STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065152	A. BUILDING _____ B. WING _____	06/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNDANCE SKILLED NURSING AND REHABILITATION	2612 W CUCHARRAS ST COLORADO SPRINGS, CO 80904

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 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, the facility failed to maintain a sanitary, orderly, and comfortable environment for residents in 10 of 33 resident rooms and on one of four hallways. Specifically, the facility failed to ensure walls and floors were repaired, painted and properly maintained. Findings include: I. Initial observations Observations of the resident living environment, conducted on 6/9/2020 beginning at 8:12 a.m., revealed: -room [ROOM NUMBER]; the resident's room was a three-person room where the resident currently lived alone. The resident's bed was made, but the other two beds had no mattresses on them, creating an institutional atmosphere that was not homelike. -room [ROOM NUMBER]; the baseboard cove next to the restroom had chipped and damaged sheetrock approximately 12 inches long by three inches wide. The bathroom floor was visibly dirty with a plastic bag on the floor. -room [ROOM NUMBER]; the wall above the bed had four large areas approximately seven inches in diameter which had been patched but not completed. The baseboard cove next to the residents' bathroom was peeling away from the wall. The wall next to the restroom had three dime sized holes on the wall next to the restroom. The floors throughout the room were visibly dirty and sticky with trash under and around the residents' beds. The heater vent between rooms #108 and #109 was damaged and had sharp corners. -room [ROOM NUMBER]; the dresser drawer was broken and hanging out at a 45-degree angle. The floors were visibly stained, dirty and had trash under the residents' beds. -Room # 107; the floors were visibly dirty with trash under and next to the residents' beds. The floor was sticky and had dark stains. -room [ROOM NUMBER]; the wall had chipped sheetrock with six areas approximately five inches in diameter. The floors were visibly dirty, stained, and cluttered with trash underneath the residents' beds. The wood baseboard was not connected to the wall. -room [ROOM NUMBER]; the heater vent was lying on the floor with trash underneath the vents. The floors were visibly stained, dirty and sticky. There was a dirty tissue underneath the resident's bed with other miscellaneous trash. The wall next to the restroom had three dime sized holes. The heater vent in front of the nursing station had a damaged heater vent cover with sharp edges. II. Environmental tour and staff interview The environmental tour was conducted with the maintenance supervisor (MS) on 6/9/2020 at 9:32 a.m. The above detailed observations were reviewed. The MS documented the environmental concerns. The MS said staff filled out requisition forms which are available at every nursing station. The MS said he did not have any repair requisition requests for the above mentioned rooms. The MS said the above-mentioned damage should have been repaired and addressed in a timely manner.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to meet professional standards of quality for one (#1) of three sample residents. Specifically, the facility failed to: -Follow signed physician orders, and -Notify the provider of medications not available and not administered for Resident #1. Findings include: I. Professional references According to the Ingrezza manufacturer's website https://www.ingrezza.com/taking-ingrezza-for-tardive-dyskinesia (6/11/2020), Taking Ingrezza: Do not stop taking INGREZZA without talking to your doctor first. According to Potter Perry, Fundamentals of Nursing, Elsevier, St Louis Missouri, 2017, pp 624: A medication error can cause or lead to inappropriate medication use or patient harm. Medication errors include inaccurate prescribing, administering the wrong medication, giving the medication using the wrong route or time interval, administering extra doses, and/or failing to administer a medication . You are responsible for preparing and filing an occurrence or incident report as soon as possible after the error occurs. The report includes patient identification information; the location and time of the incident; an accurate, factual description of what occurred and actions taken; and your signature . Report all medication errors that reach the patient including those that do not cause harm. II. Resident status Resident #1, age 69, was admitted on [DATE]. According to the June 2020 clinical physician orders [REDACTED]. The 5/13/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. Supervision by staff was needed for transfers, bed mobility, dressing, toileting, and personal hygiene. III. Record review The resident's care plan, initiated on 5/14/2020, identified the use of the antipsychotic medication Ingrezza related to the [DIAGNOSES REDACTED]. The May 2020 MAR indicated [REDACTED]. The MAR indicated [REDACTED]. The MAR indicated [REDACTED]. The most recent CPO (dated 6/11/2020) identified a discontinuation date for Ingrezza of 5/26/2020. The physician's visit note dated 6/2/2020 included: I evaluated the patient's Tremor, unspecified. Currently on Ingrezza Capsule 40 MG (Valbenazine Tosylate). Give 40 mg by mouth in the morning. Assessment and Plan: 5) R25.1 Tremor, unspecified: I did not change medication for his tremor, unspecified. Monitor. The June 2020 signed CPO included the medication Ingrezza 40 mg to be given by mouth in the morning. The date the CPO was signed was 6/2/2020. The physician note did not identify communication or notification of the missing doses of the medication or identify the discontinuation of the medication. The visit note and the June signed CPO (both dated 6/2/2020) identified the current and ongoing use of Ingrezza. The electronic chart for Resident #1 did not have any documentation of the provider being notified of missed doses. IV. Interviews The assistant director of nursing (ADON) was interviewed on 6/9/2020 at 11:24 a.m. She said she would want the nurse on the medication cart to call the pharmacy if the resident did not have the ordered medication. She said she would want to nurse to also verify if the script for the medication was current. She said the nurse would then call the provider and notify them of the missed dose(s). She said anytime a nurse had communication with a provider she would want a progress note written in the chart. The director of nursing (DON) was interviewed on 6/11/2020 at 9:59 a.m. She said she was not in her current position at the time the identified concerns occurred. She said she was not familiar with the resident and did not know there had been missing doses. She said she would want the staff to call the pharmacy to see if the missing medication could be ordered, or if the facility needed to call in a new script. She said if the pharmacy was not able to deliver the medication the nurse should have called the provider to notify of the missed dose. She said after the notification the nurse should have made a progress note to have communication with all the nurses working with the individual. She said she did not know why the medication was discontinued. She said she did not know why the physician visit note identified no medication changes and did not identify missed doses. She said she did not know why the signed CPO for June included the medication Ingrezza. She said she would look into the matter.
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 establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections including Covid-19. Specifically, the facility: -Failed to follow

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) proper housekeeping protocols to prevent cross-contamination; -Failed to maintain proper cleaning standards and procedures; and -Failed to have available and use eye protection for droplet precaution isolation rooms. Findings include: I. Improper housekeeping protocols A. Observations On 6/9/2020 at 8:51a.m., housekeeper (HSK) #1 was observed cleaning room [ROOM NUMBER], where two residents resided. HSK #1 put on a pair of gloves, and grabbed a rag, Comet and disinfectant cleaner. HSK #1 entered the residents' room and entered the restroom. She poured the remaining Comet into the toilet bowl. HSK #1 sprayed the toilet tank, lid and base of the commode. She exited the restroom and sprayed the residents' sink. She threw the empty cleaner container into the trash can, grabbed the toilet brush and reentered the residents' room. She wiped the toilet tank, seat and the base of the commode with the rag. The observed dwell time for the toilet cleaner was two minutes and four seconds. HSK #1 exited the restroom and proceeded to wipe the sink with the same rag as the toilet. The observed dwell time for the sink cleaner was two minutes and 35 seconds. She placed the rag into a plastic bag on her cart. She reentered the residents' room and entered the restroom. She proceeded to wash the toilet bowl with a toilet brush. She exited the residents' restroom and placed the toilet brush into her cart. She grabbed another rag and immersed the rag into a bucket with sanitizer and wrung out the rag. She reentered the residents' room and proceeded to wipe one resident's bedside table with the rag. She then wiped the resident's small dresser and the top of the large dresser. She exited the resident's cubicle and entered the other resident's area and proceeded to wipe his area in the same manner as the first. The observed dwell time for the sanitizer on the bedside table was 45 seconds. She exited the residents' room and placed the rag into the plastic bag on her cart. She grabbed the broom and dustpan off of her cart and proceeded to sweep the residents' room. She swept near the resident but did not sweep under the resident's bed. She then went to the other resident's area and swept in the same manner. She went to the back of the room and swept towards the door. She picked up a small amount of dirt with her dustpan and dumped it into the trash can. She then grabbed the mop handle and a microfiber mop head out of the bucket on her cart. She wrung the microfiber mop out with her gloved hands. She reentered the residents' room and proceeded to mop from the furthest part of the room working her way out of the room. She mopped the roommate's area. She then mopped the restroom floor. She removed the microfiber mop head off the mop handle and placed it into the plastic bag on her cart. She grabbed another microfiber mop head out of the bucket and wrung it out with her hands. She reentered the residents' room and finished mopping the area. The mopping was just a surface cleaning with no scrubbing actions. She did not mop the resident's area closest to the door. She exited the residents' room, removed the microfiber mop head and placed it into the plastic bag on her cart. She then placed the wet floor sign on the floor next to the door. She did not change her gloves, sanitize or wash her hands during this process. HSK #1 did not change gloves as she entered the next resident room. B. Staff interviews HSK #1 was interviewed on 6/9/2020 at 9:07 a.m. She said she started cleaning each resident room by spraying the cleaner on the toilet and sink and then cleaning the toilet bowl. She said she then wiped each resident's area, swept, and then mopped. She said the dwell time (time the surface needed to stay wet with disinfectant to ensure disinfection) for the sanitizer was 10 minutes. The housekeeping supervisor (HSKS) was interviewed 6/9/2020 at 9:32 a.m. The HSKS was told of the observations above. He said the housekeeper was supposed to clean from clean to dirty. He said the restroom should be the last thing which was to be cleaned. He said all high-touched areas should be cleaned as well all horizontal areas in the residents' rooms. He said the housekeeper then would sweep and mop the room, finishing off with the wet floor sign. He said he did not require his staff to change gloves between tasks. He said housekeeping staff would use the sanitizer and would wipe the surfaces. He said the dwell time on the sanitizer was 10 minutes. He said they used a stronger sanitizer in the isolation rooms which had a dwell time of one minute but he doesn't like using it because it strips the surfaces which it cleans. He said the dwell time isn't really an issue in a room which was not under isolation. He said they are just to be cleaned. He said it was his expectations staff would have followed the proper procedure of cleaning the residents' rooms. He said, I had to retrain the housekeeper on the second floor as she was not cleaning the rooms correctly. He said a negative outcome would be cross contamination from room to room. He said he would go and speak with the housekeeper immediately to correct the issues. The chemist (CT) was interviewed on 6/11/2020 at 8:33 a.m. She said the dwell time for the sanitizer was 10 minutes. She recommended to spray the surface, allow for adequate dwell time, then wipe the surface, ensuring the surface was wet for the 10 minutes. She said for COVID-19 the dwell time would be 10 minutes. II. Failure to don appropriate PPE in a presumed-positive resident room A. Professional reference According to the Centers for Disease Control, Preparing for COVID-19 in Nursing Homes, updated 5/19/2020, https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown. Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. Testing at the end of this period can be considered to increase certainty that the resident is not infected. B. Facility education The COVID-19 start of shift employee screening form's first question was, Reviewed education for today and everyday since last worked? The COVID-19 World Health Organization (WHO) education included a page titled Personal Protective Equipment According to Healthcare Activities, which documented: Caring for a suspected/confirmed case of COVID-19 with NO aerosol-generating procedure; goggles or face shield, medical mask, gown, and gloves. C. Observation On 6/9/2020 at 8:21 a.m. room [ROOM NUMBER] had two posted signs on the door. One sign identified contact precautions and the other sign identified droplet precautions. At 9:16 a.m. the restorative nurse aide (RNA) said the resident in 116 was a new admission. She said the only personal protective equipment (PPE) needed to enter the room to provide care for the resident was a gown, gloves, and a mask change upon entry. When RNA #1 exited the room, she said she did not have to wear goggles because she was told if she wore vision glasses she did not have to wear goggles. She said she was screened every morning and she verified she had received education on COVID-19. Review of the screening form dated 6/9/2020 revealed RNA #1 had been screened in and had identified she had reviewed the education for today and everyday since last worked. D. Interviews The nurse resource (NR) was interviewed on 6/9/2020. She said new admissions were placed in a 14-day isolation and were identified as cared for as a suspected positive until the 14 days were over. She said the staff should have worn eye protection to any isolation room identified as droplet precaution. She said she would make sure goggles were placed into the isolation room carts. The assistant director of nursing (ADON) was interviewed on 6/9/2020 at 11:24 a.m. She said new admissions were considered suspected positive until the 14-day isolation was completed with no symptoms. She said any staff member going into a droplet precaution isolation room should have worn eye protection. She said the eyes are a mucous membrane and [MEDICAL CONDITION] could get in. She said asymptomatic residents are still shedding [MEDICAL CONDITION] and the staff need to wear eye protection to protect themselves and all the residents living in the facility.