STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215109	A. BUILDING _____ B. WING _____	08/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANOR CARE HEALTH SERVICES - ROSSVILLE	6600 RIDGE ROAD BALTIMORE, MD 21237

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 -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and review of medical records and other facility documentation it was determined that the facility failed to: 1) ensure staff screening, including temperature checks were completed prior to staff arriving on nursing unit; 2) ensure staff removed gown prior to leaving the room of a resident who was currently on isolation due to being a person under investigation (PUI) for possible COVID infection; 3) ensure plastic sheeting dividing the COVID + unit from the observation unit was secured to the wall and 4) ensure recent pulse oximetry (oxygen saturation level) and temperature were obtained as part of the COVID assessment. These findings were found to be evident for 3 out of 3 residents currently residing in the facility and reviewed during the survey and have the potential to affect all the residents in the facility. The findings include: 1) Facility failure to ensure staff screening, including temperature checks, were completed prior to staff arriving on nursing unit and failure to ensure staff completed the screening questionnaire prior to gaining entry into the resident care area. On 8/12/2020 at approximately 10:00 AM the Administrator reported the process for screening visitors included the completion of a form which is checked and a temperature check. She also reported that staff were completing self checks and that the forms were being checked every shift for completion. Staff can enter the facility either thru the main entrance or an entrance on the lower level. At approximately 10:15 AM during an observational tour of the facility Nurse #4 was interviewed regarding the screening process prior to starting work. Nurse #4 reported she takes a temperature but denied having filled out a screening form or having been asked any screening questions. At approximately 10:30 AM interview with GNA #7 revealed she was aware of the screening process but she reported she had not signed in (completed the screening questions) yet today. She reported she did have her temperature taken up on the unit earlier. The interview occurred at the staff screening area and GNA #7 indicated she would be completing the screening log at this time. Prior to the interview GNA #7 had been observed in the elevator heading to the lower level of the building. At 10:50 AM interview with the Infection Preventionist (IP Staff #3) revealed she was aware the GNA #7 had her temperature checked up on the unit. The IP had the employee screening sheets in her office and confirmed Nurse #4 had not completed the form. Review of the forms used by the employees revealed an area to document temperature and the absence or presence of signs and symptoms of COVID 19. 2) Failed to ensure staff removed gown prior to leaving the room of a resident who was currently on isolation due to being a person under investigation for possible COVID infection. Review of CDC guidelines for Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19 which clearly stated in doffing (taking off gear) section, that gown should be removed and discarded prior to exiting the patient's (resident's) room. On 8/12/2020 at approximately 10:45 AM housekeeper (Staff #5) was observed in the hallway of the first floor, just outside of a room with a PUI isolation sign. The resident's door was closed. The housekeeper was observed removing her PPE gown and discarding it in the trash receptacle on her housekeeping cart which was located directly in front of her. Interview with Staff #5 revealed that her normal process is to remove the gown in the hallway and confirmed she does not remove the gown prior to leaving the room. This observation and interview was reviewed with the Administrator on 8/12/2020 at 11:00 AM. On 8/12/2020 at 3:15 PM interview with the Environmental Services (housekeeping) supervisor revealed that housekeeping staff has received PPE training and that the expectation is that they remove and dispose of PPE in the resident's room. 3) Failed to ensure plastic sheeting dividing the COVID + unit from the observation unit was secured to the wall. The first floor of the facility has one continuous hallway in the shape of a rectangle. The resident rooms are located on the outer portion of the rectangle and the nursing station and other offices/storage areas are located along the inner portion of the rectangle. The facility currently has a section of the first floor designated for COVID positive residents which contains two resident rooms. At one end of the COVID unit there is a wall of plastic with a zipper that separates the general area hallway from the donning/doffing area with another set of plastic sheeting separating the donning/doffing area from the COVID + area. Beyond the two designated COVID+ rooms there is another wall of plastic sheeting (with no zipper or means to pass thru) separating the COVID + area from the general area hallway. The nurse's station is located just beyond this plastic wall. It was possible to visualize the entrances to the COVID + rooms from the hallway adjacent to the nurse's station thru the plastic sheeting wall. On 8/12/2020 at 11:15 AM while in the hall near the nurse's station surveyor observed the plastic sheeting wall to be gapping from the hand rail to the ceiling on one side; and an approximately 3 foot area gapping along the other side of the wall where the tape had come undone. The door to the one occupied room on the COVID positive unit was noted to be open at this time. Nurse #8 reported she had already put in a request to maintenance that morning regarding the plastic sheeting wall. At 2:30 PM the IP nurse reported the area by the COVID unit had been repaired. On 8/12/2020 at 3:15 PM interview with the EVS supervisor revealed this wall is cleaned 3 times a day and when the staff see the gapping they tell him about it and either he or maintenance re-tapes it. He confirmed that he had re-tapped the wall this date. 4) Failed to ensure recent pulse oximetry (oxygen saturation level) and temperature were obtained as part of the COVID assessment. On 6/25/2020, the Centers for Disease Control and Prevention (CDC) published updated guidance (from earlier 3/21/2020, 04/15/2020 and 5/19/2020) entitled Preparing for COVID-19 in Nursing Homes. The CDC directed facilities to actively monitor all residents upon admission and at least daily for fever (T=100.0 F) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement Transmission-Based Precautions. 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. The MDH provided that nursing homes must screen all residents at least daily, including performance of temperature checks, pulse oximetry checks, observing for signs and symptoms of COVID 19, and asking questions about signs and symptoms of COVID-19. On 8/12/2020 during the initial meeting with the Administrator she reported that the daily COVID assessments could be found under Respiratory Surveillance assessment in the electronic health record and indicated it included other COVID signs and symptoms. On 8/12/2020 review of Resident #2's medical record revealed the resident had been admitted within the past two weeks and was still in isolation during the initial two week observation period. COVID assessments were being documented multiple times a day. Further review of the medical record failed to reveal documentation that a pulse ox level had been obtained on 8/10/2020. Review of the COVID assessments documented on 8/10 at 2:36 AM and at 10:28 PM both revealed pulse ox documentation from 8/9/20 at 10:29 AM. On 8/12/2020 review of Resident #4's medical record revealed the resident had been admitted within the past two weeks and was still in isolation during the initial two week observation period. COVID assessments were being documented multiple times a day. Further review of the medical record failed to reveal documentation that pulse ox levels had been obtained on either 8/7/20 or 8/10/20. Review of the COVID assessments dated 8/7/2020 at 6:39 AM and 10:20 PM, as well as 8/8/20 at 7:03 AM revealed pulse ox levels that had been obtained on 8/6/20 at 4:27 PM. Review of the COVID assessment dated [DATE] at 7:11 AM revealed a pulse ox level that had been obtained on 8/8/20 at 4:27 PM. Review of the COVID assessments dated 8/10/20 at 6:10 AM and 10:56 PM both revealed pulse ox levels that had been obtained on 8/9/20 at 6:47 PM. On 8/12/2020 review of Resident #3's medical record revealed the resident was admitted more than a year ago. Review of the COVID assessments revealed they were being completed

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 -** Few	(continued... from page 1) multiple times each day during the month of August 2020. Further review of the medical record failed to reveal documentation that the resident's temperature had been obtained on 8/2/2020. Review of the COVID assessments dated 8/2/20 at 3:48 PM and 10:20 PM both included temperature data that had been obtained on 8/1/20 at 1:01 PM, more than 24 hours prior. The concerns regarding the housekeeping staff removing gown in hallway; failure to screen staff prior to arrival on unit to begin shift; the failure to ensure the plastic sheeting providing a barrier between the COVID + unit and the observation unit was secure; and failure to ensure recent pulse ox and temperature were obtained as part of the COVID assessments was reviewed with the Administrator on 8/14/2020 at 3:45 PM.