STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215325	A. BUILDING _____ B. WING _____	08/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE HARBOUR HEALTH AND REHABILITATION CENTER	2700 SOUTH HAVEN ROAD ANNAPOLIS, MD 21401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and medical record review it was determined that the facility failed to ensure a safe and effective infection prevention and control program by failing to ensure that residents admitted to the facility with an undetermined COVID-19 status and receiving [MEDICAL TREATMENT], were maintained in separate rooms, in a designated area and kept on contact and droplet precautions for 14 days. These concerns were evident for 6 residents (Resident #7, #8, #6, #5, #4, #3) residents reviewed for infection control. As a result of these findings, a determination of Immediate jeopardy was made on 8/13/20 at 11:34 AM for failing to ensure newly admitted residents were maintained in separate rooms on isolation precautions as required. An IJ template was provided to the facility at that time. The facility submitted the first draft to remove the immediacy at 1:30 PM and it was not accepted. The facility submitted a second plan at 2:52 PM that was not accepted. The facility submitted a third plan to remove the immediacy at 3:40 PM which was accepted by the state agency on 8/13/20 at 4:15 PM. The immediacy was removed on 8/14/2020 at 3:30 PM after validation that the plan had been implemented. After removal of the immediacy, the deficient practice continued with a scope and severity of E with potential for more than minimal harm for the remaining residents. After removal of the immediacy, the deficient practice remained at potential for more than minimal harm and at a scope and severity of E. The findings include: In guidance issued on 3/13/20 in memo QSO-20-14NH, CMS directed that if possible, facilities dedicate a unit/wing exclusively for any residents coming or returning from the hospital. This can serve as a step-down unit where they remain for 14 days with no symptoms (instead of integrating as usual on short-term rehab floor or returning to long-stay original room) On 4/5/2020 the Maryland Secretary of Health issued a Directive and Order Regarding Nursing Home Matters Pursuant to Executive Order No. 20-04-05-01 I Language in the order included: Staff Assignments: Nursing homes shall immediately implement, to the best of their ability, the following personnel practices: - Establish a cohort of staff who are assigned to care for known or suspected COVID-19 residents. - Designate a room, 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. - Designate a room, unit, or floor of the nursing home to care for residents with known or suspected COVID-19 In the State Operations Manual, Appendix PP updated 11/22/2017, the Centers for Medicare/Medicaid Services (CMS) defines cohorting as the practice of grouping residents infected or colonized with the same infectious agent together to confine their care to one area and prevent contact with susceptible residents (cohorting residents). CMS notes also that during outbreaks, healthcare staff may be assigned to a specific cohort of residents to further limit opportunities for transmission. On 8/11/20 at 9:00 AM, an on-site COVID-19 focused survey was initiated. At that time, during an interview, the Nursing Home Administrator stated the facility had 3 nursing units, 2 LTC (long term care) nursing units on the 2nd floor and 1 unit on the 1st floor that had 2 hallways. One hallway was designated an observation unit for residents newly admitted to the facility from the hospital. These residents were put on isolation precautions and monitored for COVID-19 signs and symptoms. The other hallway was a skilled unit that housed residents receiving [MEDICAL TREATMENT] and residents receiving rehabilitation. The [MEDICAL TREATMENT] residents resided in the odd numbered rooms and the skilled, rehab residents were across the hall, in the even numbered rooms. On 8/11/20 at 10:00 AM, a tour of the 1st floor was conducted. In the observation unit, all observed residents were in a room by themselves, the doors were closed and there was signage to indicate the resident was on droplet precautions. Observation of the skilled [MEDICAL TREATMENT] and rehab unit revealed private resident rooms where 1 resident would reside and semi-private residents' rooms which would be shared by two residents. On 8/11/20, at 11:54 AM, in the facility's EMR (electronic medical record), the resident list, which included the residents' name, the room where they resided, their date of admission to the facility, their insurance and their status, was reviewed and indicated a newly admitted residents was not admitted to the observation unit when he/she was admitted to the facility. Resident #7 was not admitted to the observation unit, but directly admitted into room on 8/5/20 into room [ROOM NUMBER] bed A, a room shared with Resident #8. On 8/11/20 at 12:09 PM, the during an interview, the NHA indicated that residents who were admitted to the facility and required [MEDICAL TREATMENT] were admitted to the [MEDICAL TREATMENT] rooms on the skilled hallway on Unit 1. The NHA stated that new admissions and re-admissions that did not require [MEDICAL TREATMENT] were admitted to the observation unit for 14 days, in semi-private rooms utilized as private rooms and residents receiving [MEDICAL TREATMENT] who are new admissions were admitted to the skilled unit on the 1st floor into semi-private rooms where another resident receiving [MEDICAL TREATMENT] might reside. At that time, the NHA confirmed that the facility cohorted [MEDICAL TREATMENT] residents with other [MEDICAL TREATMENT] residents, regardless if they were new admissions. The NHA stated that there were empty beds available on the observation unit, however the facility did not admit residents who came from the hospital that required [MEDICAL TREATMENT] to those rooms. The NHA indicated that [MEDICAL TREATMENT] residents weren't admitted to the observation unit because they would need to be transported to a room on the skilled unit for [MEDICAL TREATMENT] and that would be using two rooms for 1 resident. On 8/11/20 at approximately 12:15 PM, the NHA administrator was made aware of the surveyor's concerns related to newly admitted residents who required [MEDICAL TREATMENT] and were considered COVID-status unknown, were admitted directly into shared, semi-private, [MEDICAL TREATMENT] rooms in the skilled unit, not on the observation unit where they would be kept for 14 days on contact and droplet precautions while being observed every shift for signs and symptoms of COVID-19. On 8/11/20 at 12:30 PM, the resident census for the residents assigned to the [MEDICAL TREATMENT] rooms on the skilled [MEDICAL TREATMENT] unit was reviewed. The census, which includes the resident's date of admission, the room the resident was admitted to and any room changes revealed documentation that newly admitted residents who required [MEDICAL TREATMENT] and were considered COVID-19 status unknown, were admitted directly into shared, semi-private, [MEDICAL TREATMENT] rooms in the skilled [MEDICAL TREATMENT] unit, not on the observation unit for new admissions. 1. On 8/11/20, a review of medical documentation revealed Resident #8, a [MEDICAL TREATMENT] resident, was admitted directly from the hospital on [DATE] to room [ROOM NUMBER], a semi-private room in the skilled [MEDICAL TREATMENT] unit instead of the observation unit. Resident #8 had a negative COVID status based on test results from the hospital and his/her 14 day observation period ended on 8/5/2020. On 8/11/20, review of medical record documentation revealed Resident #7, a [MEDICAL TREATMENT] resident, was admitted to the facility from the hospital on [DATE] into room [ROOM NUMBER], with an unknown COVID status, to a shared semi-private room occupied by Resident #8. Review of the facility's daily census for 8/5/20 revealed 6 empty rooms on the new admission observation. The facility placed Resident #7, with unknown COVID-19 status, into a room with Resident #8 who had a negative COVID-19 status. Both residents received [MEDICAL TREATMENT] due to end stage [MEDICAL CONDITION] and had multiple comorbidities. Furthermore, observation of room [ROOM NUMBER] failed to reveal signage to indicate that newly admitted Resident #7 was on contact and droplet precautions due to an unknown COVID-19 status and the door to the resident's room was open to the hallway. Furthermore, on 8/11/20 at 1:30 PM, an observation of room [ROOM NUMBER] failed to reveal signage to indicate that newly admitted Resident #7 was on contact and droplet precautions due to an unknown COVID-19 status and the door to the resident's room was open to the hallway. 2. On 8/11/20, a

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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) review of Resident #5's medical record indicated the resident, who was receiving [MEDICAL TREATMENT], was admitted to the observation unit when he/she was admitted to the facility and moved to a private room on the [MEDICAL TREATMENT] unit on 6/1/20 then to a semi-private room, 105 bed A, on the [MEDICAL TREATMENT] unit on 6/19/20. Resident #5's medical record documented the resident was COVID-19 negative on 5/30/20. On 8/11/20, a review of Resident #6's medical record revealed the resident, who was receiving [MEDICAL TREATMENT], was admitted to the facility on [DATE] following hospitalization . The medical record indicated that when Resident #6, was admitted to the facility, the resident, whose COVID-19 status was unknown, was not admitted to the facility's observation unit for new admissions where he/she would be on contact and droplet precautions for 14 days while being observed for signs and symptoms of COVID-19. Instead, the resident was admitted to a shared room, 105 bed B, a semi-private room on the skilled [MEDICAL TREATMENT] unit and occupied by Resident #5. Resident #5 was at risk of acquiring COVID-19 when Resident #6, who had an unknown COVID-19 status was admitted to the shared room. Review of the facility's census for 7/20/20 revealed the facility had 1 empty room on the observation unit and 1 empty room on the 2nd floor. 3. Resident #4, a [MEDICAL TREATMENT] resident, was admitted to room [ROOM NUMBER] on the skilled [MEDICAL TREATMENT] unit, from the hospital on [DATE], not the facility's designated observation unit. Resident #4's observation period ended 7/15/20 indicating the resident was COVID negative. Resident #3, a [MEDICAL TREATMENT] resident with an unknown COVID-19 status was admitted to the facility from the hospital on [DATE] to room [ROOM NUMBER], which was a semiprivate room occupied by Resident #4. Resident #3 was not admitted to the designated observation unit for new admissions. Resident #4 was at risk of acquiring COVID-19 when Resident #3, who had an unknown COVID-19 status was admitted to the shared room. Review of the facility's daily census for 7/21/20 revealed 1 empty room on the 2nd floor of the facility. Resident #3 was tested for COVID on 8/3/2020 and the facility obtained the negative results on 8/12/2020. On 8/11/20 at 2:28 PM, during an interview, the DON (Director of Nurses) stated that is was the facility's policy to admit new residents to the designated observation unit where they would be on enhanced droplet precautions. The DON was made aware of these findings at that time. On 8/12/20 at 8:30 AM, a review of the resident's census in the medical record revealed Resident #7, a [MEDICAL TREATMENT] resident who was admitted on [DATE] to the shared room [ROOM NUMBER] on the [MEDICAL TREATMENT] unit was moved to room [ROOM NUMBER], a private room on the observation unit. On 8/12/20 at 8:45 AM, a tour of the 1st floor skilled unit was conducted. Observation of room [ROOM NUMBER] revealed signage posted on the door that indicated the resident in the room was on droplet precautions and Resident #7 was not observed in the room, bed A was empty, and Resident #8 was in bed B. On 8/12/20 at approximately 1:15 PM, 2 residents were observed in room [ROOM NUMBER], Resident #7 was in bed A and Resident #8 in bed B. At that time, during an interview, Staff #11, GNA (geriatric nursing assistant) stated that Resident #7 was moved from room [ROOM NUMBER] to a room the observation unit, however Resident #7 returned to room [ROOM NUMBER] bed A for [MEDICAL TREATMENT]. Allowing Resident #7, who was admitted on [DATE] and was considered COVID-19 status unknown into a room for [MEDICAL TREATMENT] that was shared by Resident #8, who was COVID-19 negative put Resident #8 at risk of contracting COVID-19. Failing to isolate newly admitted residents and admitting residents with an unknown COVID status to a room occupied by another a unit, put the resident population at risk for adverse outcome due to the chronic underlying medical conditions of [MEDICAL TREATMENT] residents. According to the CDC in the guidance entitled Preparing for COVID-19: Long Term Care Facilities, given the congregate nature and resident population served (for example, older adults often with chronic underlying medical conditions), nursing home populations are at the highest risk of being affected by COVID-19. The facility was licensed for 148 beds and the census was 110 at the time of the survey on 8/11/20. The facility continued to accept new admissions while resident cohorting standards were not met. As a result of these findings, a determination of immediate jeopardy was made regarding these failures on 8/13/20 at 11:34 AM and an IJ template was provided to the facility at that time. The facility submitted the first draft to remove the immediacy at 1:30 PM and it was not accepted. The facility submitted a second plan at 2:52 PM that was not accepted. The facility submitted a third plan to remove the immediacy at 3:40 PM which was accepted by the state agency on 8/13/20 at 4:15 PM. The provisions of the plan to remove the immediacy included the following: - Resident #8, #4, #3, #5 and #6 have all completed their 14 day observation period. - Resident #7 is still under observation period and still resides within the facility. The resident was moved to the observation unit on 8/11/20 at 4:47 PM. The prior roommate of Resident #7 was placed on enhanced precautions for 14 days pm 8/11/20 at 4:50 PM. - The administrator and DON were reeducated by the district director of clinical services (DDCS) and the vice president of operations (VPO) on the MDH requirements for new admission/readmissions on 8/11/20 at 5:00 PM. - The facility conducted an audit on 8/11/20 at 4:00 PM of all residents admitted within the last 14 days to ensure they were properly placed in an observation room per the MDH guidance and that transmission based precautions were in place. - On 8/11/20 at 5:00 PM, an audit tool to be completed weekly was initiated to the facility. This audit tool is to be used weekly to ensure that all admissions/readmissions are placed in the correct area of the facility based on MDH guidance. These audits will be sent weekly to the VPO and DDCS. - All admission room placement decisions are made by the Administrator or Director of Nursing. All admissions/readmissions are placed in the observation unit in a private room unless the administrator or Director of Nursing state otherwise and direct placement to another area of the facility. - On 8/11/20 by 5:00 PM all patients on unit one were assessed for new onset of symptoms due to COVID-19. Upon assessment, no runny nose, sore throat, nasal congestion, chest congestion, cough, SOB, [MEDICAL CONDITION] fever, worsening confusion, decreasing oxygen saturation, GI symptoms, malaise, or other symptoms present at this time. Nursing will continue to monitor through the every shift screening process in place. - This deficient practice was discussed with the medical director on 8/11/20 at 4:45 PM who is aware of the observation unit practice to be used going forward. This issue will continue to be discussed as well as any changes through the facility QAPI committee. - All observation residents will be dialyzed in destination rooms numbered109, 111, or 113. Signage on the destination room doors will indicate precautions to be used. These 3 rooms will be used for [MEDICAL TREATMENT] only; no residents will reside in these rooms. Deep cleaning will be completed in these rooms after each resident receives [MEDICAL TREATMENT]. - Any Staff having the potential to accept residents into the facility will be educated that all new admissions/readmissions are required to go to the observation in a private room unless directed by the administrator of DON to do otherwise. These staff include admissions director, unit managers, infection prevention nurse and nursing supervisors. This education will be completed by 8/13/20 at 5pm. If any of these staff members are unable to be educated, they will be suspended pending the completion of the education. The immediate Jeopardy was removed on 8/14/20 at 3:30 PM after an on-site confirmation of the implantation of the plan removal by the surveyor.