STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215031	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LONG GREEN CENTER	115 EAST MELROSE AVENUE BALTIMORE, MD 21212

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 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 and nourishments. This was evident for 2 of 4 units (Joppa and Mainstreet) toured during the survey. Findings include: A tour of the facility was conducted on 07/14/20 with the Center Nurse Executive (CNE) and the Nurse Practice Educator (NPE) present. During an observation on the Joppa Unit at 12:22 PM surveyors noted a sign on one of the doorway entrances of the unit's communal dining area that indicated that it was closed. However, surveyors noted an unlabeled clear, plastic personal beverage container filled with a clear liquid. The container was wet from condensation and had ran onto the table. In addition, a small a paper cup partially filled with a pink colored liquid sat next to it. The NPE was alerted to the observation and the presence of the surveyors, she interviewed staff who indicated that the bottle of water and cup of juice belonged to a resident who routinely sat at the table to eat their meals. The items were removed by staff as instructed by the NPE who stated that she would speak further with the unit staff and confirmed surveyors' findings. At 12:27 PM during the midday meal service on the Joppa Unit, surveyors observed Geriatric Nursing Assistant (GNA) #4 and GNA #5 as they served plates to their assigned residents. GNA #4 was observed as she retrieved a plate of food from the servers and proceeded to enter room [ROOM NUMBER]. Surveyor watched as she knocked on the door, rearranged items, placed the plate on the bedside table and exited room. GNA #4 walked back to the servers, retrieved another plate, knocked and entered room [ROOM NUMBER] without sanitizing their hands. GNA #5 was observed in hallway as she entered room [ROOM NUMBER] with a plate in gloved hands. She placed the plate on a table, assisted the resident briefly, exited the room, squirted hand sanitizer on gloved hands, retrieved another plate from the servers and reentered the hallway. NPE was alerted to observations and immediately interviewed. The NPE stated it was expected of the staff to sanitize their hands between serving residents and after contact with communal items such as; doors, doorknobs in addition to handling residents' personal belongings. The NPE added that it is expected for staff to not sanitize gloves for reuse. During a tour on the Mainstreet Unit at 12:50 PM surveyors noted a code-locked nourishment room near the entrance. Next to the nourishment room door was a hand sanitizer unit attached to the wall. At 12:52 PM Nurse #12 entered on the unit and proceeded to the nourishment room. At the door she entered a code, unlocked the door and entered the room. Surveyors asked the NPE what was the expectation for staff entering the unit and the nourishment room. The NPE stated that all staff were required to sanitize their hands upon entering the unit and the nourishment room. The NPE approached Nurse #12 as she exited the nourishment room; asked her to identify herself, and immediately educated her regarding the expectation. The NPE /stated she did not recognize Nurse #12 because she was an agency nurse assigned to the facility that day. The Administrator was made aware of surveyors' findings during a pre-exit meeting on 7/14/2020.
F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, it was determined that the facility staff failed to maintain a safe, functional, sanitary, and comfortable environment for residents and staff. This was evident for 4 out of all the common bathrooms/ shower rooms in the facility. This deficient practice has the potential to affect all residents in the facility. The findings include: An observation of the facility was conducted on 7/14/20. At 2:10 PM surveyors noted on the Charles Unit water running from the faucet of the sink in an unoccupied common bathroom/shower room near room [ROOM NUMBER]. This was brought to the attention of the Center Nursing Executive (CNE) who immediately tried to turn off the faucet, however, the water continued to drip. At 12:15 PM surveyors noted a faucet in an unoccupied common bathroom/shower room on the Joppa Unit near room [ROOM NUMBER] was leaking. During an interview with the Nurse Practice Educator (NPE), she stated that although not advised to do so, the nursing staff tend to let the water run from the faucet for a while in order to let it warm. This was confirmed by Geriatric Nursing Assistant (GNA) #10 who indicated during an interview at 1:45 PM that it was not unusual for her and other care staff to leave the hot water faucet on to get it warm for use. In addition, she added that it was expected of her/him to monitor for cleanliness and function of the bathrooms every time she/he was in there and to report any concerns to either their supervisor, environmental or maintenance directors. However, GNA #10 and the NPE stated that they were not aware that the faucets were not functioning properly and confirmed surveyors' findings. During observation of the Main Street unit was conducted on 7/14/20 at 12:35 PM, with the CNE and NPE present surveyors observed an inside an unlocked, unmarked shared bathroom/shower room located near room [ROOM NUMBER]. The room contained several various items and equipment blocking the passage to the shower stall at the back of the room. Further observation revealed a large hole approximately 8 inches in diameter on the floor near the doorway. Surveyors shared observations with the CNE and NPE. The CNE retrieved and taped a sign from a nearby office with the words Out of Order, locked the door and was immediately interviewed by the surveyors. The CNE stated the bathroom/shower room was in the process of being fixed by maintenance. At 12:45 PM on 7/14/2020, surveyors noted near room [ROOM NUMBER], a shared bathroom/shower room door wide open. Visible from the doorway, were multiple gnats of various sizes flying around in the room. Also noted on the toilet tank were 2 clear plastic cups with a scant amount of a red colored liquid which was confirmed by the NPE to be from the day's lunch service. Surveyors noted the NPE approach GNA #6 as she/he entered the hallway and instructed her/him to remove the cups from the bath/shower room. GNA #6 retrieved the cups and was immediately interviewed. Surveyors asked GNA #6 what was expected of her/him regarding the monitoring and maintenance of the common bathrooms/shower rooms on her/his unit. She/he replied that the bathrooms were checked by the GNA's each time a resident used it. When asked the last time she/he had checked that bathroom, she/he said around 7 AM that morning and denied seeing the cups. On 7/14/20 at 1:35 PM, during an interviewed with the Environmental Services (EVS) Director #7, he said he was not aware of the leaking water faucets in the facility. However, he was aware of the condition in the common bathroom/shower room near room [ROOM NUMBER]. He added the room was left that way because the maintenance assistant # 15 assigned to the repairs was recently placed on quarantine for a possible COVID-19 exposure. The EVS Director acknowledged that the door should have been secured to prevent anyone from entering. The EVS Director also shared that one of his staff members is assigned to check/clean the facility grounds between 6 AM to 6:30 AM, then enter the facility at 7 AM to assist with the removal of trash and soiled linen from the units. He added that the EVS staff is expected to stop cleaning during meal service and the staff on the units are responsible to monitor and notify the EVS Director or his staff of any cleaning or maintenance issues found. When asked by surveyors, EVS Director #7 stated there were no monitoring/cleaning or maintenance schedules for the bathrooms to review.

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 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) During interviews with facility nursing staff on 7/14/20, the nurse assigned to the Joppa unit, Nurse #8, at 1:45 PM, was asked their expected responsibilities regarding the monitoring of use of the common bathrooms/shower rooms. She/he stated the staff and residents wear the proper personal protective equipment to use the bathroom/shower room. When finished the rooms are sanitized by housekeeping. She added that the GNA's are responsible for wiping down the toilet seats with bleach wipes before and after use by residents. When asked if she had seen any staff clean the bath/shower rooms that morning, she replied No. During her/his interview at 1:50 pm, Main Street Unit GNA #10 stated it was a collective responsibility to let housekeeping know when the bathrooms needed to be cleaned or restocked with soap and paper towels. She/he added that facility staff would page maintenance when the bathrooms were out of order. When asked about staff leaving water faucets to run unattended, she/he affirmed that it was a common practice, but she/he usually turned off the running water because of waste/cost reasons. However, she/he denied knowledge of the condition of the bath/shower rooms near room [ROOM NUMBER] and room [ROOM NUMBER]. Licensed Practical Nurse (LPN) #9 although routinely assigned to the Main Street unit, denied knowledge of the condition of the bath/shower rooms on Main Street during his interview at 1:45 PM on 7/14/2020. On 7/14/20 at 5:00 PM, the above findings and concerns were brought to the attention of the Center Executive Director (CED) during a pre-exit meeting.