

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 215262	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/26/2020
NAME OF PROVIDER OF SUPPLIER RESORTS AT CHESTER RIVER MANOR CORP		STREET ADDRESS, CITY, STATE, ZIP 200 MORGNEC ROAD CHESTERTOWN, MD 21620	
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 - Few	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on observation, interview and facility documentation review, it was determined the facility failed to ensure that staff followed accepted standards of practice for personal protective equipment use by residents during the COVID-19 declared health emergency. This was evident for 2 of 5 residents (Resident #2 and Resident #3) observed in the hallways during a tour of the facility. The findings include: COVID-19 (Coronavirus Disease 2019), 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 6-24-2020 at 2:00 PM during a tour of the facility with the Director of Nursing (DON), two residents were observed sitting in the hallways without the required face mask. Resident #2, who was negative for COVID-19 was observed by this surveyor and the DON sitting in a wheelchair in the hallway of Quail Point Unit, a negative COVID-19 unit on 6-24-2020 at 2:10 PM across from the nursing station without a facial mask covering his/her mouth. Resident #2 is dependent on the facility staff for all care. When questioned at 2:10 PM the DON stated Resident #2 should have a mask on and went to the nursing station and obtained a mask and placed it on Resident #2. Resident #3, who was negative for COVID-19 was observed by this surveyor and the DON on 6-24-2020 at 2:15 PM sitting in the Swan Cove Unit area lounge, which is a negative COVID-19 unit, in a geriatric chair without a facial mask. Resident #3 is totally dependent on the facility staff for all care. When questioned at 2:15 PM the DON said Resident #3 should have a facial mask on and obtained a mask and placed it on the resident. The facility had active COVID-19 cases and failed to place facial masks on 2 dependent residents who left their assigned rooms. The Centers for Medicare and Medicaid Services' COVID-19 Focused Survey for Nursing Homes states to achieve compliance with infection prevention and control practices to prevent the development and transmission of COVID-19 that when a facility has active COVID-19 cases and residents leave their room they must wear a facemask. The DON at 2:10 PM and 2:15 PM on 6-24-2020 confirmed Residents #2 and #3 were not wearing required facial masks during the facility tour.</p>		

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.