STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065113	A. BUILDING _____ B. WING _____	04/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDALLION POST ACUTE REHABILITATION	1719 E BIJOU ST COLORADO SPRINGS, CO 80909

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, interviews and record review, the facility failed to implement infection control measures to prevent possible cross-contamination with Coronavirus disease (COVID-19). Specifically, the facility failed to: -Ensure facial masks were worn appropriately; -Ensure social distancing was practiced; -Ensure new admissions were placed on isolation for the required 14 days; and, -Ensure proper infection control practices were followed during housekeeping and wound care. Findings include: I. Failure to ensure facial masks were worn appropriately A. Observations During a continuous observation throughout the facility on 4/14/2020 beginning at 10:15 a.m., the following was observed: -Two nurses were observed giving report at the nursing cart outside of the nursing station. One nurse pulled her surgical mask below her mouth, exposing her mouth and nose. Residents were observed in close proximity. -A certified nurse aide (CNA) was observed walking down the hallway. Her surgical mask was hooked around the ears and pulled down, resting under her chin. Her mouth and nose were exposed. She came within six inches of a resident and spoke with the resident about her knitted hat. The CNA's surgical mask continued to be tucked under her chin. -A nurse was observed walking down the hallway with a cloth mask. A surgical mask was not present under the cloth mask. -A staff member was observed walking into the therapy gym, pulling down her surgical mask, tucking it under her chin, and exposing her mouth and nose. Four residents were observed in the gym while the staff member's mask was tucked underneath her chin. -Four residents were observed in the common area outside of the nursing station. The residents were not wearing masks or facial coverings. -An activity staff member was observed calling out bingo for the residents. Her surgical mask was hooked around her ears and pulled down under her chin, exposing her nose and mouth. On 4/14/2020 at 10:50 a.m., a CNA was observed entering a resident's room, wearing a surgical mask that covered her nose and mouth. The CNA approached the resident, pulled the mask down and tucked it under her chin, exposing her nose and mouth to speak with the resident. On 4/14/2020 at 11:00 a.m. a therapy staff member was observed wheeling a resident down the hallway. The resident had a productive cough and was not observed wearing a mask. B. Staff interviews The director of therapy (DOT) was interviewed on 4/14/2020 at 10:50 a.m. She said the therapy staff had been provided training on the donning and doffing of personal protective equipment (PPE) by the director of nursing (DON). She said all therapy staff were required to wear surgical masks when in the vicinity of residents and in resident areas. She said the therapy gym was considered a resident area. She said the proper technique for donning a surgical mask included hooking it to the ears and ensuring the nose and mouth were covered. She said surgical masks should not be pulled down unless the staff was in a private office away from residents. She confirmed the mask was not effective in the protection of residents if worn underneath the chin. Licensed practical nurse (LPN) #1 was interviewed at 11:30 a.m. She said surgical masks should be worn at all times while in the facility and when in contact with residents. She said mask loops should be hooked around the ears and the mouth and nose should be covered. She confirmed a surgical mask would not be effective if it was hooked underneath the chin, exposing the nose and mouth. The DON was interviewed on 4/14/2020 at 12:40 p.m. She said she was the infection preventionist at the facility. She said she was responsible for providing the staff with training on infection control practices. She said additional training was provided to all staff related to [MEDICAL CONDITION], COVID-19, in March 2020. She said she provided all staff training on the donning and doffing of PPE on 3/16/2020. She said the donning of surgical masks was part of that training. She said surgical masks should be hooked around the ears and expand it over the nose and mouth. She confirmed surgical masks were ineffective if the nose and mouth were not covered. She said surgical masks should be worn properly by all staff while they are in the facility and interacting with residents. She said the requirement of staff to wear surgical masks was to assist in preventing the spread of COVID-19. She said she was not aware of the direction given by Centers of Medicare and Medicaid Services (CMS) on 4/2/2020 that all residents should wear masks or facial coverings when outside of their rooms and in the common areas of the facility. II. Failure to ensure social distancing A. Observations On 4/14/2020 at 10:15 a.m., four residents were observed sitting next to each other in the common area, not six to eight feet apart as recommended for social distancing. Two residents were observed in the therapy gym sitting approximately six inches apart, not observing social distancing requirements. Both residents were looking at each other and speaking to one another. B. Staff interviews The DOT was interviewed on 4/14/2020 at 10:50 a.m. She said communal therapy should not be conducted in the therapy gym since the COVID-19 virus pandemic. She said she had instructed her staff to ensure residents remained six to eight feet apart when in the therapy gym. She said she had placed red markers on the floor to assist the staff in recognizing the correct social distancing measurements. She confirmed she saw residents in the therapy gym that morning that were not placed six to eight feet apart from one another. She said she provided on the spot training for her staff to ensure they were following social distancing guidelines. The DON was interviewed on 4/14/2020 at 12:40 p.m. She said she had provided training to the facility staff to ensure they were observing recommended social distancing. She said each resident should be six to eight feet apart from another resident. She said the facility had not been [MEDICATION NAME] communal therapy since the start of the COVID-19 pandemic. She said staff should ensure any residents in common areas or therapy gym were seated six to eight feet apart and practiced social distancing. III. Failure to ensure new admissions were placed on isolation for 14 days A. Record review The admission record from 4/1/2020 to 4/14/2020 revealed Resident #2 was admitted to the facility from an acute care hospital on [DATE]. It indicated Resident #3 and Resident #4 were admitted to the facility from an acute care hospital on [DATE]. The medical records for Resident #2, Resident #3 and Resident #4 were reviewed on 4/14/2020. It did not reveal documentation to indicate each resident was placed in isolation for 14 days upon admission to the facility, per Centers for Medicare and Medicaid Services (CMS) guidelines. B. Observations On 4/14/2020 at 12:00 p.m., the resident rooms for Resident #2, Resident #3, and Resident #4 were observed. An isolation cart and signage to indicate each resident was placed on isolation precautions were not present. C. Staff interviews The DON was interviewed on 4/14/2020 at 12:40 p.m. She said it was the facility policy to put residents under isolation precautions for 72 hours following their admission to the facility. She said she was not aware of the directive given by CMS on 4/2/2020 to indicate any residents who were admitted to the facility, from a COVID-19 positive facility, should be placed on isolation precautions for 14 days. She confirmed Resident #2, #3 and #3 were admitted from the hospital, which was considered a COVID-19 positive facility. She confirmed with the guidance, the residents should have been placed on isolation precautions for 14 days following their admission to the facility. IV. Failure to ensure proper infection control practices were followed during housekeeping and wound care A. Observations of room cleaning During a continuous observation on 4/14/2020 at 10:39 a.m., housekeeper (HK) #1 was observed entering a resident ' s bathroom. She cleaned the resident ' s toilet and exited the bathroom without removing her gloves. HK #1 was observed holding the toilet brush with her right hand and a toilet brush holder with her left hand. HK #1 did not change her gloves. HK #1, with the same gloved hands, handed the resident lotion and assisted the resident to apply the lotion to the resident ' s hands. With the same gloved hands, HK #1 used a rag to clean the sink, countertop and over bed table. With the same gloved hands, HK #1 swept the resident ' s room. She then put the broom back on the housekeeping cart and took the

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) trash to the soiled utility room. When opening the door to leave the dirty utility room, HK #1 removed one glove, approached the housekeeping cart, removed the second glove and threw them away. HK #1 was observed cleaning her hands with hand sanitizer. B. Observations of wound care During continuous observation on 4/14/2020 at 11:20 a.m. licensed practical nurse (LPN) #1 was observed changing the dressings for a resident to the lower part of both legs in the resident ' s room. She had cleansed the wound and applied a cream to the resident ' s legs. LPN #1, with the same gloved hands, exited the resident ' s room to the medication cart. She grabbed the medication cart keys out of her scrub top pocket, opened and removed an item for the dressing change from the medication cart. Then LPN #1 doffed gloves and dropped them in the trash can of the medication cart. She reentered the resident ' s room, donned new gloves and continued the dressing change. LPN #1 did not wash her hands or use hand sanitizer in between glove changes. C. Staff interviews Housekeeper (HK) #1 was interviewed on 4/15/2020 at 11:10 a.m. She stated, I am removing the isolation cart because this resident has been on isolation for 48 hours after admission. We remove the residents from isolation 48 hours after they have been admitted (to the facility). Registered nurse (RN) #1 was interviewed on 4/15/2020 at 11:27 a.m. She stated, We are placing residents that are first admitted on isolation precautions for 72 hours. If they have symptoms we will isolate that resident in their room for 72 hours also. She stated, We are wearing this masks since this all (Covid-19 precautions and awareness) started and using hand sanitizer and other standard precautions as usual Certified nursing aide (CNA) #1 was interviewed on 04/15/2020 at 11:35 while assisting residents with eating, she stated we use these (while holding up a product that reads, Hot/Cold towel), then we help them wipe their hands. The contents of the package had a different language and there were no ingredients listed on the package.