STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215026	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
POTOMAC VALLEY REHABILITATION AND HEALTHCARE	1235 POTOMAC VALLEY ROAD ROCKVILLE, MD 20850

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of closed clinical records and an interview facility staff, it was determined that the facility failed to notify Resident #5's responsible party of abnormal Coronavirus Disease 2019 laboratory test results. This finding was evident in 1 of 15 residents reviewed during the focused infection control survey. This finding was related to complaint MD 201. The findings include: Coronavirus Disease 2019 (Covid-19) is a disease caused by the Coronavirus [DIAGNOSES REDACTED]- CoV-2. COVID -19 spreads from person to person, mainly through respiratory droplets when an infected person coughs or sneezes. On 06-11-2020 a review of the closed clinical record for Resident #5 revealed documentation on 04-23-2020 at 4:03 AM that the resident had a temperature of 99.8 F. Further review of a subsequent nursing note, documented by the Director of Nursing (DON) dated 04-24-2020 at 10:06 AM, revealed that contact was made with the facility's Medical Director regarding the resident's symptoms. The Medical Director then ordered stat (immediate) lab work and a COVID-19 swab test for Resident #5. On 06-11-2020 a review of the COVID-19 lab report revealed a nasopharyngeal (through the nostrils) swab was completed by staff on 04-24-2020 for Resident #5 and the specimen was sent to the lab for processing. A review of the lab report revealed that on 04-25-2020 that the test was processed with results. On 06-15-2020 a review of documentation from the local health department dated 04-27-2020 at 1:09 PM revealed that the facility's DON and the Infection Control Preventionist (ICP) were made aware of the Resident #5's positive test results for COVID-19 and received a report of the resident's positive results. On 06-15-2020 a continued review of the Resident #1's clinical record did not reveal documented evidence that facility staff had notified Resident #5's responsible party of the positive COVID-19 test results on 04-27-2020. On 06-15-2020 at 3:00 PM interview with the facility's ICP and Administrator in Training did not reveal additional information.
F 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the closed clinical record, review of the facility's administrative records and interviews with the attending physician and facility staff, it was determined that the facility failed to perform basic life support, including initiation of CPR (Cardiopulmonary Resuscitation) in a manner consistent with professional guidelines for Resident #4. This finding was evident for 1 of 3 residents selected for review of residents' deaths during the complaint survey. This finding was identified during the investigation of complaint MD 186. As a result of these findings, an immediate jeopardy was declared on [DATE] at 12:00 PM. The facility submitted a plan of removal at 5:50 PM on [DATE] and it was accepted by the State Agency at 6:00 PM. After removal of the immediacy, the deficiency remained at a potential for more than minimal harm at a scope and severity of D. The findings include: According to the 2015 American Heart Association Guidelines Update for CPR, if a person is found unresponsive the provider should shout for nearby help and Activate emergency response system. Then check for breathing and pulse. If no breathing or pulse the provider should begin CPR and continue until ALS (Advanced Life Support) providers take over or the (person) starts to move. On [DATE] surveyor review of the facility's current policy and procedure for CPR, revised on [DATE], revealed the procedure for Full Code includes Certified staff must start emergency first aid/procedures. Initiate CPR, Call 911, Page CODE BLUE x 3 over the loud speaker with unit and room information . GNA (Geriatric Nursing Assistant) will assist with bringing code cart, suction equipment, O2 (oxygen) etc. Also, they can direct 911 response team to location of code . Once 911 is called and CPR or other emergency measures are initiated they are to be continued until rescue squad arrives. On [DATE] surveyor review of the Resident #4's closed clinical record revealed the resident had a Medical Orders for Life Sustaining Treatment (MOLST) form, signed on [DATE] by the physician. The Maryland MOLST is a portable and enduring medical order form covering options for cardiopulmonary resuscitation and other life-sustaining treatments. The medical orders are based on the resident's wishes about medical treatments. According to Resident #4's MOLST if cardiac and/or [MEDICAL CONDITION] arrest occurred CPR, should be attempted. Further review of Resident #4's clinical record revealed that on [DATE] the facility's social worker (SW) #6 documented confirmation of Resident #4's MOLST as a full code. Full code status means that all possible measures are taken to revive a person and sustain life. In addition, documentation included that the resident was alert and oriented x 3 and his/her own responsible party with a total Brief Interview for Mental Status (BIMS) score of 15. BIMS is a test given by medical professionals that helps determine a resident's cognitive understanding. A BIMS score of between 13 and 15 indicates a person is cognitively intact. On [DATE] surveyor review of a nursing note, documented on [DATE] at 5:45 AM by RN (Registered Nurse) #1, revealed that on [DATE] Resident #4 was observed with no respirations and no pulse. RN #1 further documented that the resident's family was notified of the resident's death with the time of death noted as 5:45 AM. The note also documented an attempt by RN #1 to notify the attending physician of the resident's death was made, but there was no response. On [DATE] surveyor review of a subsequent nursing note written by RN #1, dated [DATE] at 7:15 AM, revealed the attending physician was made aware that the resident's time of death was 5:45 AM. On [DATE] at 4:00 PM the Administrator in Training (AIT) was interviewed. The AIT revealed that RN #1 documented a statement regarding the death of Resident #4 and had emailed it to the AIT upon request. On [DATE] a review of RN #1's statement, dated for [DATE], revealed that RN #1 attested to performing rounds of the B wing on [DATE] at 5:45 AM, and upon entering Resident #4's room that the resident was found with no palpable carotid pulse, cold to touch, no spontaneous movement and without respirations. RN #1 further documented that she pulled the crash cart, then placed the resident on a backboard, and initiated CPR. She pronounced the resident as being deceased at 5:45 AM. On [DATE] a review of the facility's twenty-four (24) hour report covering [DATE] at 9:00 AM to [DATE] at 9:00 AM for the B wing, where Resident #4 resided, revealed no documented evidence that RN #1 had performed CPR on Resident #4 during the shift. Further review of the report revealed that the only information in reference to Resident #4 was documented that the resident was listed under discharges for [DATE]. On [DATE] at 4:30 PM surveyor interview with the local Fire and Rescue service revealed there was no evidence that the facility staff had contacted 911 service to request advanced life support for Resident #4 on [DATE]. Interview on [DATE] at 11:15 AM with Resident #4's attending physician revealed he received a call from the ,[DATE] shift nurse (RN #1) on [DATE] informing the physician that Resident #4 had expired. The physician further stated there was no information provided by the nurse that CPR had been initiated or that 911 had been contacted for an emergency medical services response for the resident. On [DATE] at 11:00 AM an interview with RN #1 revealed that she worked the evening of [DATE] through the morning of [DATE] (on the 11:00 PM-7:00 AM shift) as the facility's night supervisor and the charge nurse for the B wing. RN #1 reported finding Resident #4 was

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 0678 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 1) unresponsive on [DATE]. RN #1 stated that she was hollering out for help, but the one GNA working on the B wing was unable to be located. RN #1 then grabbed the crash cart, put the resident on the backboard and proceeded to perform five (5) repetitions of chest compressions and respirations until RN #1 became out of breath and stopped CPR on the resident. RN #1 stated that she pronounced the resident dead at 5:45 AM. RN#1 confirmed that she was the only health professional present with the resident. She then notified the attending physician of the resident's death as well as the resident's family. When asked about whether she had informed the attending physician about performing CPR, RN #1 was unable to recall. In addition, when asked, RN #1 was unable to recall whether notification to 911 for advanced life support had been initiated. On [DATE] at 2:30 PM surveyor interview with GNA (Geriatric Nursing Assistant) #5 revealed that she was transferred to work on the B wing with RN #1 after 1:00 AM on [DATE] for the rest of the shift. She further stated she had not observed CPR being performed on Resident #4 nor the presence of an emergency management services response for the resident. Follow up interview with the AIT on [DATE] at 10:30 AM revealed a second inquiry of whether an investigation was completed by the facility of Resident #4's death. The AIT reported at that time that the facility's Medical Director would be conducting a review on this day ([DATE]) of the death. No further additional information was provided. Therefore, immediate action was needed to decrease the likelihood that CPR is not performed in a manner consistent with professional standards for residents. CPR must be performed correctly for residents who desire and require resuscitation, and the appropriate advanced life support contacts should be called to initiate medical interventions. As a result of these findings an immediate jeopardy was declared on [DATE] at 12:00 PM. The facility submitted a plan of removal at 5:50 PM that was accepted by the State Agency at 6:00 PM. The provisions of the plan to remove the immediacy included the following. 1. Resident #4 no longer resides at the facility. The facility staff filed to continue CPR until ALS (Advanced Life Support) providers took over care or the resident had return of spontaneous circulation (pulse and respiration) RN # 1 involved in the deficient practice was counseled on the corrective policies and procedures of cardiopulmonary resuscitation. Compliance [DATE]. 2. AD-HOC QAPI meeting was held to determine and review root cause analysis and corrective actions were implemented on following CPR policy and procedures for activating ALS at the initiation of CPR. Compliance [DATE]. 3. Residents who have CPR indicated on their MOLST form have the potential to be affected by the deficient practice. Licensed nurses, who are scheduled to work today, will be reeducated by QA/ICP/ Administrative Nurse/AIT on following new CPR policy and procedures dated [DATE] for activating ALS at the initiation of CPR. Compliance [DATE]. 4. Licensed nurses will be reeducated by QA ICP/Administrative Nurse/AIT on following new CPR policy and procedures dated [DATE] for activating ALS at the initiation of CPR. Licensed nurses who did not get reeducated on following new CPR policy and procedures dated [DATE] for activating ALS at the initiation of CPR will not be allowed to work and will be removed from the schedule. Compliance [DATE]. 5. The Director of Nursing /Administrator and Medical Director will review residents, who have expired in the past forty- five (45) days, to ensure residents' advanced directive were followed as per their wishes. Compliance [DATE]. 6. Weekly audits of residents who expired will be completed by the Director of Nursing/Administrator and Medical Director for a period of 90 days. Compliance [DATE]. 7. Weekly reeducation by QA/ICP and/or Administrative Nurse on following new CPR policy and procedures dated [DATE] for activating ALS at the initiation of CPR will be done for a period of ninety (90) days. Compliance [DATE]. 8. Regional Director of Clinical Operations will audit 25% of expired resident charts monthly to ensure that CPR procedures were followed as per the residents' wishes for a period of 90 days. The results of these audits will be presented to the Quality Assurance Committee during their monthly meeting for review and comment. Compliance [DATE]. The immediate jeopardy was removed on [DATE] at 8:00 PM.
F 0684 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of the clinical record and facility staff interviews it was determined that facility staff failed to promptly call 911 and monitor Resident #3 who had an acute change in condition. This finding was evident for 1 of 3 records reviewed for residents' deaths. This finding was identified during the investigation of complaint MD 919 and resulted in actual harm to Resident #3. The findings include: A MOLST is a portable and enduring medical order form covering options on cardiopulmonary resuscitation and other life sustaining treatments. The medical orders are based on a resident ' s wishes about medical treatment. On 06-10-2020 review of Resident #3's 04-10-2020 Maryland Orders for Life-Sustaining Treatment (MOLST) revealed that if Cardiac or [MEDICAL CONDITION] arrest occurred do not attempt resuscitation. However, prior to arrest, administer all medications needed to stabilize the patient. On 06-09-2020 a review of the clinical record for Resident #3 revealed a progress note written on 05-01-2020 at 2:44 PM that documented the resident's heart rate was 190 beats per minute. A normal heart rate for an adult is between 60 and 100 beats per minute. A continued review of Resident #3's clinical record revealed a nurse's note written on 05-01-2020 by registered nurse (RN) #2 that documented that Resident #3' s heart rate was 170 beats per minute. The nurse administered medication and then rechecked the heart rate which was then 190 beats per minute. The nurse notified the charge nurse who called the physician, who advised to send the resident to the emergency room (ER). Further review of the clinical record revealed a nurse's note written on 05-01-2020 by RN #2 at 11:43 PM that documented, When EMS arrived and went into the room this nurse was coming down the hall from another patient's room when EMS stated that they needed a nurse because the patient coded. Patient had a DNR. Surveyor review of the clinical record revealed no evidence that facility staff had monitored the resident's condition after an acute change on 05-01-2020 at 7:00 PM when the resident's heart rate increased to 190 beats per minute. On 06-09-2020 a review of the Emergency Medical Service (EMS) record revealed that the facility called 911 on 05-01-2020 at 8:18 PM for Resident #3 to be transported to the ER. This was more than 75 minutes after the resident's pulse was noted to be 190 beats per minute. Further review of the EMS record revealed that the EMS crew arrived at patient side at 8:37 PM. Upon assessment Resident #3 was found unresponsive, without pulse or respirations. When nursing staff confirmed that the resident had a Do Not Resuscitate (DNR) order the EMT pronounced the resident's death at 8:41 PM. On 06-15-2020 a review of a telephone transcript from the physician's answering service revealed that a call was made from the facility to the service regarding Resident #3 at 6:49 PM. The transcript indicated it was read by a provider at 6:55 PM. Another call was made to the answering service regarding Resident #3 at 7:48 PM and was read by a different provider at 7:55 PM. Interview with the administrator in training (AIT) on 06-09-2020 at 3:00 PM revealed that the nurse (RN #2) was assigned to the facility by a nurse staffing agency. RN #2 was not currently working at the facility. Despite several attempts to reach RN #2 she was unable to be interviewed. Interview with the 3:00 PM-11:00 PM supervisor on 06-12-2020 at 1:15 PM revealed that he had called the physician regarding Resident #3's increased heart rate on 05-01-2020. However, he could not recall what time he had called the physician's answering service or what time he received a return call. He did recall that the provider had given the order for the resident to go to the emergency room . The 3:00 PM-11:00 PM supervisor stated that he waited on a return call from the doctor because Resident #3 had an increased heart rate while he was previously in the hospital. He also stated that he did not remain on the unit with Resident #3 on 05-01-2020 because he was working on admissions on another unit. Interview with the Medical Director on 6-12-2020 revealed that she had not seen the resident but had reviewed the resident' s hospital record. When asked how long she would expect a nurse to wait for a return call from the doctor before calling 911 for a resident with a pulse of 190, she replied it would depend on the case but not ever more than 15 minutes. Interview on 06-12-2020 at 3:05 PM with geriatric nursing assistants (GNAs) #3 and #4 who worked on the same unit with the resident on 05-01-2020 revealed that neither GNA was assigned to the resident and neither GNA recalled taking Resident #3's vital signs or caring for Resident #3 on 05-01-2020. Follow up interview with the AIT on 06-15-2020 at 11:00 AM revealed that the GNA that worked with Resident #3 on 05-01-2020 no longer worked for the facility and was not returning their calls. The AIT provided the surveyor with the GNA's contact information however, the GNA did not answer or reply to messages that were left to return the call.
F 0773 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of closed clinical records and interviews with the attending physician and the facility staff, it was determined that the facility failed to promptly notify the attending physician of results of Resident #5's positive

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F 0773 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Coronavirus Disease 2019laboratory test. This finding was evident in 1 of 15 residents reviewed during the focused infection control survey. This finding was related to complaint MD 201. The findings include: Coronavirus Disease 2019 (COVID-19) is a disease caused by the Coranavirus [DIAGNOSES REDACTED]- CoV-2. COVID -19 spreads from person to person, mainly through respiratory droplets when an infected person coughs or sneezes. On [DATE] a review of the closed clinical record for Resident #5 revealed documentation on [DATE] at 4:03 AM that the resident had a temperature of 99.8 F. Further review of a subsequent nursing note, documented by the Director of Nursing (DON) for [DATE] at 10:06 AM, revealed that contact was made with the facility's Medical Director regarding the resident's symptoms. The Medical Director then ordered a stat (immediate) lab work and a COVID-19 swab test for the resident. The DON further documented that the facility's staff would conduct the COVID -19 swab test, and that staff were to contact both the attending. However, there was no documented evidence that staff had notified the attending physician of the medical director's orders. On [DATE] review of the COVID-19 lab report revealed a nasopharyngeal (through the nostrils) swab was completed by staff on [DATE] for Resident #5 and the specimen was sent to the lab for processing. Further review of the lab report revealed that on [DATE] that the test was processed. On [DATE] a review of the local health department's documentation revealed that the facility's DON and the Infection Control Preventionist (ICP) were made aware of Resident #5's COVID-19 positive test results, as well as received the lab report on [DATE] at 1:09 PM. However, there was no documented evidence in the clinical record of the attending physician being notified by staff of Resident #5's positive COVID-19 test results. Further record review revealed a discharge summary, completed by Resident #5's attending physician on [DATE] that the resident had expired in the facility on [DATE]. There was no documentation by the attending physician of the COVID-19 [DIAGNOSES REDACTED]. On [DATE] at 3:00 PM an interview with the facility's ICP revealed no additional information. Interview on [DATE] at 11:20 AM with the attending physician revealed that the facility's staff did not contact the attending physician to report that COVID-19 test was ordered by the Medical Director and the attending physician had not received Resident #5's positive COVID-19 test results when they were obtained by the facility on [DATE].
F 0835 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical and administrative records, and facility staff interview it was determined the facility's administration failed to: ensure an effective system to obtain and report COVID-19 lab results for 1 of 14 residents (Resident #1) reviewed for cohorting practices; investigate and correct nursing practice deficiencies identified in the deaths for 2 of 3 residents (Residents #3 and #4) reviewed for the residents' death; and failed to implement a system to inform families and residents of confirmed COVID-19 cases by 5:00 PM the day following the facility being notified of cases. This finding was identified during the focused infection control survey. The findings include: 1. According to CDC guidance, Preparing for COVID-19 in Nursing Homes, for a resident with confirmed COVID-19 nursing homes should ensure the resident is isolated and cared for using all recommended COVID-19 PPE and If the resident is confirmed to have COVID 19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit On [DATE] at 1:45 PM an interview with the facility's Infection Control Preventionist (ICP) revealed that Resident #1 tested positive for COVID-19 on [DATE]. However, the ICP did not become aware of Resident #1's positive test result until she was verbally notified by a Unit Manager on or about [DATE]. On [DATE] an interview with the Regional Director of Operations (RDO) revealed that on [DATE] the facility begin using a different laboratory for COVID-19 testing than the laboratory they used to complete other resident lab work. The RDO described the alternative laboratory's online portal as difficult to navigate. The RDO stated he developed a spreadsheet to record the lab results, and then emailed the information to the ICP for review. The ICP would implement interventions based on those results. The RDO confirmed in the case of Resident #1 there was mistake made on the spreadsheet, he had entered that Resident #'1's COVID-19 results as negative. On [DATE] a review of the facility's daily census records revealed that Resident #1 remained in the same room with Resident #2, who tested negative for COVID-19 on [DATE]. Resident #1 not being properly isolated per CDC guidance for a resident who was COVID-19 positive. On [DATE] a review of administrative records revealed no evidence of a written policy and/or procedure for resident COVID-19 testing using the alternative laboratory. See F880 for additional details. 2. On [DATE] a review of the clinical record for Resident #3 revealed a progress note written on [DATE] at 2:44 PM that documented the resident's heart rate was 190 beats per minute. A normal heart rate for an adult is between 60 and 100 beats per minute. On [DATE] surveyor review of the clinical record revealed no evidence that facility staff had monitored the resident's condition after an acute change on [DATE] at 7:00 PM when the resident's heart rate increased to 190 beats per minute. On [DATE] a review of the Emergency Medical Service (EMS) record revealed that the facility called 911 on [DATE] at 8:18 PM for Resident #3 to be transported to the ER. This was more than 75 minutes after the resident's pulse was noted to be 190 beats per minute. Interview with the Medical Director on [DATE] at 1:45 PM revealed that she had not seen the resident but had reviewed the resident's hospital record. Interview with AIT on [DATE] at 10:30 AM revealed no evidence that an investigation was completed by the facility following the death of resident #3. The absence of an administrative review of the clinical record for Resident #3 after his death placed other residents who have an acute change in condition for lack of monitoring and delayed transport to the hospital. See F684 for additional details 3. According to the 2015 American Heart Association Guidelines Update for CPR, if a person is found unresponsive the provider should shout for nearby help and Activate emergency response system. Then check for breathing and pulse. If no breathing or pulse the provider should begin CPR and continue until ALS (Advanced Life Support) providers take over or the (person) starts to move. On [DATE] surveyor review of the Resident #4's closed clinical record revealed the resident had a Medical Orders for Life Sustaining Treatment (MOLST) form, signed on [DATE] by the physician. The Maryland MOLST is a portable and enduring medical order form covering options for cardiopulmonary resuscitation and other life-sustaining treatments. The medical orders are based on the resident's wishes about medical treatments. According to Resident #4's MOLST if cardiac and/or [MEDICAL CONDITION] arrest occurred CPR, should be attempted. On [DATE] surveyor review of a nursing note, documented on [DATE] at 5:45 AM by RN (Registered Nurse) #1, revealed that on [DATE] Resident #4 was observed with no respirations and no pulse. RN #1 further documented that the resident's family was notified of the resident's death with the time of death noted as 5:45 AM. On [DATE] a review of RN #1's statement, dated for [DATE], revealed that RN #1 attested to performing rounds of the B wing on [DATE] at 5:45 AM, and upon entering Resident #4's room that the resident was found with no palpable carotid pulse, cold to touch, no spontaneous movement and without respirations. RN #1 further documented that she pulled the crash cart, then placed the resident on a backboard, and initiated CPR. She pronounced the resident as being deceased at 5:45 AM. Follow up interview with the AIT on [DATE] at 10:30 AM revealed an inquiry of whether an investigation was completed by the facility of Resident #4's death. The AIT reported at that time that the facility's Medical Director would be conducting a review on this day ([DATE]) of the death. No further additional information was provided. See F 678 for additional details.
F 0880 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on staff interview and record review it was determined that the facility failed to develop and implement an effective system to verify the accuracy of critical laboratory results received from a secondary source (the Regional Director of Operations (RDO) The facility's reliance on an unverified and inaccurately transcribed critical lab result facilitated Resident #1, a COVID-19 positive resident remaining in a room with Resident #2, a COVID-19 negative resident. This finding was evident for 1 of 14 residents reviewed for cohorting of residents during a healthcare pandemic. As a result of these findings, an immediate jeopardy was declared on June 17, 2020 at 3:00 PM. The facility submitted a plan of removal at 10:50 PM and it was accepted by the State Agency at 11:00 PM. After removal of the immediacy, the deficiency remained at a potential for more than minimal harm at a scope and severity of D. The findings include: The Centers for Medicare / 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. According to the Centers for Disease Prevention and Control (CDC) guidance for a resident with confirmed COVID-19 test result, nursing homes should ensure the resident is isolated and cared for using all recommended COVID-19 PPE and If the resident is confirmed to have COVID19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit. On 03-23-2020, the Maryland Department of Health (MDH) issued guidance on Preparing for and responding to COVID-19 in Long Term Care and Assisted Living Facilities. This guidance indicated that when a COVID-19 case is confirmed, the response

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F 0880 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 3) priority is for quick identification and isolation of the residents. On 06-15-2020 surveyor review of the clinical record for Resident #1 revealed that the resident tested positive for COVID-19 on 05-13-2020. On 06-15-2020 a review of the facility's daily census records revealed that Resident #1 remained in the same room with Resident #2 who tested negative for COVID-19 on 05-13-2020. On 06-15-2020 at 1:45 PM surveyor interview with the Infection Control Preventionist (ICP) revealed that facility staff did not isolate Resident #1 because staff did not realize that the resident had tested positive on 05-13-2020. The ICP stated that an email she had received on 5 - 13 -2020 regarding test results indicated that Resident #1 had tested negative. It was only after the ICP had a conversation with the C wing unit manager on or about 06-05-2020 that it was discovered that the resident had tested positive on 05 -13 -2020. On 06-15-2020 at 1:45 PM surveyor interview with the Regional Director of Operations (RDO) revealed that the facility used a private lab to do universal testing on all residents 05-11 -2020. The RDO was the only person who had access to the lab's portal and lab results. The RDO said that when he accessed the portal the list of residents would show, and he would have to click on each resident to see the result, after opening a lab result and looking the result could not be seen. The RDO further stated he developed his own spreadsheet to track the results. The RDO would then email that spreadsheet to the ICP to review the results and implement interventions based on those results. The RDO reported that he had mistakenly marked on the spreadsheet that Resident #1 had tested negative for COVID-19. Additionally, the RDO reported the residents' actual lab results were uploaded into each resident's electronic health record by the private laboratory or facility administrative staff. On 06-15-2020 at 1:50 PM follow up interview with the ICP and the Administrator in Training (AIT) revealed that once lab results were uploaded into the electronic health record (EHR) there was no further review for accuracy by clinical staff. Failure to implement appropriate isolation precautions for Resident #1 who tested positive for COVID-19 related to an ineffective system for obtaining and reviewing lab results placed other residents and staff at increased risk for serious harm and death. As a result of these findings an immediate jeopardy was declared on 06-17-2020 at 3:15 PM. The facility submitted a plan of removal at 10:50 PM that was accepted by the State Agency at 11:00 PM. The provisions of the plan to remove the immediacy included the following: 1. Residents #1 and #2 remained current residents at the facility. Resident #1 tested positive. Resident #2 had no signs and symptoms remained negative. 2. A list will be created containing patients, who are being tested , for COVID-19, and will be sent out to nursing management staff. All nursing management, including DON, ADON, Infection Prevention Nurse, Patient Care Managers, AIT and Administrator now have access to lab portal to review the results. The lab portal that we are currently using is Sensiva Lab. This is currently the only lab we are using for COVID-19 testing. Lab results will be reviewed at morning meetings and afternoon meetings with all management staff to look for any new results (positive and negative). The list of patients, with pending results, will be reviewed at the morning and afternoon meetings to look at any positive and/or negative results. Patient Care Managers are tasked with notifying physicians and responsible parties of all new results. Audits of residents COVID labs will be completed weekly for 90 days by the Director of QA/Infection Preventin to ensure accurate lab results are be reported to Infection Prevention Nurse. This information will be reported to QAPI monthly for 90 days. Compliance 6/17/20. 3. If Patient Care Managers are not available, the communication pathway will be utilized to notify physicians and Responsible Parties. To ensure there is no deviation from the current process we have created a communication pathway to include 1. Patient Care Managers, 2. QA Infection Prevention Nurse, 3. DON, 4. ADON, 5. AIT, 6. Administrator. The communication pathway was developed to ensure that there is no lapse in communication to physicians and responsible parties. The communication pathway is set up in such a manner that if the first person tasked with contacting the physicians and responsible parties is unavailable, it falls to the next person on the pathway. Whichever person in the communication pathway contacts the physicians and responsible parties. will document in PCC. This information will be reviewed at the morning or afternoon meeting, whichever is first. Hard copies of the COVID-19 results will be printed and additionally upload to PCC documentation. Compliance 6/17/20. 4. On the weekends, we will continue to use the communication pathways and the Patient Care Managers will still be making the initial calls on any new results. Patient Care Managers will be receiving these new results by accessing the lab portal. After the initial calls are made, they will communicate to the next person on the pathway to alert them that the appropriate individuals were contacted. If the next person on the pathway is not available, they will continue to call the following person on the pathway to assure there is no lapse in communication to the physicians and responsible parties. Compliance 6/17/20. 5. All staff involved in the communication pathway were educated on June 17, 2020 on how to successfully access the lab portal to review COVID-19 results. All staff involved in the communication pathway were additionally educated on how to appropriately utilize the communication pathway when communicating COVID-19 results to families, physicians and responsible parties. Sign-in sheet was completed. Compliance 6/17/20. 6. If a patient is on a non COVID unit, without a roommate, and the patient tests positive for COVID-19, we will immediately re-locate them to our COVID unit and they will be put on droplet and contact precautions. The communication pathway will be utilized to inform the families, physicians and Responsible Parties. The patient will be continually monitored. The attached COVID-19 Isolation - Initiating Contact/Droplet Precautions (attached) will be followed. Compliance 6/17/20. 7. If a patient is on a non-COVID unit, with a roommate who tests positive, the positive patient will be re-located to the COVID unit and the room will be thoroughly cleaned and disinfected to help mitigate any further spread of COVID-19. The non-positive patient will be put on contact and droplet precautions and will remain in that room in isolation for 14 days or after two COVID negative tests. Compliance 6/17/20. 8. 100% of scheduled staff will be re-educated on the isolation guidelines by June 17, 2020. Education will be ongoing daily to reach 100% of staff who were not available during the initial educational timeframe occurring during June 17, 2020 to include staff who on the schedule and who are off (vacation, medical leave, etc.). Staff will not be allowed to return to work until compliance is met. Sign in sheets will be completed to reflect who were present for the training. Compliance 6/18/20. 9. The issues in reviewing lab results were brought to the attention of the lab representatives on May 19, 2020, and we will be meeting with the lab representatives on June 19, 2020 to review concerns. Compliance 6/19/20. The immediate jeopardy was removed on 06-23-2020 at 8:00 PM after onsite verification of the facility's abatement plan while the surveyors remained on-site.
F 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	Based on surveyor review of administrative records and facility staff interview it was determined that the facility failed to inform residents and families of positive COVID-19 cases in the facility by 5:00 PM the day following any newly confirmed cases of COVID-19. This finding was identified during the focused infection control survey. The findings include: On 06-08-2020 surveyor review of the facility's COVID-19 book revealed that the facility sent weekly letters to residents and families regarding any COVID-19 cases. However, there was no evidence that the facility notified residents and families of new positive COVID-19 cases in the facility by 5:00 PM the day following the occurrence of new COVID-19 cases as required. On 06-22-2020 surveyor review of the infection control line list revealed new positive cases of COVID-19 in residents and or staff on the following dates 05-12-2020, 05-15-2020, 05-16-2020, 05-22-2020, 05-23-2020, and 06-10-2020. However, there was no evidence that residents and families were notified of the new cases by 5 PM on 5-13-2020, 05-16-2020, 5-17-2020, 05-24-2020, or 06-11-2020. On 06-23-2020 at 6:20 PM surveyor interview with the administrator confirmed that the facility had no process in place to notify families and residents of new cases of COVID-19 by 5 PM the day following a new positive case.