STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215160	A. BUILDING _____ B. WING _____	**05/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ELLICOTT CITY HEALTHCARE CENTER	**3000 NORTH RIDGE RD. ELLICOTT CITY, MD 21043**

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 -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility self-assessments, and interviews with facility staff, it was determined that the facility failed to ensure that facility staff utilized effective infection control practices to prevent the spread of COVID-19. This was evidenced by: 1) facility staff failing to perform hand hygiene and failing to change out personal protective equipment (PPE) prior to moving from a unit with residents under investigation for having COVID-19 to a unit with residents known to be negative for COVID-19; 2) facility staff transporting COVID-19 positive residents (Residents #5 and #6) through common spaces without placing masks on the residents. All residents have the potential to be affected by these deficient practices. The findings include: 1. The facility's designated area for co-horting Persons Under Investigation (PUI) for COVID-19 was toured with the Administrator and Acting Director of Nursing (DON) on 5/14/2020 at 12:15 PM. The area was separated from the rest of a unit by a zippered clear plastic barrier. The Administrator and Acting DON stated that residents under investigation were cared for by staff who were working on both the PUI area as well as the COVID-19 negative unit that the PUI area was connected to within the facility. At 12:20 PM, Geriatric Nursing Assistant (GNA) #10 was observed exiting Resident #2's room in the PUI-designated area. GNA #10 was wearing a disposable gown, gloves, a face shield, and an N95 mask, and she was also holding a disposable dining tray. GNA #10 was not seen performing any hand hygiene while exiting the room. GNA #10 passed through the zippered divider without removing any Personal Protective Equipment (PPE) or performing any form of sterilization. The GNA was seen through the clear divider walking past the designated negative unit's nurse's station to the hallway on the far side of the unit. The Administrator and Acting DON were present for this observation. According to guidance from the CDC titled, Coronavirus Disease 2019 Infection Control Guidance that was last reviewed on 4/12/20, health care personnel (HCP) should remove and discard gloves when leaving the patient room or care area, and immediately perform hand hygiene. Further, the same guidance states that HCP should put on a clean isolation gown upon entry into the patient room or area and remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. 2. During an observation of a COVID-19 positive patient care area that took place on 5/14/20 at 1:20 PM, Resident #5 was observed being ambulated in a hallway with the assistance of geriatric nursing assistant (GNA) #14, who was supporting the resident by his/her arm. The resident was not wearing a mask or any other face covering. The resident and GNA walked by the survey team, the Administrator, and the Acting Director of Nursing (DON). The Administrator intervened and asked another staff member to obtain a mask for the resident. The survey team observed that a mask that was kept in a supply behind the nurses' station was given to Resident #5. During the same observation on 5/14/20 at 1:25 PM, Resident #6 was seen being transported in a hallway in his/her bed by Maintenance Assistant #15 and Hospitality Aid #16. The resident was noted to not be wearing a mask or any other face covering. The Acting DON intervened and obtained a mask for the resident. Resident #5's and Resident #6's medical records were reviewed on 5/15/20 at 12:30 PM. During the review, it was identified that the residents were both COVID-19 positive. According to guidance from the CDC titled, Coronavirus Disease 2019 Infection Control Guidance that was last reviewed on 4/12/20, patients with known or suspected COVID-19 should be housed in the same room for the duration of their stay in the facility (e.g., minimize room transfers). Patients should wear a facemask or cloth face covering to contain secretions during transport. Review of the CMS (Center for Medicare and Medicaid Services) COVID-19 Focused Survey for Nursing Homes self-assessment the facility provided to the Office of Health Care Quality (OHCQ) on 4/15/20 revealed the facility reported that, Residents required to leave their room (i.e. for [MEDICAL TREATMENT] or a medically necessary off-site appointment), don a face mask, are performing hand hygiene, and are asked to practice social distancing.

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