STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065393	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVANCED HEALTH CARE OF AURORA	1800 S POTOMAC ST AURORA, CO 80012

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, record review and interviews, the facility failed to follow an effective infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection such as COVID-19 in three of three neighborhoods. Specifically, the facility failed to: - Ensure visitors and staff were actively screened for the signs and symptoms of COVID-19; - Ensure residents were encouraged to use source control precautions during care requiring direct contact with staff; and, - Ensure staff engaged in accepted hand hygiene practices at the appropriate time. Findings include: I. Screening A. Professional standards According to The Centers for Disease Control and Prevention (CDC), Preparing for COVID-19 in nursing homes, last updated 6/25/2020, Screen all HCP at the beginning of their shift for fever and symptoms of CO VID-19. Actively take their temperature and document absence of symptoms consistent with COVID-19 symptoms. If they are ill, have them keep their cloth face covering or facemask on and leave the workplace. Screen visitors for fever (T=100.0F), symptoms consistent with COVID-19, or known exposure to someone with COVID-19. Restrict anyone with fever, symptoms, or known exposure from entering the facility. Ask visitors to inform the facility if they develop fever or symptoms consistent with COVID-19 within 14 days of visiting the facility. Retrieved 7/20/2020 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html. B. Facility policies and procedures The infection prevention and control policy and procedures dated 3/1/2020, was provided by the nursing home administrator (NHA) on 7/15/2020 at 10:20 a.m. It read in pertinent part: The facility will implement practices to reduce the spread of COVID-19 following CDC, CMS (Centers for Medicare and Medicaid Services), state and local health department guidance. Any patient with confirmed coronavirus will be discharge to the hospital secondary to CDC guidelines for negative pressure room. Employee and visitor screening: The facility will actively screen and restrict employees and visitors from entering the facility for those who meet the following criteria: signs and symptoms of a respiratory infection, such as fever, cough, and shortness of breath or sore throat. Has the individual in the last 14 days had contact with someone with a confirmed [DIAGNOSES REDACTED].? Has the individual, in the last 14 days travelled internationally to countries with sustained community transmission? Resides in the community where community-based spread COVID-19 is occurring. C. Observations 7/15/2020 Surveyors entered the building at 9:05 a.m. and were escorted to the front desk to be screened. The screening area included a hand sanitizer pump, a thermometer, alcohol wipes and the screening log. Signage placed at the desk listed potential signs and symptoms of COVID-19 such as cough, shortness of breath (SOB), sore throat, chills and fever. The screening form included in the log listed date, name, telephone number, location and noted whether the person passed the screen. The business office manager (BOM), who was also the screener at the time of the visit, measured the surveyors temperatures and asked them to complete the screening form. The BOM did not screen or ask the surveyors about signs and symptoms, travel or potential exposure to COVID-19. The BOM did not encourage hand hygiene and the surveyors were allowed to proceed into the facility. 7/16/2020 At 10:35 a.m. a vendor was observed at the front entrance He wore a pair of disposable gloves and a mask. The receptionist greeted the vendor as he entered the facility, remarking she had not seen him for awhile. The receptionist measured the vendor's temperature and she asked him to fill out the screening form. The receptionist did not screen or ask the vendor about signs and symptoms, travel or potential exposure to COVID-19. She did not encourage hand hygiene and the vendor proceeded into the facility wearing the same disposable gloves. Surveyors entered the building behind the vendor and were screened in the same manner. At 2:00 p.m., the employee screening process was observed. Staff entered the building and went directly to a nearby nurses' station. A computer for staff to enter time in/out was positioned on the counter of the nurses' station. Signage that listed signs and symptoms of COVID-19 was placed next to the time clock. A thermometer and screening log were available at the nurses' station for staff to measure their own temperatures and fill in the screening form. There was not a designated staff at the nurses' station to actively screen staff as they entered the facility and proceeded to their work area. D. Staff interviews The BOM was interviewed 7/15/20 at 11:15 a.m. The BOM said he was filled in for the receptionist who was off that day. The BOM said he was responsible to screen visitors at the front desk area and staff were responsible to screen themselves at the nurses' station. He said staff took their own temperature and another staff would verify the temperature. He said the process to screen visitors was to take their temperature and ask them if they had any signs and symptoms or had been exposed to anyone with COVID-19. He said if the visitor answered yes to any of the COVID-19 symptoms questions, the visitor would not be allowed in the facility and he would notify the nurse. THe BOM said when he took the surveyor's temperatures, he should have screened for the signs symptoms for COVID-19 but he forgot to do so. The receptionist was interviewed on 7/16/20 at 2:28 p.m. She said she was responsible to screen visitors. The receptionist said staff screened themselves and took their own temperature and another staff would verify the temperature. She said the screening process for visitors was to take their temperatures and screen for the signs and symptoms of COVID-19. She said if the visitor answered yes to any of the questions, she would notify the nurse and the visitor would not be allowed into the facility. She acknowledged she did not appropriately screen the vendor and the surveyors for the signs and symptoms of COVID-19. She said she should have screened for the signs and symptoms of COVID-19 to prevent potential transmission of COVID-19 in the building The NHA was interviewed on 7/16/2020 at 12:00 p.m. He said the receptionist was responsible to screen visitors and the staff screened themselves by taking their own temperature and reading the signs and symptoms signage for COVID-19 before they clock in. The NHA said the temperature measurement would be verified by another staff member but there was no one assigned specifically to actively screen staff. The NHA said the screener should actively screen visitors for the signs and symptoms of COVID-19 and should document the absence of the symptoms. The NHA said the screener should have actively screened the vendor and the surveyors for the signs and symptoms of COVID-19 to prevent the development and transmission of COVID-19. He said education would be provided to the screener. The director of nursing (DON) was interviewed on 7/16/2020 at 12:18 p.m. She said the receptionist was responsible to screen visitors. The DON said the receptionist should actively screen visitors for the signs and symptoms of COVID-19 and document the absence of COVID-19. The DON said she should have actively screened the vendor and the surveyors for the signs and symptoms of COVID-19 before allowing them into the facility. The DON said she allowed staff to take their own temperature and have another nurse or certified nurse aide (CNA) verify the temperature. The DON said the signs and symptoms for COVID-19 were listed by the time clock. She said staff were instructed to read the signs and symptoms of COVID-19 before they clock in. She said clocking in indicated the staff was not experiencing any signs and symptoms of COVID-19. The DON said the staff were trained to self-screen but was unable to provide documentation of staff training. She said she trusted her staff and stated that she hoped they would be honest and not put residents and other staff at risk for COVID-19. CNA #1 was interviewed on 7/16/20 at 2:30 p.m. She said staff entered the facility through the back entrance through the break room and then proceeded to the nurse station (without passing through a resident care area). She said there was a time clock at the nurse station where staff clock in. The CNA said she took her own temperature and another staff member would verify the temperature. She said there was a sign next to the time clock which listed signs and symptoms of COVID-19 for staff to read before they clock in. She said there was no one actively screening staff.

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

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) II. Source control A. Professional standard According to CDC guidance, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, last revised July 15, 2020, Retrieved 7/22/2020 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html. Source control refers to use of cloth face coverings or face masks to cover a person ' s mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing. Because of the potential for asymptomatic and pre-symptomatic transmission, source control measures are recommended for everyone in a healthcare facility, even if they do not have symptoms of COVID-19 .Patients may remove their cloth face covering when in their rooms but should put it back on when around others (e.g., when visitors enter their room) or leaving their room. B. Observations 7/15/2020 At 10:01 a.m., housekeeper (HK) #1 prepared to clean room [ROOM NUMBER]. The occupant of the room, Resident #4, was newly admitted to the facility and under isolation precautions according to the clinical record. The HK gathered and donned personal protective equipment (PPE) from the cart at the entrance to the room and began cleaning. The HK did not encourage the resident to use a method of source control as she completed tasks within a few feet of the resident for several minutes. The resident did not have on a mask or use another method of source control as he spoke directly to the HK during this time. An unidentified rehabilitation therapist donned PPE and entered room [ROOM NUMBER] at 10:20 a.m. The therapist did not encourage Resident #4 to use a method of source control as he worked with Resident #4, using therabands within approximately two feet of the resident.The resident did not have on a mask or use another method of source control as he spoke directly to the therapist during this time. Two unidentified staff were observed at 10:30 a.m. as they helped the resident in room [ROOM NUMBER] stand from his wheelchair. The resident was not encouraged to use a method of source control as the two staff stood directly at his sides during the transfer. The resident, who was not wearing a mask or other method of source control, spoke directly into the faces of the staff who were assisting him. The resident was also under isolation precautions based on the signage and PPE cart at the entrance to the room. At 12:37 p.m., CNA #2 donned PPE (see additional information next section) and entered room [ROOM NUMBER] with a meal tray. The occupant of the room, Resident #5 was newly admitted to the facility and under isolation precautions according to the clinical record. CNA#2 approached the resident as he relined on the bed but did not encourage the resident to use a method of source control. The CNA stood directly next to the resident and spoke with him as she determined he needed additional assistance. The resident, who was not wearing a mask or other method of source containment, vocalized his distress to the CNA during this time. 7/16/2020 Between 12:00 p.m. and 12:31 p.m., CNA #3 was observed as she distributed room trays in hall #2. The CNA entered multiple rooms without encouraging the resident to use a method of source control. None of the residents wore a mask or used a method of source control when the CNA stood directly next to them as she helped set up their lunch tray. C. Resident interviews Resident #7 was interviewed on 7/16/2020 at 12:05 p.m. He said staff reminded him to wear a mask when he was in the hallway but never prompted him to use a method of source control when receiving care in his room, going back to his admitted . Resident #6 was interviewed on 7/16/2020 at 12:58 p.m. She said staff never reminded her to wear a mask or use another method of source control when receiving care in her room. She said she understood the potential for transmitting [MEDICAL CONDITION] but probably would not use one anyway because she felt like she could not breathe. She said she did not think this preference was a part of her care plan and did not know what she would do otherwise. D. Record review Baseline care plans and comprehensive care plans for Residents #4, #5, #6, and #7 revealed each resident was educated on COVID-19 and was expected to wear cloth face coverings or masks whenever leaving their rooms. Care plans did not include approaches to prompt residents to use source control to prevent potential transmission during in-room care. The review of care plans and nurses' notes also failed to document whether residents were cooperative with non-directed requests to use source control. Care plans did not include alternate approaches to implement preventative measures in the event a resident did not comply with such requests. E. Staff interviews CNA #3 was interviewed on 7/16/2020 at 12:31 p.m. The CNA said she knew she was supposed to make sure residents had a mask on when they were in the hall. She said she thought residents had masks with them in their rooms but she did not know she should encourage them to put them on when she entered the room to provide care. The CNA said she understood how not encouraging source control could potentially spread [MEDICAL CONDITION] from a resident to staff. Licensed practical nurse (LPN) #1 was interviewed on 7/16/2020 at 1:05 p.m. The LPN said staff were supposed to encourage residents to wear a mask if they were outside of their room but did not need to use a method of source control in their rooms if they were asymptomatic. The LPN acknowledged the potential for spreading [MEDICAL CONDITION] from newly admitted residents to staff when their COVID-19 status was unknown. She agreed new residents could be asymptomatic but still have [MEDICAL CONDITION]. The NHA and DON were interviewed on 7/16/2020 at 2:20 p.m. The NHA said all residents were expected to wear masks when going to appointments or being outside of their rooms. The DON said staff should encourage residents to use a method of source control when receiving care in their rooms. She said residents who cannot or will not wear a mask during care should be given options to try to limit the risk of transmission. The NHA said the COVID-status of newly admitted residents was unknown and that was why all new admissions undergo a 14 day quarantine. The DON and NHA agreed it was possible for a newly admitted resident to be positive for [MEDICAL CONDITION] and not have symptoms. They also agreed staff should help residents take every precaution to keep everyone at the facility safe. III. Hand hygiene A. Professional standards According to the CDC, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, last revised July 15. 2020, Retrieved 7/22/2020 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html. HCP should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. HCP should perform hand hygiene by using ABHS with 60-95% alcohol or washing hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHS. According to the CDC, Retrieved 7/22/2020 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html. Care must be taken to avoid touching the respirator, facemask, or eye protection. If this must occur (e.g., to adjust or reposition PPE), HCP should perform hand hygiene immediately after touching PPE to prevent contaminating themselves or others. According to the Colorado Food Establishment Rules and Regulations, effective January 1, 2019, pp. 47-48, Food employees shall clean their hands and exposed portions of their arms .immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single service and single use articles and .Before donning gloves to initiate a task that involves working with food . B. Observations 7/15/2020 HK #1 was observed at 10:01 a.m. as she prepared to enter room [ROOM NUMBER]. The HK donned PPE and placed gloves on her hands. She did not perform hand hygiene prior to donning the gloves. She cleaned the room, discarded her gloves and gown and washed her hands in the bathroom. The HK adjusted her mask with her hands and, without performing hand hygiene or donning gloves, touched the handle of the door to room [ROOM NUMBER] and opened it. The resident was receiving care so the HK closed the door and moved her cart across the hallway to room [ROOM NUMBER]. The HK donned gloves without performing hand hygiene, potentially contaminating the outer surface of the gloves, and began cleaning the room. She used her gloved hands to move a carafe of water on the over-the-bed table so she could clean the table surface under the container. She continued to contact items in the room with her gloved hands including the call light button and bathroom door knob as she cleaned the room. At 10:20 a.m., an unidentified rehabilitation therapist donned PPE before entering room [ROOM NUMBER]. He did not perform hand hygiene prior to placing gloves on his hands. The therapist used his gloved hands to manipulate a set of therabands which he handed to the resident in the room. At 10:22 a.m. an unidentified nurse donned PPE before entering room [ROOM NUMBER]. She used her ungloved hands to adjust her mask twice before placing gloves on her hands. The nurse did not perform hand hygiene before touching the clean outer surface of the gloves. Between 11:30 a.m. and 11:38 a.m., the dietary manager (DM) entered the kitchen and food service area three times without washing her hands. She used her hands to open doors to the walk in freezer and refrigerator. At 11:35 a.m., the DM donned gloves without performing hand hygiene and covered an open bag of bowl lids with plastic wrap. Prior to donning the gloves, the DM held the clean outer surface of the gloves in her hands. At 11:41 a.m., the cook left the kitchen and returned several minutes later. He did not perform hand hygiene before donning gloves and separating dinner rolls for service. Prior to donning the gloves, the cook held the clean outer surface of the gloves in his hands. At 11:46 a.m., the cook donned another set of gloves before slicing orange garnishes for the meal. He did not perform hand hygiene and held the clean outer surface of the gloves in his hand prior to placing them on his hands. At 12:37 p.m., CNA #2 did not place gloves on her hands as she donned PPE to enter room [ROOM NUMBER]. The CNA delivered a meal tray and approached the resident as he reclined on his bed. Several minutes later, the CNA returned to the doorway and donned a pair of gloves without first performing hand hygiene. The CNA returned to the resident to address a care request. 7/16/2020 CNA #3 was observed between 12:00 p.m. and 12:31 p.m. as she delivered room trays to residents on hall #2. -At

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) 12:25 p.m., CNA #3 donned PPE before entering room [ROOM NUMBER], a room under isolation. She did not perform hand hygiene prior to donning her gloves. Prior to exiting the room, CNA #3 discarded her mask, gloves and gown and wiped down the goggles she wore. The CNA did not perform hand hygiene after doffing the gloves or between resident rooms. -CNA #3 retrieved another room tray from the food cart and prepared to enter room [ROOM NUMBER]. The occupant of the room, Resident #3 was under isolation precautions for having a dry cough and a headache the day before. CNA #3 signed the book outside of the room and donned PPE. She did not perform hand hygiene prior to placing the gloves on her hands. C. Staff interviews CNA #3 was interviewed on 7/16/2020 at 12:33 p.m. The CNA said she worked at the facility for just a few weeks. She said she received training for PPE use and hand hygiene but was really nervous during the observation. She said she should have performed hand hygiene before putting on and after taking off gloves. She agreed touching the outer surface of clean gloves with unwashed or unsanitized hands could contaminate the outer surface of the glove. The DON was interviewed on 7/16/2020 at 2:20 p.m. The DON said hand hygiene was a key part of the infection prevention and control training provided to staff. The DON said staff were expected to wash or sanitize their hands before putting on and after taking off gloves as a part of basic nursing practice. The DON said oncoming staff were thoroughly trained and had to pass competencies with return demonstration prior to working with residents. She said monitoring of the infection prevention and control practices at the facility would be expanded to also include observations of dietary practices.