STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065146	A. BUILDING _____ B. WING _____	04/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHERRY CREEK NURSING CENTER	14699 E HAMPDEN AVE AURORA, CO 80014

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, 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; -Ensure staff were following proper personal protective equipment (PPE) guidelines, access and cleaning between use in COVID-19 positive and non-COVID-19 positive rooms; -Change nasal oxygen tubing after it had touched dirty surfaces before inserting into resident's nares; -Ensure appropriate disinfection of vital sign equipment used between residents of COVID-19 positive and non-COVID-19 positive rooms; and, -Ensure proper storage of cloth masks. Findings include: I. Status of COVID-19 in the facility A. Interview The director of nursing (DON) was interviewed on 4/15/2020 at 9:00 a.m. She reported the nursing home administrator (NHA) was out sick with COVID-19. She said she received support from the corporate office who she conferenced with daily and twice most days. She said the corporate office took over the phone calls and letters to the families, residents and visitors. The DON said the building census was 145 residents. Fifty three residents were tested for COVID-19, 44 residents were positive for COVID-19. Since March 2020 COVID-19 related deaths were 17. The DON said that 22 of the staff tested positive for COVID-19. She said that there was more than a quarter of the staff lost to illness so she contacted the corporate office who sent out nursing staff from Texas. The DON said that the first staff that was positive for COVID-19 was on 3/23/2020. The first resident tested positive for COVID-19 on 3/30/2020. The DON said the facility protocol during the outbreak was to isolate residents with any symptoms other than baseline and/or fever of 99.5 degrees Fahrenheit (F). She said she was receiving direction and guidance from the Colorado Department of Public Health and Environment (CDPHE) and TriCounty Health Department (TCHD) through daily phone conversations. She said the TCHD took a couple of virtual tours of the building prior to providing recommendations. The instructions provided by CDPHE and TCHD were to not wear personal protective equipment (PPE) in resident rooms that did not have COVID-19 status. The facility implemented taking vital signs of residents twice a day starting on 3/15/2020 and no visitors in the building. The facility was instructed to not move residents in the building/cohorting and to treat in place. The facility implemented social distancing and mask wearing in the smoking areas for residents, however, not all of the resident population had been receptive. She said the staff were instructed to encourage residents to maintain a distance of six feet and wear the mask when not in their rooms. The DON said the staff were not designated and assigned by COVID-19 positive versus non-positive rooms but instead by wings. She said each wing had double doors to close off so as to limit access to the wing. II. Failed to ensure staff were following proper personal protective equipment (PPE) guidelines, access and cleaning between use and ensure staff were following proper hand hygiene procedures. A. Observations and staff interviews 1. On 4/13/200 at 11:50 a.m., CNA # 6 was seen delivering a resident's lunch tray to his room. She placed the tray on the over-bed table and did not offer the resident a way to sanitize his hands, prior to eating. She exited the room and walked down the hall. CNA # 6 was interviewed on 4/13/2020 at 12:00 p.m. She said she did not have the resident wash his hands or apply hand sanitizer prior to eating his meal. She said Wow, I didn ' t even think of that, that's a good idea. I should have offered him a washcloth or hand sanitizer. RN # 2 was interviewed on 4/13/2020 at 12:10 p.m. She said the CNAs should have the residents wash their hands or sanitize their hands with alcohol based hand rub, prior to eating their meals. 2. On 4/15/2020 at 11:08 a.m. observed certified nurse aide (CNA) #2 wearing a N95 mask under a cloth mask with a face shield over top. She said that she wore the mask and face shield in and out of all the rooms on the unit. She said that she entered COVID-19 positive and non-COVID-19 positive rooms. She said that she wore the cloth mask over the N95 mask because she wore it for a week, unless it was wet or soiled she did not change it. She said she washed the cloth mask at the end of her shifts for the week. She said she wore the cloth mask to keep her safer because she did not trust the N95 mask was enough to protect her. She said she did not think it fit properly since the face shield fogged up. She said the facility did not offer fit testing when she picked up her supplies. She said she received training on how to don and doff PPE upon her arrival to the facility. She said she was from Texas and at the facility to help with the staffing shortage. CNA #2 adjusted the cloth mask during the interview by touching the nose and mouth area of the mask. She did not perform hand hygiene then donned a rain poncho that was used as a gown, then a pair of gloves to provide assistance to the resident in room [ROOM NUMBER], who wanted to use the restroom. CNA #2 spoke to the resident then went to the doorway and yelled down the hallway for CNA #1 to provide assistance to the resident. CNA #2 said she was on light duty and could not provide transfer assistance to the resident and doffed the rain poncho she was wearing as a gown and put it in the trash. She said the rain ponchos were not to be reused and were to be disposed of after each use. She then removed the gloves and washed her hands in the sink in the resident's room. She said there was no specific care of the face shield when exiting a COVID-19 positive room. As she exited the room she reached up to the face shield and adjusted it on the rim in the middle of her forehead and without doing hand hygiene went into a room across the hallway to answer a call light. CNA #1 said she did not know the resident's transfer ability but would assist with the resident's needs. She wore a N95 mask and a face shield. She said she was issued the mask and face shield when she arrived from Texas to help with the staffing shortage. She said that she was instructed to not remove the N95 mask or face shield whether she entered COVID-19 positive or non-COVID-19 positive rooms. She said that she had no instructions for care of the face shield when leaving a COVID-19 positive room prior to entering a non-COVID-19 positive room. She donned the rain poncho used as a gown without doing hand hygiene then gloves before entering the room. She said the rain ponchos were not being reused. CNA #1 adjusted the resident in bed A in her wheelchair into the bathroom doorway. Then went to the hallway outside the resident's doorway and yelled for assistance to other staff for assistance. CNA #2 returned to the room with the mechanical standing lift. She did not do hand hygiene prior to donning a rain poncho and gloves. She did not disinfect/clean the lift after using it in another room prior to bringing it into this room. CNA #3 arrived wearing a surgical mask and a face shield. He did not perform hand hygiene before donning a rain poncho. He said they were disposable and not reused then donned gloves. He said he received his surgical mask and face shield at the beginning of the shifts for the week. He said he would change the mask if wet or soiled. He said there was no specific disinfecting or cleaning instructions for the face shield when exiting a COVID-19 positive room. 3. On 4/15/2020 at 9:29 a.m. observations made on the 2000 hallway revealed isolation carts outside of rooms #2002 and #2010, with a sign posted on the doors that read to wear gloves, eye protection, gown, surgical or N95 respirator mask and to use hand washing or alcohol based hand rub (ABHR). The isolation cart contained rain ponchos, surgical masks, and hand sanitizer but did not contain eye protection. -Registered nurse (RN) #1 and CNA #5, assigned to the 2100 hallway, were observed from 9:45 a.m. until 10:30 a.m. RN #1 and CNA #5 were observed going in and out of COVID-19 positive and non-positive rooms. -CNA #5 was observed going into multiple COVID-19 positive rooms without donning appropriate PPE. The CNA wore a surgical mask to enter rooms and provide care but failed to don the gown, gloves and eye protection. The hallway had four rooms that were COVID-19 positive. She said that she was given a N95 mask to wear, once a week. She kept it in the break room, because it was not

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 -** Many	(continued... from page 1) very comfortable to wear. She passed the closed double doors to the unit, to enter the staff break room on the second floor common area. She revealed that her N95 mask was stored in this area, which was not in easy reach. She said instead, she was instructed that she was safe wearing only the surgical mask when entering the COVID-19 positive rooms. She said she was instructed it was not necessary to wear eye protection when entering the COVID-19 positive rooms. -RN #1 was observed coming out of a COVID-19 positive room [ROOM NUMBER] with two surgical masks on, instead of full appropriate PPE. She said she was not provided a N95 mask, and had not seen staff in the facility regularly wear them. She said she was told she would have to supply one for herself. -RN #1 and CNA #5 said that they had received regular facility training on infection control, and that the facility had regular meetings. When asked about specific training and education regarding COVID-19 and facility processes put in place, neither could provide a direct response. RN #1 said she had only been back in the country for a while, and was not aware of the facility having any specific ongoing education. CNA #5 said that she did not work often and only as needed. -At 10:45 a.m. the charge nurse for the second floor said that all rooms that were on droplet/respiratory/contact precautions, with posted signage, carts located outside of the rooms that were stocked with surgical masks, gloves, ABHR and gowns. She said the staff were issued eye protection, surgical and N95 masks. She said the staff that were not issued eye protection wore glasses. She felt that glasses were sufficient eye protection in COVID-19 positive rooms. She said that the management provided N95 and surgical masks regularly to the staff. B. Staff interviews The DON was interviewed on 4/15/2020 at 9:00 a.m. She said the N95 and surgical masks were provided to the staff at the beginning of their shifts for the week. They are reused by the staff they are issued to and staff were instructed to dispose if wet or soiled. She said the staff were issued a face shield to wear over top of the mask to extend the life. She said some of the staff insisted on wearing cloth masks over top but education was provided to the staff that it did not protect them but it did extend the life of the N95 mask. She said they had enough N95 masks for all staff and were instructed to wear the face shield over top to extend the life of the mask. She said the face shields and goggles were being reused and cleaned after exiting a COVID-19 positive room with sanitizing wipes and replaced for continued use. The director of nursing (DON) and the nursing home administrator (NHA) were interviewed on 4/24/2020 at 2:42 p.m. They both said that they had provided frequent training to staff regarding proper donning and doffing of PPE. They said that PPE should not be worn in the hallway and should be doffed before leaving the room. They said that hand hygiene should be performed prior to donning and doffing PPE. The DON said the staff received the same training about what PPE to wear such as the N95 masks, surgical masks, eye protection, gowns and gloves to enter a COVID-19 positive room. She said the staff were educated about when it was appropriate to wear a surgical mask such as when not entering a COVID-19 positive room or if the staff member wore a face shield over the surgical mask then N95 mask was not necessary. III. Failed to change nasal oxygen tubing after it had touched dirty surfaces before inserting into resident's nares. A. Observation and staff interview On 4/15/2020 at 11:08 a.m. entered room [ROOM NUMBER] after donning a rain poncho and gloves to assist with the resident in bed A's cares. CNA #1 assisted the resident with donning the nasal cannula oxygen tubing from the portable tank located on the back of the resident's wheelchair to her nares. The CNA pulled the end of the tubing closely inserted into the tank which resulted in the nasal cannula dragging along the floor, between the wheelchair wheels, and the seat cushion before inserting into the resident's nares. The tank was empty so the CNA removed the cannula and put it on the back of the wheelchair wound around the handles on the backseat. The CNA moved the concentrator closer to the resident to don the nasal cannula, however, she did not do hand hygiene and change gloves. She held the cannula from the concentrator in the palm of her gloved hand that had touched the wheelchair and the concentrator before inserting into the resident's nares. B. Staff interview The director of nursing (DON) and the nursing home administrator (NHA) were interviewed on 4/24/2020 at 2:42 p.m. via phone. The DON said that the nasal cannula should have been disposed of and a new one donned. She said the CNA should not have touched the cannula with the gloved hand that touched the dirty surfaces. IV. Failed to ensure appropriate disinfection of vital sign equipment used between residents of COVID-19 positive and non-COVID-19 positive rooms. A. Observation and staff interview 1. On 4/15/2020 at 11:58 a.m. observed licensed practical nurse (LPN) #1 standing in the doorway of room [ROOM NUMBER] that had signage for droplet/contact precautions and an isolation cart, with vital sign equipment in her hand, wearing a rain poncho and gloves. She said she needed to set the vital sign equipment down so she could disinfect it before storing it. She sat the ear probe thermometer and finger pulse oximeter on the top of the clean isolation cart in the hallway. She said there was not designated vital sign equipment for the COVID-19 positive rooms, however the facility provided plenty of sanitation wipes that she kept on the medication cart located across the hallway. She went back inside the room and removed the rain poncho, gloves and washed her hands in the sink in the room. She said she was providing end of life support to the resident and family who were visiting through the window. She said the resident she was providing support to was COVID-19 positive. She picked up the vital sign equipment and carried them to the medication cart located across the hallway. She used sanitizing wipes and wiped off the items before storing them on the top of the medication cart. She said the vital sign equipment was used in COVID-19 positive and non-positive rooms alike. The ear probe was sitting inside of a holder that contained a package of ear probe covers. The package had perforated edges that had been torn away exposing the entirety of the package contents of ear probe covers. The entire holder and ear probe were taken into the isolation room. Hallway 1000 had four rooms COVID-19 positive. After she disinfected the vital sign equipment she did not do hand hygiene or wipe off the surface of the medication cart before preparing another resident's medications. She said that she wiped off the medication cart at least twice in a shift with the sanitation wipes. B. Staff interview The DON and the NHA were interviewed on 4/24/2020 at 2:42 p.m. They said that the vital sign equipment should have been disinfected prior to placing on the clean isolation cart. The vital sign equipment should be stored in a designated area of the medication cart to ensure it does not contaminate medications. She said she would provide training to ensure that the ear probe covers do not enter resident rooms and stored in a designated area of the medication cart. V. Storing of cloth masks A. Observation and staff interviews On 4/15/2020 at 12:18 p.m. observed CNA #4 the concierge CNA from Texas here to assist with the staffing shortage. She said she was delivering the cloth masks that had just arrived to all the units. She said the residents had to wear masks if they left their rooms. She said she was not aware that residents should be offered the masks when providing care whether they were COVID-19 positive or not. LPN #1 said that she had two residents on the 1000 hallway that went outside to smoke so she made sure they had masks. She said the rest of the residents did not leave their rooms so she did not find it necessary for the residents to have masks. She said only the residents leaving their rooms needed the masks. She said instructed CNA #4 to put the cloth masks on the chair that had a box and some papers strewn across the seat. The masks were placed face down on the seat of the chair. LPN #1 said she was not sure the last time the chair was cleaned. B. Staff interview The DON and NHA were interviewed on 4/24/2020 at 2:42 p.m. They said that the cloth masks should have been stored in a clean place before providing to the residents. The DON said she was providing education to the residents and staff about encouraging the residents to cover their face during care.