STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065189	A. BUILDING _____ B. WING _____	**06/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PEAKS CARE CENTER THE	**1440 COFFMAN ST LONGMONT, CO 80501**

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 -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure effective infection control practices were maintained to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of Coronavirus (COVID-19) and other communicable diseases and infections. Specifically, the facility failed to ensure: - Residents were offered and assisted with hand hygiene prior to meals; and -Staff were following guidelines for proper personal protective equipment (PPE) use. Findings include: I. Facility policy The Novel Coronavirus Prevention and Response policy was provided by the interim nursing home administrator (INHA) on 6/16/2020 at 6:07 p.m. The policy read in part: Interventions to prevent the spread of respiratory germs within the facility: - Support hand hygiene and respiratory/cough etiquette by residents, visitors and employees by making sure tissues, soap, paper towels and alcohol-based hand rubs are available. - Educate staff on proper use of personal protective equipment and application of standard, contact, droplet and airborne precautions, including eye protection. II. Status of COVID-19 in the facility The director of nursing (DON) was interviewed on 6/15/2020 at 10:28 a.m. She reported that total resident census was 38, and there were no COVID-19 positive residents, however three residents were on droplet precautions isolation. She said there was no staff ill with COVID-19. She said since the pandemic started 10 residents passed away from COVID-19 in the facility. III. Failure to offer and assist with resident hand hygiene A. Observations On 6/15/2020 at 12:15 p.m. an observation of lunch meal service revealed the residents were not offered hand hygiene before food was served. Most residents were observed using their hands to consume the meal. On 6/15/2020 at 12:14 p.m., two residents were served meals in the assisted dining room. The residents were not offered hand hygiene and both residents ate their food with their hands. On 6/15/2020 during lunch service, multiple staff members were observed delivering lunch meal trays to residents, none of the residents were offered hand hygiene prior to their meal. On 6/16/2020 at 5:45 p.m., multiple staff members were observed to pass meal trays. None of the residents were offered hand hygiene before they ate their meals. On 6/16/2020 at 5:35 p.m. an observation of supper meal service revealed the staff did not offer hand hygiene to residents before food was served. Most residents were observed using their hands to consume the meal. B. Interviews Resident #3 was interviewed on 6/15/2020 at 12:27 p.m. She said the staff did not offer her any hand hygiene prior to her meals. Resident #1 was interviewed on 6/15/2020 at 12:40 p.m. She said the staff did not offer her hand washing or hand sanitizing before the meal was served. Resident #2 was interviewed on 6/15/2020 at 12:45 p.m. He said the staff did not offer him assistance with hand washing or hand sanitizing before the meal was served. He said, Once in a while throughout the day I wheel myself to the hallway and use the hand sanitizer dispenser that is on the wall across from my room. He said, They don't like when I leave my room but I don't have the hand sanitizer and no one has offered to help me wash my hands in very long time. He said he was unable to use the sink in his bathroom to wash his hands independently. Residents #1 and #2 were interviewed again on 6/16/2020 at 5:50 p.m. They both said the staff did not offer hand washing or hand sanitizer before the supper meal. The DON was interviewed on 6/16/2020 at 6:20 p.m. She said the staff was trained and reminded to use hand sanitizer or offer hand washing to all residents prior to meal service. She said her expectation was residents' hands were washed before and after meals, after bathroom use or pericare was done, and as needed. She said the staff would receive refresher training on the necessity of offering hand washing and hand sanitizing to residents before meals. IV. Failure to properly wear PPE A. Professional reference The Centers for Disease Control (CDC) Key Strategies to Prepare for Coronavirus COVID-19 in Long Term Care Facilities, dated April 2020, read in pertinent part: If COVID-19 was identified in the facility, have health care providers (HCP) wear all recommended PPE for care of all residents (regardless of symptoms) on the affected unit (or facility-wide depending on the situation). This includes: an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and gown. HCP should be trained on PPE use including putting it on and taking it off. This approach is recommended because of the high risk of unrecognized infection among residents. Recent experience suggests that a substantial proportion of residents could have COVID-19 without reporting symptoms or before symptoms develop. B. Observations and interviews A physician assistant (PA) was observed on 6/15/2020 at 11:15 a.m. to enter a droplet precaution isolation room [ROOM NUMBER] without full PPE gear. After she exited the room she said she only delivered water to the resident and did not need to wear full PPE (gown, gloves, mask and eye protection). Registered nurse (RN) #1 was interviewed on 6/15/2020 at 11:25 a.m. He said full PPE gear worn in a droplet precautions isolation room included a gown, gloves, eye protection and a mask. He said no staff should enter the room without full PPE. RN #2 was interviewed on 6/16/2020 at 3:45 p.m., she said a gown, gloves, surgical mask, and eye protection was worn in an isolation room. She said all staff members who entered the room wore the PPE to prevent the spread of infection. Upon entrance to the facility, on 6/15/2020 at 10:00 a.m., the director of nursing (DON) was observed with a KN95 mask worn upside down and resting below her nose. On 6/15/2020 at 12:19 p.m. certified nurse aide (CNA) #1 was observed delivering lunch room trays to residents. She had eye protection on and her N95 mask was worn upside down. At 12:51 p.m. she delivered a lunch meal tray to the resident in a room on isolation droplet precautions. She donned her PPE in the following order: gloves, then gown, then shoe covers, then hair cover, then a second pair of gloves. Her facemask was still upside down and she did not perform CDC recommended hand hygiene while donning her PPE. CNAs #2 and #3 were observed on 6/16/2020 at 4:41 p.m. entering the droplet precautions isolation room. They donned PPE in the following order: they put on their gown, then N95 mask, then eye protection, then two pairs of gloves. They did not perform hand hygiene at any time during the donning process. CNAs #2 and #3 were observed again on 6/16/2020 at 5:35 p.m. entering the droplet precautions isolation room. They donned PPE in the following order: they put on their gown first, then shoe covers, then hair cover, then the N95 mask and gloves. They did not perform hand hygiene before putting on their gloves. C. Staff interviews CNA #2 was interviewed on 6/16/2020 at 4:53 p.m. She said she wore two pairs of gloves because she wanted to have an extra pair of gloves just in case she needed to take a pair off while in the room. She said she did receive training on how to properly wear PPE. The DON was interviewed on 6/16/2020 at 6:23 p.m. She said staff should put their PPE in order from top to bottom. She said they should perform hand hygiene, then put on their mask, then eye protection, then gown, then perform hand hygiene again and put on one pair of gloves. She said the staff should not double glove. She said the last PPE training for all staff was conducted about six weeks ago. She said she will provide another training to ensure staff were following proper donning and doffing of the PPE.

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.