STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	07/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR LANE BETHESDA, MD 20814

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 surveyor review of clinical records, review of administrative records, surveyor observations and interviews with facility staff, it was determined that the facility failed to ensure consistent infection control measures for residents under suspicion for Coronavirus Disease 2019 (COVID-19). This finding was evident for 4 of 15 residents selected for review during the COVID-19 Focused Infection Control Survey. (#5, #6, #7, #8). The findings include: COVID-19 is a disease caused by the Coronavirus [DIAGNOSES REDACTED] -CoV-2. COVID-19 spreads from person to person, mainly through respiratory droplets produced when an infected person coughs or sneezes. On 04-02-2020, CMS (Center for Medicare and Medicaid Services) and CDC (Center for Disease Control) released the COVID-19 Long-Term Care Facility Guidance, which alerted facilities to actions they should take to prevent transmission of COVID-19. These actions included the separation of residents based on COVID-19 status (i.e., positive, negative, unknown/under observation). The guidance stated Long-term care facilities should separate patients and residents who have COVID-19 from patients and residents who do not, or have an unknown status. To this end, long-term care facilities should work with State and local community leaders to identify and designate facilities dedicated to patients and residents with known COVID-19-positive and those with suspected COVID-19, ensuring they are separate from patients and residents who are COVID-19-negative; ii. COVID-19-positive units and facilities must be capable of maintaining strict infection control practices and testing protocols, as required by regulation; 1. When possible, facilities should exercise consistent assignment, or have separate staffing teams for COVID-19-positive and COVID-19-negative patients. On 07-07-2020 review of the facility's administrative policies for Infection Control Caring for a Resident with Suspected/Confirmed COVID-19, effective 03-30-2020, revealed in the event that a resident is Suspected of having COVID-19: limit the movement of the movement of the resident by having them remain in a private room and closing the door. If a roommate is involved, move the roommate to a clean private room and increase temperature, oxygen saturation rate checks, and symptom monitoring to every shift for 14 days .begin moving symptomatic residents to the dedicated isolation unit if applicable. In addition, dedicate staff (team A or B) to care for residents with suspected COVID-19 to reduce potential for spread of infection to other areas of the center .initiate droplet transmission based precautions and post appropriate signage .note in medical record when the resident's first symptoms appeared, as well as when the resident was placed on Transmission Based Precautions. Transmission Based Precautions per CDC include contact precautions, airborne precautions and droplet precautions with appropriate Personal Protective Equipment (PPE) in use by staff. Further review revealed that the policy addressed Care Considerations that stated residents who are suspected of having COVID-19 infection are considered positive until testing confirms otherwise .Cohorting residents in one room may only be considered when both residents have been confirmed as positive for COVID-19. 1. On 07-08-2020 surveyor review of the clinical record for Resident #6 revealed nursing documentation for a change in condition on 04-13-2020 that the resident had a cough, but no elevated temperature. The attending nurse practitioner (NP) ordered a chest X-ray to rule out pneumonia and cough medication to be administered every six (6) hours. Further review revealed nursing documentation on 04-14-2020 of the continuation of the resident's cough while the chest X-ray was still pending to be completed. According to Resident #6's record, the NP ordered that a nasal swab for a respiratory panel be completed on the resident. On 04-15-2020, the nasal swab was completed by facility staff with results pending, and on 04-16-2020 the chest X-ray results were found to be negative for pneumonia. An order was put into place on 04-16-2020 for an antibiotic medication in the treatment for [REDACTED].#6 remained in a semi-private room with Resident #5, who showed no signs and symptoms of respiratory symptoms. A continued review of Resident #6's clinical recored revealed that On 04-21-2020 nursing documentations showed the resident's respiratory panel results were found to be positive for COVID-19. The resident was transferred to the designated COVID-19 unit on the Gateway unit at this time, while orders for contact and droplet precautions as of 04-21-2020. Further record review did not reveal evidence that Resident #6 had been transferred to a private room at the time of initial respiratory symptoms and while awaiting results of the COVID testing. In addition, there was no documented evidence of the resident being placed on transmission based precautions until 04-21-2020, the day the resident's COVID-19 results were documented by the facility. 2. On 07-08-2020 surveyor review of the clinical record for Resident #5 revealed 04-21-2020 nursing documentation that the resident's roommate (Resident #6) was found to be positive for COVID-19 on this day. On 04-21-2020,Rresident #6 was transferred out of the semi-private room and the room was sanitized per COVID prevention protocol. Resident #5 was then ordered to be on contact and droplet precautions. However, there was no evidence that Resident #5 had previously been placed on transmission precaution or moved out of the room from Resident #6 prior to 04-21-2020. Further record review revealed Resident #5 vital signs, including COVID symptom checks were assessed at every shift with no abnormal results. On 05-06-2020, during the facility's universal COVID-19 testing, Resident #5 was tested for COVID- 19. On 05-07-2020, test results revealed the resident was positive for COVID-19 and transferred to the Gateway COVID unit. 3. On 07-09-2020 surveyor review of the clinical record for Rresident #8 revealed nursing documentation on 04-14-2020 of a change in condition with the resident observed with cough and chest congestions. The attending physician was notified and ordered a chest X-ray and medications for the treatment of [REDACTED]. Further review revealed on 04-17-2020 nursing documentation revealed that the chest X-ray results were found to be positive for pneumonia and the attending physician ordered an antibiotic medication for the treatment of [REDACTED].#8 had been transferred to a private room at the time of initial respiratory symptoms on 04-14-2020 and prior to the resident's transfer out to the hospital on 04-18-2020. In addition, there was no documented evidence of the resident being on transmission based precautions prior to transfer to the hospital. During the time of 04-14-20 initial symptoms until the 04-18-2020 hospital transfer, Resident #8 was in a semi-private room with resident #7, who showed no signs and symptoms of respiratory symptoms. A continued review of Resident #8's clinical record revealed the 04-18-2020 change in condition, documented at 7:00 AM, noted the resident with labored breathing, skin cool, a temperature of 100.3 F, oxygen saturation at 91%, pulse rate at 114 beats/minute, and respiration rate at 23 breaths/minute. Further review revealed facility administered two (2) liters of oxygen per minute by nasal cannular to the resident and the the attending physician was notified. The attending physician ordered Resident #8 be transferred to the emergency room via emergency services for further evaluation. The resident was tested for COVID-19 while and the hospital, and found the results were positive. 4. On 07-09-2020 surveyor review of the clinical record for Resident #7 revealed on 04-20-2020 nursing documentation that the attending physician ordered an antibiotic for [MEDICATION NAME] treatment due to the resident's roomate's (Resident #8) positive test results for COVID-19 on 04-19-2020. In addition, the physician ordered the resident at this time be placed on contact and droplet precautions. In addition, on-04-21-2020 the attending nurse practitioner ordered a swab for COVID- 19 testing. Further review revealed, due to the lack of available COVID-19 swab tests from the local health department for asymptomatic residents, resident #7 was not tested until 05-02-2020. Test results revealed the resident was found to be positive for COVID-19. However, there was no evidence that Resident #7 had been placed on contact and droplet precautions or isolated from resident #8 prior to 04-20-2020, during the period of resident #8 was under suspicion for respiratory illness or COVID-19. On 07-07-2020 at 1:30

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	**07/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

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	(continued... from page 1) PM surveyor observation of the Gateway unit revealed an area with available unoccupied rooms designated for positive COVID- 19 residents with no residents currently. Further observation of the Gateway unit revealed a designated area with rooms for new admissions and other residents under suspicion. During observation, there were nine (9) residents under a fourteen (14) observation day period and dedicated staff members on the unit, who only worked on the unit. Staff were observed with N95 masks in place and use of appropriate hand washing as well as individual gowns observed in each individual resident's room for the staff member's use. The gowns were located on a hook inside the resident's room, while a isolation cart located outside of each room with gloves, face shield and gowns were in place. On 07-13-2020 at 10:00 AM interview with the facility administrator and the Director of Care Transition revealed that as of 04-07-2020 and 04-08-2020 there were designated unoccupied rooms available on the Gateway unit for the use of residents under observation or found to be positive for COVID-19. Then by 04-20-2020, another group of unoccupied rooms were available on the Gateway unit for residents under observation or found to be positive for COVID-19. When asked if Resident #6 and Resident # 8 could have been transferred to these designated rooms while under suspicion for COVID- 19, no additional information was provided. On 07-13-2020 at 10:30 AM surveyor interview with the attending physician for Resident #8 revealed that the esident's initial respiratory symptoms were being addressed with a chest X-ray to rule out other potential [DIAGNOSES REDACTED]. In addition, COVID-19 testing kits at that time were difficult to obtain readily so Resident #8 had not been tested until transferred to the hospital. On 07-13-2020 at 11:00 AM interview with the attending nurse practitioner (NP) for Resident #6 revealed that based on the initial resident's respiratory symptoms, an order for [REDACTED]. Further interview revealed the NP had only been aware that the resident had been transferred out of his/her initial room when results of COVID test came back positive. No additional information was provided. Surveyor interview on 07-13-2020 at 11:20 AM with Licensed Practical Nurse (LPN) #1 revealed that at the time of resident #6's respiratory symptoms, staff were in the use of full PPE that included N95 masks, face shields, gloves, shoe covers and gowns for all residents, whether they were symptomatic or asymptomatic. Staff changed gloves between resident contact and handwashing prior to application of gloves and after removal of gloves. Staff also changed gloves with each individual resident contact. On 07-13-2020 at 3:58 PM interview with the former Director of Nursing (DON) (staff #2) revealed that residents suspected for COVID-19 were being worked up for other possible respiratory [DIAGNOSES REDACTED]. When inquired that with the availability of observation rooms during the timeframe for the initial respiratory symptoms for resident #6 and #8, why weren't these residents separated from their respective asymptomatic roommates (#5, #7)? No additional information was provided by the staff #2. On 07-14-2020 at 2:20 PM, interview with the facility administrator revealed that licensed staff were in full PPE from 04-09-2020 until 05-08-2020. However, full PPE was still in full use after 05-08-2020 on the designated COVID-19 unit/Gateway unit areas. Full PPE included N95 or a surgical mask, gowns, gloves and face shield. After 05-08-2020, PPE use included surgical mask, gloves and gown as needed during care on a non-COVID unit. Surveyor interview on 07-15-2020 at 9:06 AM with former Infection Control Preventionist (ICP)/staff #3 revealed that she had been out of the facility due to extended leave from 04-15-20 through 05-04-2020. Prior to being on leave, staff were in-serviced on appropriate infection control measures including the cohorting of staff and residents. In addition, as stated in the Infection Control manual, if a resident had any form of respiratory symptoms, including whether cough, congestion or temperature, the resident would be isolated and placed on transmission based precautions and considered under suspicion. If the resident had a roommate the symptomatic resident would be moved, and the roommate would be also placed on transmission based precautions and monitored for symptoms. All staff were aware of the infection control measures that were put into place. Prior to going on leave, staff #3 educated all management staff and updated on guidelines during morning meetings held daily. On 07-15-20 at 4:45 PM interview with the facility administrator and the present Director of Nursing revealed no additional information.
F 0885 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	Based on surveyor review of the administrative records and interview with the facility staff, it was determined that the facility failed to inform residents, their representatives, and families of those residing in the facility by 5:00 PM the next calendar day following the occurrence of a single confirmed infection of COVID-19. This finding was identified during the focused infection control survey. The findings include: On 07-07-2020 at 3:00 PM surveyor interview with the facility's administrator revealed that designated staff members made weekly face to face contact with residents and phone contact with resident's representatives and/or families since 03-23-2020. However, further interview revealed there was no system in place to contact residents, their representative and/or families by 5:00 PM the next calendar day following the occurrence of a single confirmed infection of COVID-19. On 07-08-2020 surveyor review of administrative records revealed documentation that weekly contacts had been made with residents and families regarding status of COVID-19 cases in the facility since 03-23-2020. Further review of the facility's infection control line list revealed new positive COVID-19 residents and/or staff cases on 05-08-2020, 05-16-2020, 05-23-2020, 05-26-2020 and 06-01-2020. However, there was no documented evidence that residents and representatives/families had been notified of new positive resident and/or staff cases by 5:00 PM on 05-09-2020, 05-17-2020, 05-24-2020, 05-27-20 and 06-02-2020 of a new COVID-19 cases as required. On 07-15-2020 at 11:00 AM surveyor interview with the facility's administrator revealed no additional information.