STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215149	A. BUILDING _____ B. WING _____	**07/31/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PEAK HEALTHCARE AT DENTON	**420 COLONIAL DR DENTON, MD 21629**

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 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined the facility physician failed to maintain medical records in the most accurate form for residents (Resident #4, #5 and #6). This was evident for 3 of 3 residents reviewed for accurate medical records. The findings include: A medical record is the official documentation for a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate. Resident #4 was admitted to the facility on [DATE] and as of 7-31-2020 the initial history and physical completed by the attending physician was not included in the medical record. Resident #5 was admitted to the facility on [DATE] and as of 7-31-2020 the initial history and physical completed by the attending physician was not included in the medical record. Resident #6 was admitted to the facility on [DATE] and as of 7-31-2020 the initial history and physical completed by the attending physician was not included in the medical record. The findings of incomplete medical record were confirmed by the Director of Nursing on 7-31-2020 at 12:30 PM.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** Based on observations and interviews, it was determined the facility staff failed to promote an environment that decreased the potential of transmission of communicable diseases for residents. This was evidenced by 1.) 1 of 1 un-emptied trash cans overflowing with medical waste in the reception area, due to staff from potentially all units of the facility failing to doff Personal Protective Equipment (PPE) appropriately in resident care areas, and 2.) observation of PPE being worn incorrectly by 1 of 8 staff (Nurse #3) during the COVID-19 Focused Survey. The findings included: 1. Upon entering the facility on 7-30-2020 at 9:00 AM this surveyor was screened for COVID-19 at a table set up in the reception area. The resident care area was beyond the reception area behind double doors. Next to the screening table was a trash can overflowing with discarded plastic isolation gowns. The discarded gowns were hanging outside the trash can and down the sides of the can reaching to the floor. Interview with the Director of Nursing (DON) on 7-30-2020 at 9:20 AM revealed the facility adopted the Centers for Disease Control's February 19, 2020 policy statement for Coronavirus (COVID-19) which states discard the gown in a dedicated container for waste or linen before leaving the resident room or care area. On 7-30-2020 at 9:40 AM the DON confirmed that the used plastic gowns had been disposed of outside the resident care areas and in an hazardous manner. 2. Upon entering the facility on 7-30-2020 at 9:00 AM and waiting in the reception area for the entrance conference staff to arrive, Nurse #3 was observed leaving the resident care area through double doors with his/her face mask only covering his/her mouth and not their nose. When stopped by this surveyor and questioned, Nurse #3 then pulled the mask up to cover his/her nose. Interview with Nurse #3 On 7-30-2020 at 9:45 AM revealed the facility has had no problems with obtaining PPE and he/she had been educated by the facility on proper wearing of PPE. 3. On 7-30-2020 at 11:10 Nurse #3 was observed by the DON and this surveyor wearing a mask and a disposable isolation gown in the front parking lot of the facility. The gown had not been disposed of in the resident care area before exiting the building. When asked, the DON said she had no idea why Nurse #3 was wearing the isolation gown outside the facility. The facility staff failed to reduce the risk of spreading communicable diseases. These 3 incidents were confirmed by the DON on 7-30-2020.

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.