the Resident was readmitted to the facility on [DATE] at 3:45 AM from the hospital back to room [ROOM NUMBER]A. Further review of the resident's medical record revealed [REDACTED]. The Resident was later moved on 6/5/20 to the observation area. Interview with the Administrator and DON on 6/8/20 at 12:30 PM confirmed the Resident was not placed in the observation area immediately on readmission.

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.