STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065368	A. BUILDING _____ B. WING _____	04/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF GREELEY	4800 W 25TH ST GREELEY, CO 80634

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 ensure infection control practices were established and 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 staff were following proper hand hygiene procedures; -Provide hand hygiene opportunities for residents; -Ensure staff were following proper personal protective equipment (PPE) guidelines. Findings include: I. Facility policies The Hand Hygiene policy, last revised March 2020, was provided via email by the nursing home administrator (NHA) on 3/31/2020. It read in part, Purpose: To decrease the risk of transmission of infection by appropriate hand hygiene. Policy: Handwashing/hand hygiene is generally considered the most important single procedure for preventing healthcare associated infections. The facility should provide education on hand hygiene routinely. Procedure: Washing with soap and water is appropriate when the hands are visibly soiled or contaminated with blood or other body fluids. Using an alcohol-based hand rub (ABHR) is appropriate for decontaminating the hands before direct patient contact; before putting on gloves; after contact with a patient; when moving from a contaminated body site to a clean body site during patient care; after contact with body fluids, excretions, mucous membranes, non intact skin, wound dressings; after removing gloves; and after contact with inanimate objects in the patient ' s environment. The Hand Hygiene for Residents policy, last revised August 2018, and last reviewed March 2020, was provided via email by the NHA on 3/31/2020. It read in part, Purpose: To decrease the risk of transmission of infection by enabling residents to perform appropriate hand hygiene. Policy: The shared living environment of a long term care (LTC) facility can allow the spread of easily [MEDICAL CONDITION] and bacteria leading to respiratory and gastrointestinal infections among both staff and residents. Handwashing/hand hygiene is generally considered the most important single procedure for preventing infections. Procedure: Staff will encourage and assist the resident as needed to ensure proper hand hygiene through hand washing or the use of an ABHR. Hand hygiene should be offered/performed upon waking, after toileting, after coughing/sneezing, prior to handling and/or consumption of food/drink, prior to leaving his/her room for therapy or shared activities, after ending therapy or shared activities, anytime hands are visibly soiled, and upon request. The Personal Protective Equipment (PPE) policy, last revised March 2020 was provided via email by the NHA on 4/6/2020. It read in part, Purpose: to reduce the risk and prevent the spread of infection to patients, visitors, and staff. The facility should train on PPE, this training should include but is not limited to: appropriate don/doff process and appropriate use, based on care activities. The use of PPE during resident care is determined by the nature of staff interaction and the extent of anticipated body, body fluid, or pathogen exposure to include contamination of environmental surfaces. Furthermore, appropriate use of PPE includes PPE appropriately discarded after resident care prior to leaving the room followed by hand hygiene. II. Failure to ensure staff were following proper hand hygiene procedures A. Observations On 3/31/2020 at 11:47 a.m. certified nurse aide (CNA) #3 was observed delivering a meal tray to Resident #4 in her room. The CNA set the tray down on the resident's bedside table, and left the room. The CNA used some ABHR to sanitize her own hands, however she had a brace on her left hand and was unable to effectively sanitize her left hand. At 11:51 a.m registered nurse (RN) #1 was observed delivering a meal tray to Resident #5 in her room. The RN placed the tray in front of the resident. The RN then went immediately over to assist the roommate, Resident #6, who had not received the correct meal tray. The RN did not perform hand hygiene in between assisting Resident #5 and Resident #6. B. Interviews The NHA was interviewed on 3/31/2020 at 12:15 p.m. She said that staff had been educated on hand hygiene. She also said that the facility was performing audits on hand hygiene. C. Record Review A copy of a staff education in-service that was conducted at the facility on 3/17/2020 was provided by the NHA via email on 3/31/2020. Review of the in-service revealed that it included education on hand hygiene and PPE. Review of the sign in sheets for the in-service revealed that RN #1 and CNA #3 had received the education. III. Failure to provide hand hygiene opportunities for residents A. Observations On 3/31/2020 at 11:33 a.m., CNA #1 was observed in the TV room where five residents were awaiting their lunch meal. CNA #1 assisted Resident #1 with putting on a clothing protector. At 11:35 a.m., Resident #1 received her meal from CNA #1. CNA #1 did not offer the resident the opportunity to perform hand hygiene prior to eating. At 11:35 a.m., Resident #2 received her meal tray from an unidentified CNA. The CNA did not offer the resident the opportunity to perform hand hygiene prior to eating. The resident was observed to begin eating. At 11:38 a.m., Resident #3 was assisted into the TV room by CNA #2. She informed the resident his meal would be coming and then left the room without offering the resident the opportunity to perform hand hygiene. CNA #4 brought the resident his meal tray, set him up to eat, and put a clothing protector on him. She also did not offer the resident the opportunity to perform hand hygiene prior to eating his meal. At 11:47 a.m., CNA #3 was observed delivering a meal tray to Resident #4 in her room. The CNA placed the tray on the resident's bedside table. She did not offer the resident the opportunity to perform hand hygiene prior to eating her meal. At 11:51 a.m. RN #1 was observed delivering a meal tray to Resident #5 in her room. The RN placed the tray in front of the resident, but did not offer the resident the opportunity to perform hand hygiene prior to eating her meal. B. Interviews The NHA was interviewed on 3/31/2020 at 12:15 p.m. She said that residents should be assisted to wash their hands or use ABHR prior to eating. She said that staff had received education on resident hand hygiene. C. Record review A copy of an education in-service that was conducted at the facility on 3/31/2020 was provided by the NHA via email on 3/31/2020. Review of the in-service revealed that it included education on hand hygiene for residents. Review of the sign in sheets for the in-service revealed that RN #1, CNA #1, CNA #2, CNA #3, and CNA #4 all received the education. IV. Failure to ensure staff were following proper personal protective equipment (PPE) guidelines A. Observations On 3/31/2020 at approximately 11:15 a.m., laundry aide (LA) #1 was observed pushing a covered cart in the hall, delivering clean personal folded laundry and laundry on hangers to resident rooms. The LA had gloves on both hands. She knocked on a resident's door, entered the room, placed a blanket on the resident's bed and left the room. The LA then went to the shared room of Resident #3 and Resident #7, removed clothes from the laundry cart and went into the room with the same gloves on. She opened the closet door, hung the clothes in the closet, removed empty hangers from the closet and left the room. She did not perform hand hygiene or remove her gloves upon exiting the room. The LA then got more clothes from the covered laundry cart and returned to the same room, opened the other closet door, hung the clothes in the closet, removed empty hangers from the closet, and exited the room again without performing hand hygiene or removing her gloves. The LA then proceeded to the room of Resident #8 still wearing the same pair of gloves. She removed Resident # 8's clothes from the laundry cart, entered the room, opened the closet door and hung the clothes in the closet, then left the room. Again, she did not remove her gloves or perform hand hygiene prior to exiting the room. B. Interviews LA #1 was interviewed on 3/31/2020 at 11:25 a.m. She said that she wore the gloves for her own protection when putting clothes away. She said that she would put all of the clothes on the laundry cart away in all of the residents rooms on the hall before she would change her gloves. She said she was trained on PPE, however she said she did not know that she had to change gloves and perform hand hygiene in between each room and resident. C. Record Review A copy of an all staff education in-service that was conducted at the facility on 3/17/2020 was provided

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) by the NHA via email on 3/31/2020. Review of the in-service revealed that it included staff education on hand hygiene and PPE. Review of the sign in sheets for the in-service revealed that LA #1 had received the education. LA #1 received further education regarding hand washing and laundry distribution on 3/31/2020.