STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215347	A. BUILDING _____ B. WING _____	**06/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEADOW PARK REHABILITATION AND HEALTHCARE CENTER	**1525 NORTH ROLLING ROAD CATONSVILLE, MD 21228**

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 observation and staff interview it was determined that facility staff failed to follow appropriate infection control protocol for 1) isolation of suspected COVID-19 positive residents on the interim unit as recommended by the Centers for Disease Control (CDC), 2) donning personal protective equipment (PPE) per CDC guidelines, 3) and maintaining clean linens on nursing units. This was evident for 5 of 5 occupied rooms on interim unit, 5 of 8 staff observed and interviewed, and 2 of 6 units observed. The findings include: 1) On 6/15/20 at 9:45 AM, an observation of the designated interim unit, which included rooms 127-135 and housed residents suspected of COVID-19 infection, revealed all the resident doors were open. The unit connected to the open area where the nurses' station was centrally located between three hallways. An interview with the Assistant Director of Nursing (ADON) and Director of Nursing (DON) on 6/15/20 at 11:05 AM, revealed that on the interim unit each resident room was an isolation area and staff were expected to put on and take off PPE at the doorway and close the resident's door at all times. A subsequent interview with the ADON on 6/17/20 at 11:36 AM, revealed that the facility decided not to hang a physical barrier at the entry of the interim unit to contain the spread of COVID-19, but to keep each resident room door closed at all times. The ADON stated there was signage hung on each door to remind staff to close the door when leaving. During a review of the findings with the Nursing Home Administrator (NHA) and DON on 6/17/20 at 12:15 PM, they confirmed that the resident's doors were to be closed at all times on the interim unit to contain spread of COVID-19. 2) An observation on 6/15/20 at 9:30 AM, revealed Geriatric Nursing Assistant (GNA) #2 had their isolation gown open in the front. During this observation an interview was conducted regarding education on how to properly put on PPE during which GNA #2 stated the staff had an in-service regarding how to put on PPE and a video on the TV in the lobby was constantly playing to remind staff of what they were taught. GNA #2 stated that no one checks to see if they were continually putting on their PPE properly. During an observation on 6/15/20 at 9:40 AM of GNA #3, it was noted that the tie at the neck of their isolation gown was not tied and the gown was hanging off their shoulders. GNA #3 reported they had in-services on PPE, but no one was watching them now to ensure they were properly putting on their PPE. An observation of Licensed Practical Nurse (LPN) #6 on 6/15/20 at 10:00 am on 2nd floor, revealed they were wearing a N95 mask with the top elastic band around their head and the bottom elastic band hung loosely at the front of the neck. During an interview at the time of the observation LPN #6 stated they had received education regarding how to properly put on PPE by the DON/ADON. LPN #6 stated that a video on the TV in the lobby plays constantly to reinforce proper attire, however, no one watches them put on PPE to ensure it is done properly. On 6/15/20 at 10:01 AM, LPN #7 was observed wearing an N95 mask with one elastic band around their head and the other hung loosely at the front of the neck. On 6/15/20 at 10:02 AM, Housekeeping Staff #8 was observed wearing an N95 mask with top elastic band properly around the head with the bottom band loose around the front of the neck. Housekeeping Staff #8 stated they were instructed by their supervisor on how to properly wear PPE. On 6/17/20 at 11:36 AM, during an interview with the ADON, it was confirmed that these observations were not appropriate use of PPE. The ADON reported that starting on March 4, 2020 staff were in-serviced on how to properly put on and take off their PPE. The ADON reported that Administrative staff and all supervisors were responsible for monitoring staff for proper attire and handwashing/hand sanitizing every day. On 6/17/20 at 12:15 PM, the DON and NHA were made aware of concerns observed regarding PPE. 3) During a tour of Unit 1 on 6/15/20 at 9:27 AM, a small linen cart was observed unattended in front of room [ROOM NUMBER] with the green cover pulled up on one side exposing the linens inside. Sheets were piled on top of the cart holding the green protective cover up. During a tour of Unit 2 on 6/15/20 at 10:02 AM, a small linen cart was observed unattended in front of room [ROOM NUMBER] and the cover was pulled up on one side exposing the linens inside. An interview with the ADON who was also the Infection Control Preventionist on 6/17/20 at 11:36 AM revealed that this was not the normal practice of the facility and that the cover should be down over the linens when unattended. On 6/17/20 at 12:15 PM the DON and NHA were informed of concerns and the DON confirmed that this is not the normal practice and the linen carts cover should have been down over the sides.

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.