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 _____	08/28/2020

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 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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 review of the medical records and interview with staff it was determined that the facility staff failed to maintain complete and accurate medical records by failing to document 1) follow up assessment information, 2) resident refusal of treatment and 3) measures implemented to minimize residents potential exposure to infectious organisms prior to moving to a single occupancy room. This was evident for 4 (#5, #3, #7 & #8) of 23 residents reviewed during the focused infection control survey. The findings include: 1) Resident #5's medical record was reviewed on 8/24/20 at 2:41 PM. The record revealed Resident #5 [DIAGNOSES REDACTED]. A COVID-19 (Coronavirus Disease 2019) Screening tool was dated 8/14/20 05:00. Resident #5's Oxygen saturation (SaO2) level was recorded as 91% (low) and that his/her saturation had decreased by 3 points or greater since it was last checked. No documentation was found in the record to identify what the nurse did in response to the resident's low oxygen saturation level. A telephone interview was conducted with Staff #14 on 8/25/20 at approximately 12:40 PM. She confirmed that she assessed Resident #5's SaO2 on 9/14/20 as 91%. She indicated that the resident was not wearing his/her oxygen so she educated the resident and reapplied his/her oxygen. Staff #14 explained that she rechecked Resident #5's SaO2 level within an hour and it had increased to around 96%. She confirmed that she did not document that the resident had removed his/her oxygen, the interventions she implemented nor the outcome. 2) During an interview on 8/26/20 at 10:45 AM, Staff #9, Unit Manager, explained that Resident #5 had a history of [REDACTED]. Further review of Resident #5's record failed to reveal that staff were documenting these occurrences. Staff #2, the Director of Nursing (DON), was made aware and confirmed these findings on 8/26/20 at 11:39 AM. 3A) Review of Resident #5's Change in Condition Progress note dated 8/16/20 03:31 revealed that Resident #5 had a temperature of 101.2 degrees F (Farenheit) accompanied by a cough. The on call practitioner was notified and ordered laboratory tests, a Stat Chest X-Ray and a COVID-19 swab. On 8/16/20 Resident #5 was residing in a room with Resident #3. No documentation was found in Resident #5's record to indicate if precautions were put into place at that time or why Resident #5 was not moved to another single room. During an interview Staff #2 indicated that Resident #5 was very large and was using a Bariatric (extra-large) bed. Moving his/her bed would require disassembling the bed to get it through the door. An interview was conducted with Staff #10 on 8/26/20 at 12:58 PM. She confirmed that due to the size of Resident #5 and the bed, the decision was made to move Resident #5's roommate (Resident #3) to a single room. The Administrator confirmed that Staff #10 the Nursing Supervisor, called him on the morning of 8/16/20 and the decision was made to move Resident #3 to another room. This was done at approximately 2:00 PM on 8/16/20. During an interview on 8/26/20 at 3:52 PM Staff #11, a Registered Nurse, confirmed that she worked the night of 8/16/20. She indicated that she assessed Resident #5 and educated him/her regarding the need for isolation. She indicated that Resident #5 did not want to be moved to another room during the night and requested to wait until morning, that Resident #5 had an uncomfortable gagging feeling from the mask from his/her Bi PAP (a machine used to assist with breathing at night). Staff #11 indicated that the resident's beds were moved further apart, toward the opposite sides of the room, and the privacy curtains were kept closed between the residents. Personal Protective Equipment (PPE) was worn and changed between residents and the door was kept closed. Staff #11informed the other nurse and staff working that night. She indicated that she informed the oncoming Nursing Supervisor during report in the morning on the need to follow up with separating the residents. During an interview on 8/28/20 at 9:09 AM Staff #2 revealed that the room shared by Resident #5 and #3 was very large, a half wall approximately 4 feet tall separated the beds, as well as, a privacy curtain on each side of the wall. The distance between beds in their usual position was 19 feet apart prior to staff separating the beds further on 8/16/20. The bedroom doors on that unit were kept closed and the room was already on extended plus droplet precautions, with signs posted on each door. An isolation cart was located outside of the room. Staff #2 indicated that the sign was changed and the residents were placed on extended contact plus airborne precautions when Resident #5 was identified with an increased temperature and cough. Review of Resident #5 and #3's records revealed that the staff failed to document the interventions, communication and plans that were put into place on 8/16/20 when Resident #5 was assessed with [REDACTED]. The Administrator, the Director of Nursing and the Corporate Nurse were made aware of these findings on 8/28/20 at approximately 12:20 PM. 3B) A medical record review was conducted for Resident's #7 and #8 on the morning of 8/27/20. Both residents resided in the same room and were on the Transitional Care Unit (TCU) unit or admissions unit. Resident #7 was admitted to this facility on 12/30/20 and had a history of [REDACTED]. Resident #7 was 425 pounds and was in a bariatric bed. On the evening of 8/4/20 at 22:47 (10:47 PM) a change of condition was noted. Resident #7 shortness of breath, dry cough and complained of light headedness. Vital signs were 102/54, pulse 99, respirations 18, temperature 99.9 and oxygen saturation was 97% on oxygen; Blood sugar was 235. The physician on call was notified at 11:25 PM and an order was received to do a stat CBC (Complete blood count) with diff, CMP(Comprehensive metabolic panel), chest x-ray and repeat COVID-19 test. The Family member was, also, notified that evening. On 8/5/20 the resident was transferred to the hospital. and returned from the hospital on [DATE]. Resident #8 was admitted to this facility on 1/6/20. Resident #8 had a history of [REDACTED]. Both residents were in the same room since admission. The DON informed this surveyor that both residents were not transferred to other rooms on the night of 8/4/20 when Resident #7 first had symptoms because the bed Resident #7 was in could not fit through the doorway and needed to be broken down. Resident #8 was not transferred due to history of disability of being deaf and not being able to understand instructions. He/She, also, had a history of [REDACTED]. The DON informed this surveyor that the room the residents were in was large and there was 19 feet between the beds and more if the side tables were moved over. There was, also, a four foot wall between the beds with curtains on each resident's side that were pulled. The nurse on night shift placed an infection control cart at the outside of the doorway and replaced a sign on the door that stated STOP EXTENDED CONTACT PLUS AIRBORNE PRECAUTIONS. There were, also, instructions to perform hand hygiene before and after contact with residents, and what PPE needed to be worn prior to entering the room, such as N95 mask or respirator, gown, gloves, face shield and to pull curtain between residents. This information was not in the note written by the nurse on 8/4/20. Resident #7 was tested for COVID-19 on 7/30/20 and the report date was positive on 8/6/20 for COVID-19. Resident # 8 was tested on [DATE] and his/her report came back on 8/5/20 positive for COVID-19, however he/she remained asymptomatic. During the exit meeting on 8/28/20 at approximately 12:20 PM the DON, Administrator and Corporate Nurse were made aware that the nurse failed to document the measures that were put in place to isolate the residents.

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