STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065391	A. BUILDING _____ B. WING _____	05/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COLORADO VETERANS COMMUNITY LIVING CTR AT HOMELAKE	3749 SHERMAN AVE MONTE VISTA, CO 81144

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 and interviews, the facility failed to maintain an infection and prevention control program to provide a safe environment to help prevent the development and transmission of COVID-19 for two of two neighborhoods in the facility. Specifically, the facility failed to: -Encourage, assist to properly wear, and/or provide residents with, protective masks when in common areas. -Store residents' protective masks in a safe manner. -Encourage or assist residents with hand hygiene prior to meal service. - Encourage, assist to properly wear, and/or provide residents with, protective masks, or tissue to cover their nose and mouth when within less than six feet of them. -Ensure hand hygiene was completed appropriately. -Ensure residents' personal use items were stored in a way to prevent cross-contamination and/or spread of infection. Findings include: I. Face masks for residents A. Professional reference The Center for Disease Control (CDC), Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings (4/30/2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations. html#minimize, (Update April 13, 2020) Patients may remove their cloth face covering when in their rooms but should put them back on when leaving their room or when others (e.g., HCP, visitors) enter the room. Screening for symptoms and appropriate triage, evaluation, and isolation of individuals who report symptoms should still occur. B. Observations On 4/29/2020 at 11:31 a.m., an observation revealed while in a common area, Resident #1 had his mask under his chin and Resident #4 had his mask under his nose. Staff walked through the area and did not stop to assist or encourage them to cover their nose and mouth with their masks. On 4/29/2020 at 11:46 a.m., an observation revealed restorative aide (RA) and did not provide, encourage, or assist Resident #12 to cover his nose and mouth with a protective mask, or a tissue, when she was within less than three feet of him as she interacted with him. On 4/29/2020 at 12:10 p.m., an observation revealed while in a common area, Resident #3's mask laid face down on the bedside table in front of her as certified nurse aide (CNA) #1 sat next to her to provide feeding assistance for lunch. CNA #1 did not remove her mask from where it laid. In the same common area Resident #4's mask laid face down on the bedside table in front of him as CNA #1 sat next to him to provide feeding assistance for lunch. CNA #2 did not remove his mask from where it laid. An observation on 4/29/2020 at 12:21 p.m. revealed CNA #3 entered Resident #5's room did not provide, encourage, or assist him to cover his nose and mouth with a protective mask, or a tissue, when she was next to him as she interacted with him. An observation on 4/29/2020 at 12:26 p.m. revealed dietary aide (DA) placed a lunch tray on Resident #4's bedside table next to his mask which laid face down on the bedside table. DA left the mask where it laid. CNA #2 began to feed Resident #4 and did not remove his mask from where it laid. An observation on 4/29/2020 at 12:29 p.m. revealed Resident #6 wore his mask under his nose while in a common area; CNA #4 sat next to him and did not encourage, or assist him to cover his nose and mouth with his mask. An observation on 4/29/2020 at 12:31 p.m. revealed the accountant (ACCT) did not provide, encourage, or assist Resident #7 with a method to perform hand hygiene when she served her a lunch tray. Resident #7 proceeded to eat her lunch without performing hand hygiene. An observation on 4/29/2020 at 12:33 p.m. revealed the transportation (TRANS) staff did not provide, encourage, or assist Resident #8 with a method to perform hand hygiene when he served him a lunch tray. Resident #8 proceeded to eat his lunch without performing hand hygiene. An observation on 4/29/2020 at 12:35 p.m. revealed CNA #3 did not provide, encourage, or assist Resident #9 with a method to perform hand hygiene when she served her a lunch tray. Resident #9 proceeded to eat her lunch without performing hand hygiene. An observation on 4/29/2020 at 12:38 p.m. revealed the TRANS staff did not provide, encourage, or assist Resident #10 with a method to perform hand hygiene when he served him a lunch tray. Resident #10 proceeded to eat his lunch without performing hand hygiene. An observation on 4/29/2020 at 12:41 p.m. revealed Resident #5 was in the hallway and did not have a mask or tissue to cover his nose and mouth. The certified occupational therapist assistant (COTA) approached him, and did not provide, encourage, or assist Resident #5 to cover his nose and mouth with a protective mask, or a tissue, when she was less than three feet of him as she interacted with him. CNA #3 approached him, and did not provide, encourage, or assist Resident #5 to cover his nose and mouth with a protective mask, or a tissue, when she was less than three feet of him as she interacted with him. An observation on 4/29/2020 at 12:45 p.m. revealed CNA #5 entered Resident #11's room and did not provide, encourage, or assist her to cover his nose and mouth with a protective mask, or a tissue, when she was less than three feet of her as she interacted with her. An observation on 4/29/2020 at 12:52 p.m. revealed Resident #2's mask hung behind her on wheelchair handle while she was in a common area. Staff walked by her and did not get her mask and encourage, or assist her to cover his nose and mouth with her mask, or with a tissue. C. Staff interviews The director of nursing (DON) was interviewed on 4/29/2020 at 1:35 p.m. She said the facility planned to store residents' masks in paper bags for storage to prevent the spread of infection. The DON said the resident's hands should be washed prior to meals. She said staff should encourage the residents to use the face mask when staff were talking to residents. The nursing home administrator (NHA) was interviewed on 4/29/2020 at 1:40 p.m. She said she did not want residents' masks placed on any surface, she wanted them to be properly stored in a manner to prevent the spread of infection. II Storage of personal items A. Observations: Random rooms were observed throughout the facility. On 4/20/2020 beginning at 11:52 a.m., the following rooms had unmarked toiletry items stored incorrectly in shared rooms: -room [ROOM NUMBER] had an unmarked toothbrush siting directly on the sink. -room [ROOM NUMBER] had an unmarked bar of soap sitting directly on the towel dispenser. -room [ROOM NUMBER] had a green cup which had unmarked toothbrushes. The cup also did not have a name on it. --room [ROOM NUMBER] had an unmarked toothbrush laying directly on the sink. The laundry aide was observed to wash her hands at the sink with the toothbrush laying directly on the sink. -room [ROOM NUMBER] had two unmarked white toothbrushes laying on the sink. -room [ROOM NUMBER] had a unmarked white toothbrush, blue denture brush and a shaver laying near the sink. -Room # 205 had an unmarked hair brush on the shelf near the sink, and a unmarked comb laying on the sink. On 4/29/2020 begging at 12:26 p.m., the director of nurses (DON) toured the rooms and observed the rooms (see above) with the unmarked personal items in the shared rooms. B. Interview The DON was interviewed on 4/29/2020 at 12:30 p.m. The DON said the certified nurse aides were to label the personal items. The personal items were to be stored in a baggie and then stored in the resident's night stand. The DON said she would provide training to the staff. III. Hand washing A. Professional reference According to the Centers for Disease and Prevention (CDC) Hand Hygiene in Healthcare Settings, last up updated 1/31/2020, retrieved from https://www.cdc.gov/handhygiene/providers/index.html, included the following recommendations: Multiple opportunities for hand hygiene may occur during a single care episode. Following are the clinical indications for hand hygiene: Use an alcohol-based hand sanitizer immediately before touching a patient, before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids or contaminated surfaces, and immediately after glove removal. Wash with soap and water when hands are visibly soiled, after caring for a person with known or suspected infectious diarrhea, and after known

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 -** Many	(continued... from page 1) or suspected exposure to spores. When using alcohol-based hand sanitizer, put the product on hands and rub hands together. Cover all surfaces until hands feel dry. This should take around 20 seconds. When cleaning hands with soap and water, wet hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Avoid using hot water, to prevent drying of skin. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times. B. Observations On 4/29/2020 at 12:02 p.m., an unidentified CNA washed her hands at a sink, however, she only washed her hands for 13 seconds On 4/29/2020 at 12:10 p.m., the dietary aide #1 was serving lunch to residents in their rooms. She was observed to use the ABHR between the trays after being served to residents. However, she only hand rubbed for 12 seconds. On 4/29/2020 at 12:12 p.m., an unidentified staff member was observed to wash his hands at the sink for 10 seconds. On 4/29/2020 at 12:28 p.m. revealed after he served Resident #4 his lunch tray, DA #2 rubbed ABHR in his hands for less than 10 seconds and proceeded to serve another resident a lunch tray. Interview The DON and the NHA were interviewed on 4/29/2020 at 1:23 p.m. The NHA said the hands should be washed for 20 seconds and the DON said the hands should be hand washed with the ABHR for a minimum of 20 seconds.