STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215129	A. BUILDING _____ B. WING _____	**09/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CROMWELL CENTER	**8710 EMGE ROAD BALTIMORE, MD 21234**

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** - Some	**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 the residents, staff and visitors in the facility. The findings include: Cross Reference to F 880. The facility failed to: 1) ensure screening of visitors which included an assessment of the currently known signs and symptoms upon entry to the facility. 2) ensure nursing staff perform proper hand sanitizing procedures while serving food and caring for residents as evidence by observation of 3 Geriatric Nursing Assistants (GNA #2, #3, #6) that failed to sanitize their hands in between assistance to residents while serving meals. Observation of 1 GNA (GNA #3) that failed to sanitizing hands prior to and between provision of care for residents. 3.) ensure nursing staff properly removed and dispose of used personal protective equipment (PPE) appropriately as evidenced by observation of 1 GNA (GNA #6) who provided care to residents in a room then entered a hallway during dining service without removal or disposal of their PPE prior to exiting the resident room. 4) ensure staff performed proper soiled linen transport as evidence by 1 GNA (GNA #5) observed in hallway walking with unbagged uncontained contaminated linen on a resident unit. 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 135 beds. On 9/21/2020 during the entrance conference interview, when the Administrator, Director of Nursing (DON) and Clinical Consultant were asked who was the infection control nurse and the DON responded that she was covering this role. On 9/23/20 A review of requested training in-services attendance record titled Patient -Specific Contact Precautions Droplet/Airborne dated 9/4/20 revealed that none of the nursing staff observed failing to apply appropriate standard and transmission-based precautions were listed on the attendance sheets. (Refer to CMS 2567 F 725 and F 880) On 9/29/20 a review of the employee and resident line listings for the second outbreak failed to indicate where the employees were working or what unit the residents were on when identified positive for COVID. In addition, the listing failed to indicate a timeline for when symptoms were displayed, testing(s) occurred, and current status. At 11:30 AM on 9/29/2020, when asked about this the DON responded that they have this information available online and it is viewed corporately. When asked if any other staff was assisting her in the infection control monitoring and education the DON responded that the former infection control nurse was allowed to resign her position in late spring to work as a night time supervisor and that the open position was available for the infection control role. When asked who was responsible for the initial, supplemental infection control education and monitoring of staff standard and transmission-based practices the DON reported that she was covering this role also due to the position's vacancy.
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** Based on observation, record review and interview it was determined that the facility failed to ensure staff were trained to properly perform established guidance for standard and transmission-based precautions for screening visitors, hand sanitizing practices, proper disposal of personal protective equipment (PPE), and soiled linen transport for the prevention of the spread of the COVID-19 infections for residents in the facility. This deficient practice has the potential to affect all residents, staff and visitors in the facility. Findings include: Standard precautions are the minimum infection prevention and control practices that must always be used for all patients/residents in all situations. Transmission-based precautions are used when standard precautions alone are not enough to prevent the spread of an infectious agent. The facility failed to: 1) ensure nursing staff perform proper hand sanitizing procedures while serving food and caring for residents as evidence by observation of 3 Geriatric Nursing Assistants (GNAs) (GNA #2, #3, #6) that failed to sanitize their hands in between residents while serving meals. Observation of 1 GNA (GNA #3) that failed to sanitizing hands prior to and between provision of care for residents. 2.) ensure nursing staff properly removed and dispose of used personal protective equipment (PPE) appropriately as evidenced by observation of 1 GNA (GNA #6) provide care to residents in a room then entered a hallway during dining service without removal or disposal of their PPE prior to exiting and 3) ensure staff performed proper soil linen transport as evidence by 1 GNA (GNA #5) observed in hallway walking with unbagged uncontained contaminated linen on a resident unit. On 9/23/20 A review of requested training attendance record titled Patient-Specific Contact Precautions Droplet/Airborne dated 9/4/20 revealed that none of the nursing staff observed failing to apply appropriate standard and transmission-based precautions were listed on the attendance sheets. (Refer to CMS 2567 F 725 and F 880) Interview with the Administrator, Director of Nursing (DON) and Clinical Consultant on 9/29/20 revealed that some of the staff observed on 9/21/20 and 9/22/20 were assigned from a contracted staff agency and that a request was sent to the agency to provide training documentation. However, review of additional training documentation submitted on 09/29/20 revealed that agency staff, GNA #3, #4, #5 did not have documentation to support that they received current competency training including standard and transmission-based precautions based on the COVID pandemic. On 9/29/2020 at 11:30 AM during an interview with the DON when asked who was responsible for the nursing staff's routine competency training including initial and supplemental infection control education and monitoring of staff performance of standard and transmission-based practices the DON reported that she was covering this role also due to the position's vacancy. (Refer to CMS 2567 F725, F812 and F880.)
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview it was determined that the facility staff failed to use proper sanitary practices while handling food for residents. This was evident for 2 of 2 dining services observed during the survey. This deficient practice has the potential to affect all residents. Findings include: A tour of the facility was conducted on 09/21/20 at

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 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) 5:15 pm with the Director of Nursing (DON) and the corporate Clinical Consultant (CC) present. At 5:33 PM in the back hall of the Long-Term Care (LTC) unit an observation of the dinner meal service was conducted. Surveyor noted Geriatric Nursing Assistant (GNA#2) walk inside room [ROOM NUMBER] occupied by 3 residents carrying a plate of food. GNA#2 placed the plate down on the table in front of the first occupant in room, returned to the doorway to retrieve another plate and placed it on the bedside table of the second resident. Surveyor noted that inside the doorway there was a hand sanitizer dispenser available however the GNA #2 failed to use it. After the GNA served the 2nd plate she grabbed and donned a pair of gloves and walked over to the third resident in room and began to reposition the linen on their bed. The DON was alerted to surveyor's observation. The DON pointed to the doorway and indicated to the surveyor that there were hand sanitizer dispensers available at the entrance of each residents' room. GNA #2 was called to the doorway and immediately interviewed. GNA #2 admitted to the DON that she failed to sanitize their hands between interactions with the residents, was immediately re-educated by the DON. Immediately across the hall, surveyor noted GNA #3 stood at the doorway of room [ROOM NUMBER], occupied by 3 residents, as she retrieved a plate from a server, and re-entered room. Surveyor watched as GNA #3 positioned the plate on the center occupant's bedside table, walked back to doorway, retrieved another plate and re-entered the room without sanitizing their hands. Surveyor noted that there was not a hand sanitizer dispenser available at the doorway inside the room. GNA #3 approached the doorway and attempted to retrieve a third plate. The DON was alerted to the surveyor's observation and GNA #3 was immediately interviewed. GNA #3 confirmed surveyor's observations. When the DON began to re-educate the GNA, she replied there was no hand sanitizer available in the room. The DON retrieved a bottle of hand sanitizer from a cart across the hall and squirted it into GNA #3's hands. (Refer to CMS 2567 F 880) On 9/22/20 an observation of the lunch service on the LTC unit was conducted in the presence of the DON and Clinical Consultant. Surveyor noted GNA #6 in the hallway. The GNA wore a protective gown as she carried three plates from the service cart and entered room [ROOM NUMBER]. The GNA was observed as she placed one plate on each bedside table and exited the room. Surveyor observed that although there was a hand sanitizer dispenser available at the doorway to room [ROOM NUMBER], the GNA failed to use it. In addition, GNA #6 did not attempt to remove their gown before she exited the room. The DON immediately approached to re-educate however, GNA #6 proceeded past the DON and removed her gown in the hallway in front of the food service cart. The DON approached the GNA again and asked where her bags were to dispose of the gown. GNA #6 replied that no one told her about the use of bags to put her used gowns in. GNA #6 was given immediate re-education by the DON. (Refer to CMS 2567 F 880)
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 established guidance for standard and transmission-based precautions for screening visitors, hand sanitizing practices, proper disposal of personal protective equipment (PPE), and soiled linen transport for the prevention of the spread of the COVID-19 infections. This deficient practice has the potential to affect all residents, staff and visitors in the facility. Findings include: Standard precautions are the minimum infection prevention and control practices that must always be used for all patients/residents in all situations. Transmission-based precautions are used when standard precautions alone are not enough to prevent the spread of an infectious agent. On 09/21/20 at 4:20 PM, surveyor entered the facility and approached the Receptionist #1 at their desk in the lobby, displayed the surveyor badge and requested to speak with the facility's Administrator. The receptionist attempted to place a call to the Administrator however with no reply excused herself from the front desk to inform the Administrator in person. She returned at 4:24 PM, directed the surveyor to a chair in lobby and instructed to wait. At 4:27 PM, the Administrator entered the lobby, greeted and escorted the surveyor to a nearby area to conduct the entrance conference. Although supplies were visible at the front desk the facility staff failed to conduct a COVID-19 screening on the surveyor. At 4:55 PM during the Entrance Conference interview, the Administrator explained the procedure for screening residents, staff, and visitors using the recommended screening and documentation tools. When asked, the Administrator stated that it was expected for the receptionist to screen the surveyor when they arrived. When the Administrator was informed of surveyor's observation, he immediately went to the reception desk, interviewed and re-educated the receptionist. The Receptionist performed the screening process with surveyor in the presence of the Administrator after surveyor intervention at 4:58 PM. A tour of the facility was conducted on 09/21/20 at 5:15 PM with the Director of Nursing (DON) and the corporate Clinical Consultant (CC) present. During an observation on the Long-Term Care Unit at 5:22 PM, surveyor noted Geriatric Nursing Assistant (GNA #2) walking out of resident room [ROOM NUMBER] carrying a plate, cup and utensils. The GNA entered the hallway, placed the items in a cart and proceeded to another resident room without sanitizing their hands. The DON and CC were alerted to the observation and the GNA was immediately interviewed. GNA #2 stated to the CC that she was removing dirty plates, cups and utensils from the residents' rooms, failed to sanitize their hands between the rooms and verified surveyor's findings. At 5:33 PM in the back hall of the Long-Term Care (LTC) unit an observation of the dinner meal service was conducted. Surveyor noted GNA #2 walk inside Room # 51 occupied by 3 residents carrying a plate of food. GNA#2 placed the plate down on the table in front of the first occupant in room, returned to the doorway to retrieve another plate and placed it on the bedside table of the second resident. Surveyor noted that inside the doorway there was a hand sanitizer dispenser available however the GNA #2 failed to use it. After the GNA served the 2nd plate she grabbed and donned a pair of gloves and walked over to the third resident in room and began to reposition the linen on their bed. The DON was alerted to surveyor's observation. The DON pointed to the doorway and indicated to the surveyor that there were hand sanitizer dispensers available at the entrance of each residents' room. The GNA was called to the doorway and immediately interviewed. GNA #2 admitted to the DON that she failed to sanitize her hands between interactions with the residents and was immediately re-educated by the DON. Immediately across the hall, surveyor noted GNA #3 stood at the doorway of room [ROOM NUMBER] as she retrieved a plate from a server, and reentered room. Surveyor watched as the GNA positioned the plate on the center occupant's bedside table, walked back to doorway, retrieved another plate and re-entered the room without sanitizing her hands. Surveyor noted that there was not a hand sanitizer dispenser available at the doorway inside the room. The GNA approached the doorway and attempted to retrieve a third plate. The DON was alerted to the surveyor's observation and the GNA was immediately interviewed. GNA #3 confirmed surveyor's observations. When the DON began to re-educate the GNA, she replied there was no hand sanitizer available in the room. The DON retrieved a bottle of hand sanitizer from a cart across the hall and squirted it into GNA #3's hands. (Refer to CMS 2567 F 812) On 9/22/20 an observation of the lunch service on the LTC unit was conducted in the presence of the DON and Clinical Consultant. Surveyor noted GNA #6 in the hallway. The GNA wore a protective gown as she carried three plates from the service cart and entered room [ROOM NUMBER]. The GNA was observed as she placed one plate on each bedside table and exited the room. Surveyor observed that although there was a hand sanitizer dispenser available at the doorway the GNA failed to use it. In addition, GNA #6 did not attempt to remove her gown before she exited the resident room. The DON immediately approached to re-educate however, the GNA proceeded past the DON and removed her gown in the hallway in front of the food service cart. The DON approached the GNA again and asked where her bags were to dispose of the gown. GNA #6 replied that no one told her about the use of bags to put her used gowns in. The GNA was given immediate re-education by the DON and confirmed surveyor's concerns. (Refer to CMS 2567 F 812) An observation on the Transitional Care Unit (TCU) on 9/22/2020 at 5:50 PM revealed GNA #5 entered room [ROOM NUMBER] with several linen and disposable items in hand. GNA #5 and Resident #5 bumped into each other in the doorway. Surveyor noted that the resident did not have on a mask. Further observation revealed that the resident's lower face and upper front of shirt was damp. Surveyor observed while the resident stood inches away from the GNA #5, as s/he made several hand gestures and spoke in a fast but low voice. The GNA leaned forward to communicate with the resident. When the conversation ended the resident remained in the hallway while GNA #5 pulled the items in her hands close to her body and traveled passed the surveyor to enter a soiled utility room. The GNA exited the utility room and was immediately interviewed. She stated that she had planned to use the items for Resident #5 but s/he was upset and refused care. She added that although she knew that the items were contaminated, she failed to bag or contain the items to properly transport them to the soiled utility room and confirmed surveyor's findings. The DON and the Administrator were present on the unit and were made aware of surveyor's observations.