STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215165	A. BUILDING _____ B. WING _____	**07/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRADFORD OAKS CENTER	**7520 SURRATTS ROAD CLINTON, MD 20735**

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 observation, interview with facility staff, and review of facility policy and guidance from the Centers for Disease Control and Prevention (CDC), it was determined that the facility failed to ensure that direct care staff were utilizing Personal Protective Equipment (PPE) in a way that optimally reduced the risk of spreading infectious agents. That occurred during a declared pandemic of COVID-19 and had the potential to affect all uninfected residents in the facility. This was evident for 2 of 4 units housing residents under investigation for COVID-19. The findings include: An observation took place on 7/27/20 at 1:15 PM of the area of the facility including Rooms 75 through 84. The observation was performed in the presence of the Regional Corporate Nurse and the faciltiy's Infection Preventionist and Nurse Practice Educator (NPE). Rooms 75 through 84 were separated from the rest of the facility by a plastic barrier and contained both COVID-19 positive and negative residents. The Infection Preventionist and Regional Corporate Nurse explained that the facility was in the process of relocating residents based on direction from the local health department and positive and negative residents would not be cohorted together when moving was completed. During the observation, a container was found that was labeled with dirty isolation gowns and appeared to be half full of balled up linen gowns. The gowns were not contained in separate bags inside the container. The lid of this container was noted to not be closed all the way with a gap of several inches. The Corporate Regional Nurse closed the lid fully upon noticing it. Geriatric Nursing Assistant (GNA) #1 was interviewed outside of room [ROOM NUMBER] at 1:20 PM. During the interview, GNA #1 stated that after caring for a resident, GNA #1 would remove his gown before leaving the resident's room and then dispose of it it into the rolling laundry bin that had been partially open during the observation at 1:15 PM. When asked if he would take off the gown and then walk down the hall to dispose of it, he said, yes, and sometimes I would bring the bin in front of the resident's room as I go from patient to patient. It was noted that there was only one laundry bin on the unit despite multiple direct care staff working on the unit at that time. CDC guidance located at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html and updated 6/25/20 was reviewed on 7/27/20. The guidance stated, Position a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room. An observation took place on 7/27/20 at 1:30 PM of the area of the facility including Rooms 51 through 61. The observation was performed in the presence of the Regional Corporate Nurse and the facility's Infection Preventionist and NPE Educator. These rooms were, also, separated from the rest of the faciltiy and were confirmed to contain both COVID-19 positive and negative residents in the process of being relocated. During an observation outside of room [ROOM NUMBER], GNA #2 was noted to exit room [ROOM NUMBER] while wearing a linen isolation gown, close the door, and speak a few words with other staff in the hallway. The GNA was interviewed at that time and stated that she would wear a new gown for each resident and take the gown off prior to leaving each resident's room. When asked about the gown that she was still wearing, she stated that she was going to take it off now and place it into a linen bin located near the plastic barrier. GNA #2 did so, removing the used gown in the hallway and carrying it past two rooms to place it in the dirty laundry bin. During an interview with the facility's Infection Preventionist that took palce at 1:50 PM, the Infection Preventionist confirmed that staff were to remove their isolation gowns inside resident rooms and dispose of them in those rooms. The facility's policies developed in response to COVID-19 were reviewed on 7/27/20. The review revealed that the facility's expectation of staff caring for COVID-19 suspected or positive residents was to follow standard, droplet, and contact isolation precautions. All three precautions require PPE to be removed and disposed of prior to exiting resident rooms.

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.