STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215301	A. BUILDING _____ B. WING _____	07/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANOR CARE HEALTH SERVICES - ROLAND PARK	4669 FALLS ROAD BALTIMORE, MD 21209

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 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** Based on observation, record review and interviews it was determined that the facility failed to have sufficient nursing staff to ensure an effective infection control program was in place during the COVID 19 pandemic as evidenced by failure to have a full time Infection Control nurse. This deficient practice has the potential to affect all of the residents. The findings include: Cross Reference to F 880. The facility failed to 1) ensure staff wore personal protective equipment (PPE) appropriately as evidenced by observation of two geriatric nursing assistants observed wearing masks below their noses and one maintenance worker who failed to wear an N95 mask while working on the COVID + unit; 2) ensure signage regarding PPE usage was posted; 3) ensure isolation orders were in place for newly admitted residents who were placed in private rooms among COVID negative residents, 4) ensure nursing staff completed daily COVID assessments and that vital sign and oxygen saturation information was current when the COVID assessments were completed, 5) ensure daily screening of staff included an assessment of the currently known signs and symptoms of COVID, and 6) ensure all staff had been tested for COVID as mandated by the state. These deficient practices put all the residents in the facility at risk for contracting COVID-19. Review of CDC website revealed the following: Facilities should assign at least one individual with training in IPC (infection prevention control) to provide on-site management of their COVID-19 prevention and response activities because of the breadth of activities for which an IPC program is responsible. Core Practices include: Assign One or More Individuals with Training in Infection Control to Provide on-site management of the IPC Program. This should be a full-time role for at least one person in facility that have more than 100 residents. The facility is licensed for 120 beds. On 7/15/2020 during the initial interview when asked who the infection control nurse was the Administrator and Director of Nursing (DON) reported that the DON is covering this role. Review of the resident line listing revealed that 4 residents tested positive as of 6/29/2020 and 1 additional resident tested positive in July based on the mandated weekly testing of all residents. At least 3 staff were identified as COVID positive based on the mandated testing completed in the beginning of July. On 7/17/2020 review of the employee line listings failed to reveal documentation of where the employees were working. At 2:30 PM when asked about this the Director of Nursing reported they have access to that information on the staffing sheets. When asked if any other staff was assisting him in the infection control monitoring the DON responded that they have an open Assistant DON position that would be responsible for infection control. On 7/17/2020 at 4:15 PM surveyor reviewed with the DON and the Administrator the concern related to one individual being responsible for the Infection Control program in addition to those of the Director of Nursing.
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, record reviews and interviews it was determined that the facility failed to 1) ensure staff wore personal protective equipment (PPE) appropriately as evidenced by observation of two geriatric nursing assistants observed wearing masks below their noses and one maintenance worker who failed to wear an N95 mask while working on the COVID + unit; 2) ensure signage regarding PPE usage was posted; 3) ensure isolation orders were in place for newly admitted residents who were placed in private rooms among COVID negative residents, 4) ensure nursing staff completed daily COVID assessments and that vital sign and oxygen saturation information was current when the COVID assessments were completed, 5) ensure daily screening of staff included an assessment of the currently known signs and symptoms of COVID, and 6) ensure all staff had been tested for COVID as mandated by the state. These deficient practices put all the residents in the facility at risk for contracting COVID-19. The findings include: 1) Facility failed to ensure staff wore personal protective equipment (PPE) appropriately. a) On 7/15/2020 at approximately 12:30 PM on the 3rd floor geriatric nursing assistant (GNA -Staff #1) was observed at the meal cart while wearing a mask that exposed her nose. The GNA was then observed to ambulate onto the nursing station and back out to hall by the elevator all the while with her nose exposed. When surveyor stopped GNA to obtain name, she fixed mask so that is covered her nose. Surveyor then informed the Director of Nursing (DON) of the observation and that the GNA fixed the mask after surveyor asked for her name. b) On 7/15/2020 at approximately 12:55 GNA(#7) was interviewed in the 2nd floor hallway. During the interview surveyor noted that the mask worn by the GNA was below the GNA's nose, the GNA would adjust the mask which would again fall below the GNA's nose. The GNA reported this occurs when she talks. The GNA reported she had been fit tested for an N95 mask but only wears it when caring for a resident on isolation, or when on the COVID + unit. c) On 7/15/2020 at 1:00 PM surveyor toured the COVID + unit with the DON. During this tour the Floor Technician (#2) was observed wearing a regular surgical mask. The Floor Technician reported that he had access to a N95 mask but indicated he was not wearing it because it pinches his nose. The DON addressed this issue with the Floor Technician at the time of the observation. On 7/15/2020 at approximately 1:30 surveyor reviewed the concerns regarding the two GNAs wearing masks inappropriately and the failure of the floor technician to wear an N95 while on the COVID + unit with the DON and the Administrator. 2) Facility failed to ensure signage regarding the use of and indication for Personal Protective Equipment was posted. On 7/15/2020 between 12:00 noon - 1:25 PM during the tour of the resident care units surveyor observed red signs to see the nurse, indicating resident was on isolation, on the rooms of each of the residents who had been admitted to the facility in the past 14 days. Residents are required to be on droplet precautions/isolation for the first 14 days of admission or re-admission. The doors of each of these rooms were noted to be closed and isolation PPE was located either at the door or within easy access. However, no signage was observed indicating the specific Personal Protective Equipment (PPE) that would be indicated. Further observation on the 2nd floor near the elevators and nursing station also failed to reveal signage regarding PPE. At 1:35 PM observation of the main lobby and first floor hallway failed to reveal signage regarding PPE. The receptionist (#5) reported that there had been PPE signage taped to the reception desk, she then indicated a blank area on the reception desk near the sign in books. On 7/15/2020 surveyor reviewed the concern regarding lack of PPE signage with the Administrator. On 7/17/2020 at 10:10 AM the DON reported they have recently improved their process for signage at the doors, indicating the type of isolation was now included on the back of the isolation sign on the door. 3) The facility failed to ensure isolation orders were in included in the admission orders [REDACTED]. This was found to be evident for 3 out of 3 newly admitted residents (#5, #6 and #7) reviewed during the survey. On 7/15/2020 at approximately 11:30 AM the Director of Nursing (DON) reported there was no barrier to the observation area and that residents on observation where being maintained in private rooms for 14 days. Review of the new admissions list and tour of the facility revealed residents were on isolation for admission/readmission on two separate floors of the facility. 3a) On 7/17/2020 review of Resident #5's medical record revealed the resident was admitted to the facility on [DATE]. Further review of the medical record failed to reveal an order for [REDACTED].#5's door was shut and there was a sign indicating the resident was on isolation. 3b) On 7/17/2020 review of Resident #6's medical

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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(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

(continued... from page 1)

record revealed the resident had been admitted on [DATE] but no current order for isolations precautions was found. Observation on 7/15/2020 revealed that Resident #6's door was shut and there was a sign indicating the resident was on isolation. 3c) Review of Resident #7's medical record revealed the resident was readmitted to the facility after a hospitalization on [DATE]. The order for strict isolation was dated 7/6/2020, the day after admission. On 7/17/2020 at 10:10 AM the DON reported that not every new admit has specific orders for isolation but that this information is conveyed to staff during huddle and that the isolation sign is at the door. The concern regarding the failure to ensure isolation orders were in the medical record upon admission was addressed with the DON and the Administrator on 7/17/2020 at 4:15 PM. 4) The facility failed to ensure nursing that staff completed daily COVID assessments and that current blood pressure and oxygen saturation information was obtained when the COVID assessments were completed. This was found to be evident for 7 out of the 7 residents reviewed during the survey. On 4/29/20, the State of Maryland Health Secretary issued an order which included the following: As the clinical status of individuals infected with COVID-19 may change quickly and nursing home residents may have an atypical presentation of the infection, each nursing home resident shall be evaluated daily to check for COVID-19 by the nursing home's clinical staff. The evaluation shall include vital signs as well as the identification of new or worsening signs or symptoms. An atypical presentation of COVID-19 infection may include: lower temperature (<100.0 F); muscle aches; nausea; vomiting diarrhea; abdominal pain; headache; runny nose; or fatigue. On 7/15/2020 the Director of Nursing (DON) reported the daily COVID assessments could be found in the medical record under Respiratory Surveillance and indicated it included the non-respiratory symptoms as well. On 7/16/2020 review of the Respiratory Surveillance form (COVID assessment) in the electronic health record revealed it included: temperature, blood pressure, and oxygen saturation (also known as pulse ox); as well as assessment of lung sounds; and if any of the following symptoms were present: cough, shortness of breath, sore throat, body aches, headache, loss of taste, loss of smell, nausea, vomiting or diarrhea. 4a) On 7/16/2020 review of resident #3's medical record revealed the resident was admitted more than 6 months ago. Further review failed to reveal COVID assessments having been completed on July 3, 6, or 9, 2020. Review of the the 7/12/2020 COVID assessment revealed it was effective as of 3:02 PM on 7/12, however the blood pressure and the oxygen saturation measurements were dated 7/10/20 at 8:32 AM. Further review of the COVID assessments that had been completed in July revealed they frequently included blood pressures and oxygen saturation rates that had been obtained more than 24 hours prior. Review of the vital sign documentation failed to reveal a blood pressure having been obtained on July 2, 6, 7, 9, 11, 12. The only oxygen saturation levels recorded for July were dated July 10 and 13. During the initial interview with the DON on 7/15/20 he indicated they recently completed another round of facility wide COVID testing. On 7/16/2020 further review of Resident #3's medical record revealed that on 7/13/2020 the resident's COVID test came back positive. The physician was contacted, orders were obtained and the resident was moved to the COVID + unit. Review of the COVID assessment dated ,[DATE] at 10:52 PM revealed the oxygen saturation level that had been obtained on 7/13. Further review of the medical record failed to reveal a COVID, or any respiratory assessment, having been completed on 7/14/2020. 4b) Review of Resident #2's medical record revealed the resident was readmitted to the facility in May 2020. On 7/15/2020 during the tour of the resident care area surveyor observed a isolation indicator on Resident #2's room. DON reported that the resident's roommate (Resident #3) was recently found to be positive and thus Resident #2 was in isolation due to the potential exposure. On 7/16/2020 review of Resident #2's medical record failed to reveal a COVID assessment having been completed on 7/15, two days after the resident's roommate had been diagnosed COVID +. Further review revealed the COVID assessment with an effective time of 2:50 PM on 7/14/2020 included oxygen saturation level from 7/13/2020 at 9:26 AM. Further review of the medical record failed to reveal a COVID assessment for 7/15/2020. On 7/16/2020 the surveyor reviewed the concern regarding the missing COVID assessments for 7/15/2020 with the DON. On 7/17/2020 DON provided a copy of a COVID assessment with an effective date of 3:24 PM on 7/15/2020, however it had been signed by the nurse on 7/17/2020. 4c) On 7/16/2020 review of Resident #4's medical record revealed the resident had resided at the facility for more than a year. Further review of the medical record failed to reveal a COVID assessment having been completed on 7/11 or 7/12. 4d) Review of Resident #1's medical record revealed the resident had resided at the facility for more than a year. On 7/16/2020 review of Resident #1's medical record failed to reveal a COVID assessment having been completed on 7/5 or 7/15/2020. Further review of the COVID assessments that had been completed in July revealed they frequently included blood pressures and oxygen saturation rates that had been obtained more than 24 hours prior. Review of the vital sign documentation failed to reveal a blood pressure having been obtained on July 9 or 14. The only oxygen saturation levels recorded for July were dated July 7 and 16. 4e) On 7/17/2020 review of Resident #7's medical record revealed the resident was re-admitted on [DATE] after a hospitalization . Further review of the medical record failed to reveal a COVID assessment on 7/10/2020 or 7/15/2020. Review of the COVID assessment with an effective date of 7/7/2020 at 5:31 PM revealed blood pressure and oxygen saturation level from 7/6/20. Review of the COVID assessment with an effective date of 7/11/2020 at 6:37 PM revealed a temperature from 7/10 at 6:33 PM, a blood pressure from 7/10 at 6:34 PM and a oxygen saturation level from 7/9/20 at 9:34 AM. Further review of the COVID assessments for 7/12, 13, 14 and 16 revealed oxygen saturation levels that had been obtained on 7/9/2020. 4f) On 7/17/2020 review of Resident #5's medical record revealed the resident was admitted on [DATE]. Further review of the medical record revealed COVID assessments completed on 7/11, 12 and 13 all included an oxygen saturation level that had been obtained on 7/10. The COVID assessments completed on 7/15 and 7/16 included blood pressure and oxygen saturation levels that had been obtained on 7/14/2020. 4g) On 7/17/2020 review of Resident #6's medical record revealed the resident was admitted on [DATE]. Further review of the medical record failed to reveal a COVID assessment having been completed on 7/15/2020. Review of the COVID assessments completed on 7/12 and 7/13 revealed oxygen saturation levels obtained on 7/11 at 12:54 AM. Review of the COVID assessment completed on 7/16 revealed an oxygen saturation level that had been completed on 7/14. The concern regarding missed COVID assessments as well as failure to include current vital sign assessments was reviewed with the DON and the Administrator on 7/17/2020 at 4:15. 5) The facility failed to ensure daily screening of staff included an assessment of the currently known signs and symptoms of COVID. Review of Maryland Executive Order No. MDH 2020-06-19-01 revealed: Facilities shall screen all persons who enter the facility (including volunteers, vendors, and visitors when permitted) for signs and symptoms of COVID-19, including temperature checks. Facilities shall refuse entrance to anyone screening positive for symptoms of COVID-19. Review of the CDC website revealed the following: Screen all HCP (Health Care Providers) at the beginning of their shift for fever and symptoms of COVID 19. Actively take their temperature and document absence of symptoms consistent with COVID 19. On 7/15/2020 at 10:45 AM surveyor observed the receptionist (Staff #5) taking visitor's temperature then having the visitor (i.e. hospice worker, surveyor) sign in the book. The receptionist reported that she takes the individuals temperature and have them sanitize their hands and that everyone has to wear a mask above the nose. When asked if she does any other screening she indicated the temperature is all that she does. Review of the sign in logs for both employees and visitors revealed the only signs and symptoms listed were dry cough and shortness of breath. Review of the Employee Temperature and Signs /Symptoms Log dated 7/15/2020 revealed most staff were not completing the form thoroughly. Only 3 out of the 15 employee screens reviewed included documentation of No Sign or Symptoms as evidenced by the column to indicate no was left blank. At least 9 of the employees did not include a last name. Further review of the Employee Log revealed Directions that indicated someone other than the employee being screened was to complete the log. The directions included: If temperature >100.4 *F or signs and symptoms present, refer to administrative review and place a (check) in referral box. Review of the Visitor Log revealed columns to document the name of the patient they would be seeing; the name of the visitor and their address, the visitor's phone number and that there identification was verified. There was columns to indicate No Temperature; and No S/S Dry Cough/Shortness of Breath. Further review of the Visitor Log revealed 12 visitors since 7/13. Of those 12 visitors 5 failed to document anything in the column for No S/S Dry Cough/Shortness of Breath. All the visitors documented their temperature reading or indicated absence of fever. Further review of the Visitor Log revealed that on 7/15 there is a notation of Hospice and a temperature. There is no name of the Hospice worker or any indication as to what resident(s) s/he would be seeing. At least 4 of the visitors only provided a name, failing to provide any contact information or indication as to who, where or why they were in the facility. On 7/15/2020 at 1:26 PM surveyor reviewed concerns regarding screening process with the DON and the Administrator. The Administrator reported the screening forms had been updated today and provided copies of the new forms. 6) Review of Maryland Executive Order No. MDH 2020-06-19-01 revealed: All staff, volunteers, and vendors who are in the facility regularly, shall be tested on a weekly basis for COVID-19 using a reverse transcription polymerase chain reaction-type test (PCR assay) pursuant to MDH guidance. Staff who have previously tested positive for COVID-19 and whose positive test results have been documented are exempted. On 7/15/2020 at approximately 1:30 PM the DON reported the facility is now conducting weekly testing of staff. The DON provided a list of all the employees with the date they were tested , date the results were received and wether they were negative or positive. The list also included if the employee had previously had a positive test. He went on to report that if an employee had not been tested he or she would not be allowed to work, and confirmed that any employee interviewed today should be on the list as having been recently tested . On 7/16/2020 review of the list of tested employees revealed testing dates from 6/30 to 7/9. On 7/15/2020 GNA #1 and GNA #7 had been observed working on the units and were included on the schedule. Although GNA #7 was on the employee list, no documentation was found to indicate a COVID test had been completed. Further review of the list failed to reveal GNA #1's name. On 7/16/2020 at 1:55 PM the DON reported that the Human Resource (HR) Director (Staff #9) keeps the line listing and monitors it daily but then provides it to him for review. The DON clarified that HR keeps track of who has been test and links with the scheduler and again stated that if the employee has not been tested then they will not be allowed to work. On 7/16/2020 at 2:30 PM the HR Director reported that the corporate policy is that if you do not complete the COVID test you cannot work until the test is obtained. She went on to report the initial testing was in June and that this is the second week of weekly testing. She reported staff are to come to the facility on Monday or Tuesday to be tested . 7/15/2020 was a Wednesday. In regard to GNA #7 she reported the employee has been contacted and instructed to come in to get tested . She later reported that she had not yet updated the line listing with the most recently obtained samples from this week, and indicated she would be updating the report today. During the interview with the HR Director on 7/16/2020 she reported that she has been submitting the employee line listing to the local health department contact. The facility did provide evidence that GNA #7 had been tested in the first round of employee testing in June and was negative at that time. No documentation was found to indicate any testing had occurred between 7/1 and 7/15/2020. Further review of the list of tested employees failed to reveal GNA #1's name. On 7/16/2020 during the 12:30 PM interview the DON reported that staffing agency staff are also expected to have been tested weekly and that it is the responsibility of the staffing agency to test weekly. On 7/16/2020 at 2:05 PM the staffing coordinator (Staff #8) confirmed that GNA #1 worked for a staffing agency. When asked about the process for ensuring agency staff were being tested weekly, he reported that the agency is suppose to send over a profile. Surveyor requested they provide a copy of the profile, or other documentation that a COVID test had been completed for GNA #1. On 7/17/2020 at 10:30 AM the Administrator reported they had verbal confirmation of a COVID test for GNA #1 but were working on obtaining credible evidence. At 4:00 PM the Administrator reported that the GNA had not been truthful when she reported having had a COVID test, and that she has since been tested and sent home. On 7/17/2020 at 4:15 PM surveyor reviewed with the DON and the Administrator the concerns regarding the screening process and failure to ensure testing of staff as mandated by the state. Surveyor also reviewed concern about the line listing being maintained by the Human Resource Director.

F 0885 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	Based on review of pertinent documentation and interview it was determined that the facility failed to ensure the website used to convey COVID status and updates were updated when indicated; and failed to have a process in place to ensure residents and family who do not have internet access were kept informed of COVID status and updates. These failures have the potential to affect all of the residents and responsible representatives. The finding include: 1) On 7/15/2020 the Administrator reported that the facility website has live time updates regarding COVID status. Administrator provided a copy of the information currently availble on the website. Review of this printout and review of the referenced website revealed information on the number of residents with pending COVID tests, number testing positive, and number meeting COVID recovered critieria. Infomation was also found for the number of employees with pending test results and number of employees COVID positive. Of note, this information was provided in a grid format and included the information for more than 50 other facilities. Of employees currently COVID positive the information provided for 7/15 revealed 1 employee was currently positive. On 7/16 review of documentation of employee testing and results revealed that at least 3 employees had tested positive in July, with the information being available to the facility between 7/9-7/11. This information was not reflected in the 7/15/2020 information on the website. On 7/16/2020 at 3:53 PM the Administrator confirmed the printout provided on 7/15 was the most up to date as of 7/15 but stated that there might be a 24- 48 hour lag time. Surveyor reviewed the concern that this information indicated only one positive employee but review of the documentation provided by facility indicated several employeess were found to be positive as of 7/11 and this was not reflected in the website information on 7/15. On 7/16/2020 interview with the Human Resource Director revealed 9 staff had been identified as COVID positive since June. On 7/17/2020 at 10:30 AM the Administrator reported that in regard to the staff numbers listed on the website, he was not sure if those numbers were cummulative or current. Surveyor reviewed the concern that if he is unable to interpret these numbers how were resident's and representative to know the status of COVID infections in the facility. 2) On 7/17/2020 at 10:30 AM the Administrator was unable to provide information regarding how a resident or family would be able to get facility updates if they did not have internet access.