STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215365	A. BUILDING _____ B. WING _____	**07/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CADIA HEALTHCARE - HAGERSTOWN	**14014 MARSH PIKE HAGERSTOWN, MD 21742**

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility staff failed to notify the Resident's physician when a Resident had a change in condition in a timely manner (Resident #21). This was evident for 1 out of 27 residents reviewed during a complaint survey. The findings include: 1. The facility staff failed to notify the physician after a fall in a timely manner. Complaint # MD 359 was reviewed on 6/19/20 and 6/23/20 for allegations related to injuries of unknown origin. The medical record review revealed that the resident was admitted to the facility with unsteadiness on feet, muscle weakness, and a history of falls. An interview was conducted with the complainant on 6/22/20 at 11:30 AM and s/he stated that resident # 21 had sustained multiple falls within 2 weeks. Medical record review on 6/19/20 revealed resident # 21 was ambulatory, often wandered the unit, and had falls on the following dates: 6/6/20, 6/15/20, 6/16/20, and 6/18/20. The facility submitted an investigation for the fall that occurred on 6/6/20 to the survey team on 6/23/20. Review of a statement submitted by RN # 4 revealed that, on 6/6/20 at 2030, GNA # 6 went into the resident room and observed resident # 21 sitting on the floor close to the door with his/her nose bleeding. The resident had shoes on and had previously been observed walking a lot and it was noted that his/her legs appeared weaker from walking. Additionally, the documentation revealed that the resident was confused and that s/he had been walking towards the door prior to fall. Review of the Concurrent Review form on 6/23/20 for resident # 21 revealed the resident had a fall on 6/6/20 at 2030. Listed on the form under: (D) Actions: Physician/NP Notified 6/7/20 at 4:00 AM. An interview was conducted with the DON on 6/23/20 at 12:30 PM and she was asked when the physician was notified of the resident fall. The DON stated that the MD was notified on 6/7/20 at 4:00 AM. The DON went on to say that the normal procedure is for the nurse to notify the physician immediately. Cross Reference Federal Tags F726, and F842, and CO[DATE], 0760 and 1370
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** Based on medical record review and interview, it was determined that the facility failed to provide the written transfer notice to the resident and or the responsible representative. This was found to be evident for the two out of two residents (Resident #15 and #34) reviewed for provision of transfer notice related to recent transfer from the facility. The findings include: 1) On 9/15/2020, review of Resident #15's medical record revealed that the resident had been discharged to the hospital in August 2020. On 9/16/2020, further review of the medical record failed to reveal documentation that the written transfer notice had been provided to either the resident or a responsible representative at the time of discharge, or after the discharge. On 9/16/2020 at 1:56 PM, surveyor informed the Administrator and the Director of Nursing (DON) that no documentation was found regarding the written transfer notice having been provided to the resident, or the responsible representative, for the August hospitalization . DON and Administrator indicated they would investigate. As of time of exit on 9/17/2020 at 5:45, no additional documentation had been provided regarding the provision of the written transfer notice for Resident #15. 2) On 9/17/2020, review of Resident #34's medical record revealed the resident had been transferred to another health care facility on 9/15/2020. Further review of the medical record failed to reveal documentation that the written transfer notice had been provided to either the resident or a responsible representative. On 9/17/2020 at 4:22 PM, surveyor reviewed the concern with the DON regarding failure to provide the written transfer notice to Resident #34. The corporate clinical consultant (Staff #8) reported that there is a four page document that is provided that includes the transfer information. At 4:55 PM, the corporate clinical consultant confirmed that they could not find the transfer notification in Resident #34's documentation.
F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** Based on medical record review and interview, it was determined that the facility failed to provide the bed hold policy to residents when transferred. This was found to be evident for the two out of two residents (Resident #15 and #34) reviewed for provision of bed hold policy related to recent transfer. The findings include: 1) On 9/15/2020, review of Resident #15's medical record revealed the resident had been discharged to the hospital in August 2020. On 9/16/2020, further review of the medical record failed to reveal documentation that the bed hold policy had been provided to either the resident or a responsible representative at the time of discharge or after the discharge. On 9/16/2020 at 1:56 PM, surveyor informed the Administrator and the Director of Nursing (DON) that no documentation was found regarding the the bed hold policy having been provided to the resident or the responsible representative for the August hospitalization . DON and Administrator indicated they would investigate. As of time of exit on 9/17/2020 at 5:45 PM, no additional documentation had been provided regarding the provision of the bed hold policy for Resident #15. 2) On 9/17/2020, review of Resident #34's medical record revealed the resident had been transferred to another health care facility on 9/15/2020. Further review of the medical record failed to reveal documentation that the bed hold policy had been provided to either the resident or a responsible representative at the time of, or since, the discharge on 9/15/2020. On 9/17/2020 at 4:22 PM, surveyor reviewed the concern with the DON regarding failure to provide the written bed hold policy to Resident #34. As of time of exit on 9/17/2020 at 4:45 PM, no documentation was provided to indicate that the bed hold policy had been provided to Resident #34, or a responsible representative, at the time of, or since, the discharge on 9/15/2020.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined that the facility failed to ensure that supplemental fluids were provided when indicated. This was found to be evident for one out of twelve residents (Resident #15) reviewed during the survey. The findings include: On 9/15/2020, review of Resident #15's medical record revealed the resident was dependent on a [DEVICE] for nutrition and hydration. Review of registered dietitian (RD) note, dated 8/25/2020 at 3:22 PM, revealed

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) that the RD had been notified that the resident's urine was dark in color and that the primary care physician was recommending the addition of 500 mls of fluid to the tube feeding regimin. The note also stated .recommend bolus-ing 250 ml of fluid BID in the resident's down time tomorrow,,, A bolus is when the full 250 ml of fluid is administered via the [DEVICE] at one time. BID indicates two times a day. A review of the resident's [DEVICE] orders and treatment administration record (TAR) revealed orders for feeding to be administered for 18 hours a day starting at 2:00 PM and finishing at 8:00 AM the following morning.Thus the resident's down time would be between 8:00 AM and 2:00 PM. Review of the TAR revealed that an order had been entered with a start date of 8/25/2020 for Enteral Feed Order every 2 hours as needed until 8/27/2020 00:01 (12:01 AM) 250 ml fluid flush bolus in down time BID (1100 and 1300 (1:00 PM)). In the section of the TAR where staff document the actual administration of the fluid, the 1100 and 1300 times were not listed. What was found was one entry listed as PRN, which indicates something is to be given as needed, but no specific time is indicated. The area to document the PRN administration was noted to be blank for 8/26. Review of an RD note, dated 8/26/2020, revealed the following: (S/he) is receiving 500 ml extra fluid per day However, further review of the medical record, including the TAR and nursing progress notes, failed to reveal documentation that the BID administration of 250 ml of fluid during the down time was administered on 8/26/2020 as indicated in the RD's note and order dated 8/25/2020. On 9/16/2020 at 10:53 AM, during an interview with the RD (Staff #9) it was revealed that the RD can enter feeding orders directly into the electronic health records at this facility. She went on to report that the nurses had informed her that the order for the flushes had not been entered correctly and that she then put the order in correctly. After review of her note, dated 8/25/2020, the RD confirmed the resident was to have received the two 250 ml boluses on 8/26/2020. On 9/16/2020 at 11:40 AM, surveyor reviewed the concern with the Administrator regarding the failure to put the flush order in the electronic health record correctly and no documentation that the additional 250 ml BID bolus fluids had been administered on 8/26/2020. As of time of exit on 9/17/2020 at 5:45 PM, no additional documentation had been provided to indicate that nursing staff had administered the additional 500 ml of fluid as indicated on 8/26/2020.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on administrative record review and interviews with facility staff, it was determined the facility staff failed to complete skilled level assessments on residents after unwitnessed falls. This was found to be evident for 3 (Resident #7, #8 and #9) of 8 residents reviewed for falls during a COVID-19/Complaint survey conducted at the facility. Findings include: Complaint # MD 061 was reviewed on 6/16/20 through 6/19/20 for concerns involving multiple falls sustained by residents in the facility. 1. Medical record review for resident # 7 on 6/16/20 at 1:00 PM revealed that the resident was admitted to the facility with the following Diagnoses: [REDACTED]. The resident had a fall on 5/18/20 and 5/27/20, and both falls resulted in injuries. Further record review revealed that a skilled level assessment and/or concurrent review was not completed on the resident after the falls on 5/18/20 and 5/27/20. Resident #7 sustained an injury after the fall on 5/18/20. No new interventions were put in place when Resident #7 returned from the hospital and he/she fell again suffering another injury. The facility inaccurately coded only one of the 2 falls with injury into the 5/27/20 MDS discharge assessment. In initial interview on 6/16/20 at 3:00 PM, the DON was asked to provide copies of the assessment that was completed for resident # 7 for the falls on 5/18/20 and 5/27/20. The DON stated that the facility does not complete an assessment after the resident leaves the facility. The DON further explained that the nurse documents in a soft file and is sometimes able to go in immediately and complete a skilled note. 2. Medical record review for resident # 8 on 6/17/20 at 11:00 AM revealed the resident was admitted to the facility with the following Diagnoses: [REDACTED]. The resident fell on [DATE]. Further record review revealed a skilled-level assessment and/or concurrent review was not completed on the resident after the fall on 6/8/20. In interview on 6/17/20 at 1:20 PM, the DON corroborated that the concurrent review assessment was not completed. Without conducting the required review after the 6/8/20 fall, Resident #8 then suffered another fall with injury on 6/16/20. 3. Medical record review for resident # 9 on 6/18/20 at 11:30 AM revealed the resident was admitted to the facility with the following Diagnoses: [REDACTED]. The resident fell on [DATE] and again on 6/8/20. Further record review revealed that a skilled-level assessment and/or concurrent review was not completed for this resident fall on 6/8/20. In interview with the DON on 6/17/20 at 1:20 PM, she confirmed that a skilled level assessment/concurrent review was also not completed for resident #9 for the fall they sustained 6/8/20. Cross Reference Federal Tags F0580, and F0842 and CO[DATE], 0760 and 1370
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** 2. Record review on 6/16/20 at 1:00 PM revealed that on 5/19/20 Resident #7 suffered a fall with major injury. Review of the record and subsequent interview with the Director of Nursing revealed that did not document a skilled-level assessment and/or concurrent review after the 5/18/20 fall. The DON reported that this falls documentation goes into a soft file and is not always entered into the medical record. Resident #7 was sent out to the hospital and the DON reported that they don't complete assessments after residents leave the building. With no documented skilled-level assessment and no documented concurrent review, when Resident #7 returned from the hospital, s/he suffered a second fall with serious injury. In the same pattern no skilled-level assessment was documented after the second fall. The facility then inaccurately coded only one of the 2 falls with major injury into the 5/27/20 MDS discharge assessment. Record reviews revealed that skilled-level assessment were also not documented after falls for Resident #8 on 6/8/20, or for a fall on 6/8/20 for Resident #9. Cross Reference Federal Tags, F0726 and F865, and CO[DATE], 0760 and 1370 Based on medical record review and interview, it was determined that the facility staff failed to maintain clinical records in the most complete and accurate form for resident #25 and resident #7. This was evident for 2 out of 27 residents reviewed during a complaint survey. The findings include: A medical record is the official documentation for a healthcare organization and the means for communicating important clinical information about each resident in order to meet their needs. 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 must be legible and accurate. 1. Review of a Facility Reported Incident #MD 30 revealed an incident that occurred on 6/19/20 at 2:00 AM between Resident #25 and Resident #26. Interview of the Director of Nursing (DON) on 6/23/20 at 10:00 AM revealed at the time of the incident, Resident #25 was placed on 1 on 1 observation until discharge to the hospital on [DATE] at 10:30 AM. The DON stated that, on the Resident's return to facility on 6/20/20 at 2:00 PM, the Resident was placed on hourly observation checks. During interview with the DON on 6/23/20 at 10:00 AM, the DON stated the facility staff is expected to document both 1 on 1 observations and hourly checks for a resident on a Treatment Administration Record. Review of Resident #25's Treatment Administration Record for June 2020 revealed no documentation that the 1 on 1 observation was completed. Further review of the Resident's June 2020 Treatment Administration Record revealed the facility staff failed to document that hourly observation were completed on 6/22/20 at 12 AM, 1 AM, 2 AM, 3 AM, 4 AM, 5 AM, 6 AM and 11 PM. Interview with the Director of Nursing on 6/23/20 at 2:00 PM confirmed that the facility staff failed to accurately document on a medical record for a resident.
F 0880 **Level of harm -** Immediate jeopardy **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 of resident care areas, interviews, and review of documentation including resident records and facility policies, it was determined that, during the COVID-19 pandemic, the facility failed to: 1) ensure that newly admitted and readmitted residents received care and services in a manner that was safe and was consistent with guidance from the Centers for Disease Control and Prevention (CDC), the Centers for Medicare & Medicaid Services (CMS), and the Maryland Department of Health (MDH). This was evidenced by the facility demonstrating, both in policy and in staff practice, that Personal Protective Equipment (PPE) was not being utilized safely and according to the above guidance. Additionally, the facility failed to, 2) ensure that nursing staff who had assessed COVID-19 signs and symptoms in

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) residents reported those findings to the resident's attending physician or nurse practitioner in a timely manner, resulting in related failures to update resident care plans, to move newly symptomatic resident rooms to protect from spread of [MEDICAL CONDITION], to initiate appropriate isolation precautions, and to timely obtain COVID-19 testing. Last, the nursing home failed to report known COVID-19 cases amongst both residents and staff as required. These noncompliant practices increased the risk for harm and possible death to all residents, staff, and visitors during a potentially fatal infectious outbreak in the building. As a result of these findings, an immediate jeopardy was declared on [DATE] at 1:20 PM. The facility submitted a plan of removal at 4:10 PM and it was accepted by the State Agency at 4:39 PM. The Immediate Jeopardy was removed on [DATE] at 2:30 PM after on-site confirmation of the completion of the facility's plan of removal. After removal of the immediacy, the deficiency remained with a potential for more than minimal harm and at a scope and severity of E. The findings include: 1) It was determined that the facility failed to ensure that caregivers of newly admitted or readmitted residents utilized all recommended PPE while the residents were kept on a 14-day quarantine post-admission. This was evident for 4 out of 4 residents (# 1, #2, #10, #15) reviewed for infection control during a complaint/ focused infection control survey. According to [DATE] guidance from the CDC reviewed by surveyors on [DATE] entitled Coronavirus Disease 2019 (COVID-19): Nursing Homes & Long-Term Care Facilities and located at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, the CDC advised facilities to Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown: Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP (health care providers) should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. According to additional guidance from the CDC reviewed by surveyors on [DATE] entitled Considerations for the Public Health Response to COVID-19 in Nursing Homes and located at https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html, the CDC also advises, All recommended COVID-19 PPE should be worn during care of (newly admitted or readmitted) residents under observation, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. Testing residents upon admission could identify those who are infected but otherwise without symptoms and might help direct placement of asymptomatic [DIAGNOSES REDACTED]-CoV-2-infected residents into the COVID-19 care unit. However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. According to a directive from the MDH dated [DATE] and pursuant to Executive Order No. [DATE]-01, the MDH ordered that, Nursing homes shall immediately implement, to the best of their ability, the following personnel practices: . Designate a room, series of rooms, unit, or floor of the nursing home as a separate observation area where newly admitted and readmitted residents are kept for 14 days on contact and droplet precautions while being observed every shift for signs and symptoms of COVID-19. According to the CDC, contact precautions include, wearing a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens. (Droplet precautions include) wearing a mask when entering the resident room and utilizing single rooms when able. According to a directive from the MDH, dated [DATE], and pursuant to Executive Order No. [DATE]-01, the MDH ordered that all facilities shall report the following information to the Chesapeake Regional Information System for Our Patients (CRISP). On a daily basis, each facility report should include at least the following: I. The census of occupied beds; II. Number of residents with positive COVID-19 test results; III. Number of residents with suspected COVID-19; IV. Number of residents with negative COVID-19 test results; V. Number of deaths, by COVID-19 status; VI. Number of staff with positive COVID-19 test results; VII. Number of residents with severe respiratory infection or COVID-19 resulting in hospitalization ; VIII. Number of staff with severe respiratory infection or COVID-19 resulting in hospitalization ; 3 IX. Number of residents or staff with new-onset respiratory symptoms that occur within 72 hours of another resident or staff developing respiratory symptoms; and X. Any other information required. During an interview on [DATE] at 12:45 PM, Registered Nurse (RN) #8 stated that one resident (Resident #1) on her shift was under a 14-day quarantine after being newly admitted to the facility. RN #8 also stated that new admissions did not require her or other staff to use additional PPE when caring for that resident. Contrary to CDC guidance, RN #8 indicated that, when caring for Resident #1, she would follow standard precautions (gloves and performing hand hygiene) and wear a surgical face mask that she wore throughout her shift. Over the course of the survey, residents under observation were observed to be stationed on all units of the facility. During the [DATE] interview with RN #8, he/she indicated that the nursing home also did not dedicate staff members for residents under observation. Instead, those residents were on the assignment of nurses and caregivers who were also caring for COVID-19 negative residents that were not being quarantined. RN #8 further indicated that she did not utilize PPE differently when caring for the quarantined residents, than when caring for the non-quarantined residents. At 12:47 PM on [DATE], Geriatric Nursing Assistant (GNA) #7 was observed stepping outside Resident #1's room wearing only a surgical face mask. GNA #7 was not wearing a gown or gloves. GNA #7 obtained supply from a cart next to the resident's door and then returned inside Resident #1's room without performing any hand hygiene or donning any additional PPE. During an interview on [DATE] at 12:50 PM with the Chief Nursing Officer (CNO), the CNO stated that new admissions and readmissions were being placed under a 14-day quarantine at the time of admission to the facility. The CNO also stated there was no expectation for staff to change their use of PPE for new admissions or readmissions unless the residents showed symptoms of COVID-19. On [DATE] at 12:48 PM, Residents #2 and #10, who were both recent admissions and therefore under quarantine for 14 days, were observed with a sign outside their door stating, Leave Door Closed. No additional PPE was noted outside either room. At 12:50 PM on [DATE], GNA #9 was interviewed and stated that she would not utilize additional PPE for a resident unless there was a donning station placed at the entrance to the room. When asked about Residents #2 and #10, GNA #9 confirmed that she would only wear gloves and a surgical mask. On [DATE] at 9:33 AM during an interview with the Director of Nursing (DON), CNO, and Infection Preventionist, the CNO confirmed that new admissions and readmissions were to be kept on a 14-day quarantine. The CNO indicated that staff were to wear all recommended PPE while providing care to that resident only if the resident was symptomatic for COVID-19. Otherwise, asymptomatic residents were to be treated only with standard precautions and a surgical mask. The DON stated that they had reviewed this practice in regular weekly teleconferences with the local health department and that the health department was satisfied with these practices. However, the local health department was not satisfied with these practices. In interview on [DATE] at 11:10 AM, the Local Health Department Employees #1 and #2 were interviewed and stated that they provide facilities with guidance to treat new admissions and readmissions as if they had COVID-19 for the duration of their 14 day quarantine, including wearing all recommended PPE for a resident suspected of COVID-19. Local Health Department Employees #1 and #2 further stated that this very guidance was given to the facility on [DATE]. However, review of the facility's COVID-19 policies on [DATE] corroborated the noncompliant staff practice and confirmed that asymptomatic residents that were new admissions or readmissions, were by policy to be cared for using only standard precautions and a surgical face mask. As of [DATE], the facility was caring for 4 residents on observation for possible COVID-19 exposure. The 4 residents resided on different units in rooms 509, 704, 711 and 713. Observation of these 4 rooms on [DATE] at 11:30 AM revealed there was no additional PPE outside any/each of these 4 rooms. 2) It was determined that the facility failed to ensure that nursing staff who had assessed COVID-19 signs and symptoms in residents reported those findings to the resident's attending physician or nurse practitioner in a timely manner, resulting in related failures to update resident care plans, to move newly symptomatic resident rooms to protect from spread of [MEDICAL CONDITION], to initiate appropriate isolation precautions, and to timely obtain COVID-19 testing. This was evident for 3 out of 3 (#4, #5, #6) residents reviewed for Covid-19 symptom assessments during a complaint/focused infection control survey. According to guidance from the CDC reviewed on [DATE] and entitled, Evaluate and Manage Residents with Symptoms of COVID-19, (located at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html), the CDC recommended that facilities Actively monitor all residents upon admission and at least daily for fever and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry . Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures > 99.0oF might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further

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In a section labeled 'Who Should be Evaluated as a Suspected Case, the policy stated, Cadia Healthcare will consider testing for COVID-19 in residents with a fever (99 or greater), severe lower respiratory infections (cough, shortness of breath), body aches, and or gastrointestinal symptoms (nausea, vomiting, diarrhea) without an alternative diagnosis. Cadia Healthcare will follow CDC guidance and will test residents who are symptomatic after consultation from the provider. Residents #4 and #5 become roommates on [DATE], prior to the below COVID-19 assessments in which symptoms known to be associated with COVID-19 were both observed and documented. During [DATE] review of resident medical records, the Surveyor noted that COVID-19 assessments for Resident #4 dated [DATE] and [DATE], both indicated Resident #4 was experiencing symptoms of COVID-19 including fever of 99.1, dry cough, and body aches. At the time of the COVID-19 assessments on [DATE] and [DATE], there was no evidence of physician notification, no change in the resident plan of care, no new orders for isolation precautions, no orders to obtain COVID-19 testing, and no relocation of the resident from the room shared with Resident #5. During a [DATE] interview with the Certified Registered Nurse Practitioner (CRNP) #1 at 2:30 PM, CRNP #1 indicated that she was not notified of Resident #4's symptoms until [DATE], which was two days after the symptoms were first documented by nursing staff on [DATE]. The resident was seen by CRNP #1 on [DATE]. The provider reviewed the resident's symptoms but did not place the resident on isolation precautions, did not order COVID-19 testing, and did not initiate any room change to protect Resident #5 from possible ongoing exposure. Despite the known community spread of COVID-19, when Resident #4 became symptomatic the CRNP attributed the symptoms to prior GI symptoms and a sore throat from the spring related to allergies [REDACTED]. Under State mandate, all residents in the facility were tested on or by [DATE]. On [DATE], positive COVID-19 test results were obtained for Resident #4. Resident #5's medical record was reviewed on [DATE]. The review revealed a nursing COVID-19 assessment for Resident #5 dated [DATE], the day after mandated testing was conducted and more than a week after his/her roommate (Resident #4) first showed signs and symptoms of COVID-19. This assessment indicated that Resident #5 by then had body aches. However, no notification to a provider could be found regarding these identified body aches on [DATE]. At the time of the assessment on [DATE], there was no evidence of physician notification, no change in the resident plan of care, no new orders for isolation, and no relocation of the resident. During the CRNP [DATE] interview at 2:30 PM, CRNP #1 stated that she was not notified of Resident #5's symptoms until [DATE]. Review of Resident #5's medical record revealed this was one day after the symptom associated with COVID-19 was documented by nursing staff on [DATE]. With two known positive staff cases the level of suspicion for COVID in the building should have been even higher than when Resident #4 was assessed by the CRNP on [DATE]. However, as was evident with Resident #4, when Resident #5 was seen by CRNP #1 on [DATE], with insufficient rationale he/she elected again not to initiate any room change or isolation precautions. Once tested under State mandate, on [DATE] positive COVID-19 test results were obtained for Resident #5. After the failure to protect Resident #5 when his/her roommate was first symptomatic, Resident #5 then became symptomatic in the same room. Once symptomatic the plan of care was not revised and appropriate precautions were still not initiated, and the facility then reported in an MDS record (an electronic assessment record) that on [DATE] Resident #5 died . Resident #6's medical record was reviewed on [DATE]. During the review, a nursing COVID-19 assessment on Resident #6 dated [DATE] documented a temperature of 99.3. Another on [DATE] identified the resident had gastrointestinal symptoms and a fever of 100.2. On [DATE], another identified a temperature of 99.5. On [DATE], another identified a temperature of 99.0. Over the course of these 4 days, there was no evidence of physician notification, no change in the resident plan of care, no new orders for isolation, no orders for COVID-19 testing, and no relocation of the resident. The resident was seen by the Medical Director on [DATE]. Resident #6 was symptom-free and afebrile on the date of this visit, but the Medical Director's progress note did not document any awareness of any of the symptoms staff had documented for Resident #6 over the immediate prior four days, and no actions were ordered to treat resident #6 or to protect other residents from possible exposure given the days long history of symptoms known to be associated with COVID-19. Once tested under the State mandate, on [DATE] positive COVID-19 test results were obtained for Resident #6. With three residents with known COVID symptoms, under State mandate all residents in the facility were tested on or by [DATE]. On [DATE], the facility inaccurately published on their web site that for the week of [DATE] through [DATE], no residents were under investigation for possible COVID-19. Nursing home documentation revealed that positive COVID-19 results were obtained for three different nursing home staff. Documentation indicated that Staff #2 tested positive on [DATE]. Staff #3 notified the Administrator of positive testing on [DATE] and this staff positive test was then confirmed to the nursing home by the local health department on [DATE]. A third staff with an illegible name documented in infection prevention and control documentation was tested on [DATE] with a positive result obtained [DATE]. In a mandatory reporting program, the nursing home inaccurately reported to the State daily (every day from ,[DATE] through [DATE]) that no staff had tested positive. One staff case was reported on [DATE] during the survey. No other staff cases were ever reported to the State reporting program before or during the survey. Additionally, in reporting posted to the nursing home web site on [DATE] for the week of [DATE] - [DATE] the nursing home inaccurately published that there were no positive staff and no staff under investigation during that seven day window. During [DATE] interview with the Administrator and the Director of Nursing (DON) at 9:00 AM, the Administrator indicated that the facility had three residents (Residents #4, #5, and #6) who were COVID-19 positive. The Administrator also confirmed that the facility had received positive COVID-19 test results for those residents on [DATE] after universally testing all residents and staff in the facility. During the same interview, the DON indicated that nursing staff were expected to assess for COVID-19 symptoms every shift, including taking resident temperatures and measuring oxygen saturation via pulse oximetry. These assessments were to be documented in an assessment form entitled the 'COVID-19 assessment' that had been specifically developed in the facility's electronic medical record system. During an interview with the DON on [DATE] at 1:28 PM, the DON confirmed, based on her review of Resident #4, #5 and #6's medical records and her own interview with the Medical Director on [DATE], that there was no evidence any facility medical staff had been notified of the above symptoms for Residents #4, #5, and #6 at the time those symptoms were first identified. During the same interview, the DON then stated that facility staff are expected to notify the residents' physician when the facility staff identify any symptoms of COVID-19 at the time of the assessment. Further corroborating the above findings, on [DATE] at 3:00 PM the Medical Director stated he did not recall being notified by nursing staff of the COVID-19 assessments for positive symptoms in Residents #4 on [DATE] or [DATE], for Resident #5 on [DATE] and for Resident #6 on [DATE], [DATE], [DATE] or [DATE]. As a result of these findings, an immediate jeopardy was declared on [DATE] at 1:20 PM. An IJ summary tool was provided to the facility at that time. The facility submitted a draft of their plan to remove the immediacy at 3:50 PM and it was not accepted. The facility submitted a second plan at 4:10 PM and it was accepted by the state agency at 4:39 PM. The provisions of the plan to remove the immediacy included the following: For Part 1) 1. Residents #1, #2, and #10 were placed on quarantine isolation on [DATE]. Precautions included wearing gowns, gloves, eye protection, and N95 mask or higher-level respirator for 14 days post admission to the facility. All other residents under 14-day quarantine isolation will follow the same guidelines. The signs labeled leave door closed on the doors of residents #2 and #10 were removed. 2. All new admissions /readmissions will be placed on a 14-day quarantine isolation. All nursing staff, therapy staff, housekeeping staff, and facility department heads will be re-educated on caring for residents who are in isolation and the procedures for required personal protective equipment (PPE). Dietary will be educated not to enter the facility nursing units. In-servicing for staff began on [DATE]. 3. The facility revised its policy on [DATE] for admissions/readmissions to include instituting full PPE for 14 days after the admissions/readmitted to the facility. 4. The DON will coordinate daily audits until substantial compliance is met of all new admissions / readmissions to ensure that proper isolation precautions are in place and that all staff are donning full PPE upon entering/exiting isolation rooms. In-servicing for staff began on [DATE] by the Staff Educator. All results for the audits will be reviewed in the facility weekly Quality Assurance Committee Meeting until 100% compliance is achieved over 2 weeks. The Committee will review and decide if further action is needed. For Part 2) 1. Resident #4 remains in the facility with no signs or symptoms of COVID-19. The provider was made aware of Resident #4's symptoms on [DATE]. Resident #5 no longer resides in the facility. Resident #6 remains in the facility and has no further signs or symptoms of COVID-19. The provider was made aware of the resident's symptoms on [DATE]. 2. A facility wide audit was conducted on [DATE] on all residents from [DATE] to [DATE] to assure the provider was notified for identified symptoms related to COVID-19 and changes in condition. All

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215365	A. BUILDING _____ B. WING _____	07/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CADIA HEALTHCARE - HAGERSTOWN	14014 MARSH PIKE HAGERSTOWN, MD 21742

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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) findings were corrected upon discovery. 3. The DON will coordinate in-servicing on notifying the provider for changes in condition that could be related to COVID-19. The NHA/DON/Staff Educator will conduct daily audits on all residents on all changes in condition/COVID screening to assure that the provider has been made aware of any changes and interventions that are needed. All results for the audits will be reviewed in the facility weekly Quality Assurance Committee Meeting until 100% compliance is achieved over 2 weeks. The Committee will review and decide if further action is needed. The Immediate Jeopardy was removed on [DATE] at 2:30 PM after on-site confirmation of the completion of the facility's plan of removal. Cross Referene Federal Tags F885 and COMR 1410 and 1440
F 0882 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of pertinent documentation and interview with staff, it was determined that the facility failed to have an infection preventionist who was responsible for the facility's Infection Prevention and Control Program as it relates to COVID - 19. This practice has the potential to affect all residents in the facility. The findings include: Cross reference to F 880 related to failure to ensure the local health department was notified when a cluster of potential COVID-19 cases were identified; and failure to ensure visiting providers were screened for most recent currently known signs and symptoms of COVID-19 as well as COMAR S 1410 for failure to ensure a primary care physician completed weekly COVID testing as mandated by the state of Maryland. Review of the www.cdc.gov website regarding Preparing for COVID-19 in Nursing Homes, updated 6/25/2020, revealed the following: 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 facilities that have more than 100 residents or that provide on-site ventilator or [MEDICAL TREATMENT] services. The facility provides on-site ventilator services. On 9/15/2020 at 10:00 AM, the Director of Nursing (DON) reported that the Infection Preventionist (IP) was nurse #7, that the IP works 24 + hours per week but was not in the facility today. The DON later indicated the IP would be in the facility the next day, but would be conducting training all day. On 9/16/2020 at 1:48 PM, during an interview with the DON and Administrator, it was revealed that the IP was conducting all day CNA (certified nursing assistant) training for the rest of the week. Surveyors clarified that an interview with the IP will need to be conducted during this survey. On 9/17/2020 at 1:17 PM, the IP (nurse#7) presented with the Chief Nursing Officer (CNO corporate Staff #6) for an interview. The IP was unable to answer questions regarding the line listing and monitoring regarding COVID-19. During this interview, it was revealed that, in addition to the infection preventionist duties, nurse #7 was also involved in staff development. The IP reported she has been at the facility since June 15, 2020, was there 24 hours per week, but that the DON does the line listing (for infection monitoring). The IP reported that her infection control time is limited right now and that she doesn't have as much time to spend on infection control as she would like. On 9/17/2020 at approximately 1:30 PM during an interview with the DON and the CNO, in response to who was responsible for monitoring new guidelines from CMS and the CDC, the CNO reported that corporate was responsible for monitoring CMS and CDC releases. On 9/17/2020 at 3:30 PM, the DON reported she would contact the health department if there was a confirmed COVID case in the facility. She went on to report that the IP nurse handles the line listing for antibiotic usage but that she (the DON) is responsible for the COVID line listing. Review of the facility's Infection Prevention and Control Program Policy (with a revision date of March 3, 2020) revealed the following statements regarding the IP: The IP gathers surveillance data and works with the Medial Director and providers to identify, treat, and prevent the spread of infection and possible communicable disease. The IP provides oversight and reporting for Communicable Diseases. In conjunction with the facility Staff Developer, the IP plans orientation, education and training of staff. Review of the job description for the Quality Assurance/Infection Control Nurse revealed the following: This position will also be responsible for overall infection control and prevention related to programs in the nursing facility On 9/17/2020 at 3:30 PM, surveyor reviewed the concern with the DON and the Administrator regarding the failure to have an IP for a sufficient number of hours per week. Reviewed that, initially, surveyor was informed the IP was working 24 hours per week, but based on interviews on that date, it was revealed that a significant portion of her time was not spent on infection prevention activities and that the DON was handling the COVID related monitoring. On 9/17/2020 at 5:45 PM, during the exit conference the CNO reported that they have a consultant who is continuing to provide infection preventionist assistance. Surveyor informed CNO that no one had mentioned the continued use of the consultant during the survey, but if they provided documentation of the hours worked by the consultant it would be reviewed. As of 9/24/2020, no additional documentation has been provided to indicate a infection preventionist consultant was providing servicing since the date of compliance, 8/13/2020, from the Focused Infection Control Survey that was conducted in June 2020.
F 0885 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and review of facility documentation, it was determined that the facility failed to ensure that residents, their representatives and families were informed by 5 PM the next calendar day following a newly identified COVID-19 infection. This was found to be evident for one staff member, GNA #3, reviewed during the survey The findings include: On 6/18/20 at 10:52 AM, during interview with Local Health Department (LDH) Employee #1, he/she stated the LDH did not receive notification from the facility that a staff member had a positive COVID-19 diagnosis, and were notified through a community contact [MEDICATION NAME]. LDH #1 stated that, on 5/26/20, the LDH was notified that a staff member of the facility, Geriatric Nursing Assistant (GNA) #3 received a positive COVID-19 [DIAGNOSES REDACTED].#1 stated LDH called the facility on 5/26/20 and confirmed the [DIAGNOSES REDACTED]. During interview with the ICP on 6/19/20 at 9:23 AM, she stated she was notified by phone on 5/23/20 from the Director of Nursing (DON) that GNA #3 had called the facility and stated he/she had received a positive COVID-19 [DIAGNOSES REDACTED].#3 via phone and confirmed GNA #3 had received a positive COVID-19 [DIAGNOSES REDACTED].#3 if he/she had the results in writing and GNA #3 stated no the health department would contact her. The ICP was asked if she or the facility made any notification to residents, their representatives and families of a newly identified COVID-19 [DIAGNOSES REDACTED]. During interview on 6/19/20 at 2:15 PM, GNA #3 stated on 5/23/20 he/she was contacted by phone on 5/23/20 and notified that he/she was COVID positive and immediately called the facility and notified them. He/She stated that he/she was later called by the ICP and also told him/her he/she was COVID positive. The Administrator provided documentation to the survey team of her notification to the residents, representatives and families that was made on 5/26/20, 3 days after the facility was notified of GNA#3's Covid-19 diagnosis. On 6/23/20 at 3:00 PM, surveyor reviewed the concern with the Administrator regarding the facility's failure to notify residents and family of a newly identified COVID-19 positive case in a timely manner, as required. The facility failed to report new onset of symptoms and failed to report this positive test result into required State reporting. Cross Reference F-0880 and CO[DATE], 1410 and 1440.