STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065272	A. BUILDING _____ B. WING _____	04/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIERRA REHABILITATION AND CARE COMMUNITY	1432 DEPEW ST LAKEWOOD, CO 80214

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 0744 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to provide dementia treatment and services for one (#2) of three out of seven sample residents. Specifically, the facility failed to implement care planned interventions to prevent Resident #1's poor coping ability to handle loud noises resulting in a physical altercation which Resident #1 repeatedly punchedResident #2 while Resident #2 was in bed. Cross-reference to F600 (Free from Abuse and Neglect) because the facility failed to protect Resident #2 from physical abuse by Resident #1 who had a history of [REDACTED]. Findings include: I. Facility's investigation into the altercation The 3/13/2020 Alleged Physical or Verbal Abuse Incident Report read in pertinent part that roommates Resident #1 and #2 had an altercation. Resident #1 yelled at Resident #2 to turn off the television but Resident #2 responded back, you first. Resident #1 walked over to Resident #2 and began punching him. Staff separated residents and moved Resident #1 into a private room. -Resident #2 sustained lacerations to his mouth and arm. Resident #1 had no injuries. II. Resident #1 A. Resident's status Resident #1, below the age of 60, admitted to the facility on [DATE] and readmitted on [DATE]. According to the computerized physician orders [REDACTED]. The 1/28/2020 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BI[CONDITION]) score of eight out of 15. He was understood by others and could understand others. No behavioral symptoms identified. He was independent with ambulation and locomotion. B. Record review The care plan, last revised on 11/2/18, read that the resident had a history of [REDACTED]. Interventions included documenting behaviors in the behavior record and ensuring the resident had his headphones on to listen to the television. The resident said it cut down on his aggression and frustration with roommates. Place the resident on 15 minute checks as necessary. The social service department was to conduct investigations as needed. Meet with the resident as needed to provide support and address behaviors, issues and concerns. Remind the resident that his daughter would not want him to get physically and verbally aggressive. Staff to assist the resident in speaking with his daughter daily, she provided the resident reminders about appropriate behaviors. Although, the care plan documented that when the resident wore headphones while watching the television to decrease agitation with the roommate, however the staff did not ensure the resident wore them to prevent the altercation. C. Resident #1 interview and observation Resident #1 was interviewed on 3/31/2020 at 2:29 p.m. He said he did hit his roommate and he was remorseful. He said that he currently lived in a private room but missed his old roommate. He said he wrote a letter after the event saying he was sorry. He said Resident #2 accepted the apology so they no longer had any issues. He said he sometimes got angry and would react and before he knew it he hit someone. He said he did not get angry often but the television turned on and startled him and he overreacted. During the interview, a staff member asked a few questions and the resident said, Why do you need to interrupt? Go away. I don ' t care about all that right now. Licensed practical nurse (LPN) #1 said to the resident that she was sorry but he had asked her for the information and she was providing it to him. She asked if he wanted to talk about it later. The resident said he did not and said, Just tell me now. 3. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 3/31/2020 at 2:05 p.m. She said that she had the care planned interventions to use if residents had altercations. She said she was aware that Resident #1 could get agitated but usually by talking to him he would calm down. She said she was not sure what would upset Resident #1 but knew that when he yelled at someone it was because he needed something. She was not aware the resident did not have adequate coping skills for loud noises. LPN #2 was interviewed on 3/31/2020 at 2:09 p.m. She said she received abuse and dementia care training recently on the computer. She said she felt she had enough adequate coping interventions to deal with someone who had escalating behaviors. She said the care plan was useful for obtaining coping interventions. She said she was aware of Resident #1's frequent verbal outbursts. She said she was not aware that he would get physical when frustrated. She said the care plan contained interventions to help with his agitated state. She said usually redirection and calm tone of voice was enough to change Resident #1's mood. She was not aware the resident did not have adequate coping skills for loud noises. Certified nurse aide (CNA) #1 and #2 were interviewed on 3/31/2020 at 2:28 p.m. They said that they received recently on the computer abuse and dementia care training. They said they felt adequately equipped to handle an agitated resident. They said the interventions were on the care plans. They said that they were trained on how to de-escalate a resident. They said that they were aware that Resident #1 would get physical with other residents but mostly staff. They said almost anything would get Resident #1 agitated and yelling at staff and/or residents. They were not aware the resident did not have adequate coping skills for loud noises. The nursing home administrator (NHA) was interviewed on [DATE]20 at 10:05 a.m. He said that Resident #1 was known for yelling when frustrated but it had been over a year since his last physical altercation with another resident. He said that Resident #1 was moved to a private room so an incident would not happen in the future. He said Resident #1 was remorseful and continued to hang out with Resident #2 just not alone in a room. He said that he felt there was no warning for the facility to prevent the altercation since both residents got along and had been roommates for a year. The social service director (SSD) was interviewed via email on 4/7/2020. She said, In the event that an altercation takes place while Social Services is in the building, we make ourselves available to de-escalate behaviors in the hopes that all involved parties can avoid a crisis type outburst. Whether we are successful or not, Social Services spearheads any investigations as a result of resident altercations. We also coordinate communication between (facility name) and the [MEDICATION NAME] PCP's (primary care physician), Mental Health Providers, (name) Police, and family members. Finally, we assist, along with the IDT (interdisciplinary team), in developing and implementing appropriate intervention strategies to avoid further altercations. We use our (name) Behavior documentation system to analyze behavior patterns, as well as effective interventions for resident behaviors. This information is passed to floor staff either through huddles, care plan tasks, or on the (name) system directly. I was not present during the altercation, nor during the investigation, however one of the social workers completed it and I was able to review it. The care plan was not updated after the review of this altercation. The life enrichment director was interviewed via email on 4/7/2020. She said, Proactively, staff are talking with residents to strengthen communication and trusting relationships where residents can process stress. Staff validate residents' feelings and work together to meet the changing needs of residents during this difficult time. Staff are individualizing activities for staff , getting specific magazines or games for them to ease the situation. Staff checking-in to see what else residents may want to do or play, listen to or work on.
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 observation and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of Coronavirus disease (COVID-19) and infection. Specifically, the facility failed to: -Ensure social distancing for residents outside smoking in

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) the designated smoking area; -Perform hand hygiene with disposal of dirty linen prior to using the elevator to return to the floor; -Perform hand hygiene prior to filling up ice water in resident drinking cups; -Perform hand hygiene after doing resident cares before assisting Resident #7 with her electronic device; -Disinfect the mechanical lift prior to storing it for use on the next resident; -Ensure a system to disinfect the laboratory technician ' s case that was used in multiple resident rooms; and, -Dispose of dirty linens and trash immediately, instead of leaving on the floor outside of room [ROOM NUMBER] in the hallway utilized by residents and staff. Findings include: I. Status of COVID-19 in the facility A. Interview The nursing home administrator (NHA) was interviewed on [DATE]20 at 10:22 a.m. He reported that 24 staff were out sick with a variety of symptoms, 22 staff tested positive for COVID-19. Total resident census was 88, seven residents were sick with a variety of symptoms and three out of those seven residents tested positive for COVID-19. B. Posted information for staff Posted in the employee bathroom was a notice on the wall that read, Keep calm and carry-on! Please read about the coronavirus. We have supplies, PPE (personal protective equipment) and a plan to extend the supplies should we run low. Everyone is screened prior to entering to ensure the front of [MEDICAL CONDITION] stays out of our community. Passes are restricted to keep the residence safe and away for the general public. Smoking is still OK. No visitation has been allowed to minimize traffic. We have a plan. We have learned how to better prepare from other cases throughout the world. (Key personnel) are on daily conference calls to keep the building prepared. (Staff member) is following all CDC (Centers for Disease Control) guidelines. The best thing for staff to do is social distance yourself, that is how we beat this! Please call or text (staff member name) if you have any questions or concerns or symptoms (phone number). We got this! C. Observations and staff interviews 1. Adherence to social distancing On 3/31/2020 at 1:30 p.m. the entrance to the facility had an area designated as the smoking area. There were 12 residents sitting in the area. Eight residents were wearing masks. When asked about the reason for sitting in the area, they said they were sitting out there to visit with each other and enjoy the fresh air. They said it was not smoking time but they wanted to enjoy the warm weather outside. The residents were sitting within close proximity of each other, within 2-3 feet apart. They said they were to wear masks and keep their distance. Two residents sitting next to each other giggled and pulled their mask on their face, however, they were sitting within two feet apart for each other. Four residents had their masks down around their chins. Most wore the masks below their nose and over their mouth. However, when the residents were observed in the front foyer, a staff member was at the van transferring a resident into the van. When she was done she passed by the residents and said hello then went inside the building without providing direction to the residents about social distancing or how to appropriately wear the masks. The nursing home administrator (NHA) was interviewed at 1:33 p.m. He said that the facility had constant problems with residents congregating and they had staff trained to intervene. He said that the maintenance director painted colored dots on the ground to show six feet apart for distancing. He said it was difficult to get the residents to adhere to the changes. He said he was working with the [ORG] (CDPHE-state agency) and they had left his building the week prior. Licensed practical nurse (LPN) #1 was interviewed at 2:05 p.m. She said that she received training on COVID-19 and received daily updates from the facility. She said the instruction included preventing residents from congregating. She said it was a struggle to get residents to follow the no congregating rule. She said most of the residents either forgot or did not understand so the staff had to provide constant reminders. She said the staff and residents were to wear masks if they were in the same space together. She said the residents wore masks outside of their rooms and when staff were in their rooms providing care. She said most of the residents did not understand how to properly wear the masks so the staff had to constantly remind the residents. She said some residents hung the mask around their chin and felt as though they had the mask on. She said constant reminders to residents to keep safe distance and to wear the mask. LPN #2 was interviewed at 2:09 p.m. She said she received COVID-19 training, which included keeping at least six foot distance and wearing a mask at all times. She said that for the most part, most of the residents were willing to keep the spacing and the mask on. Certified nurse aide (CNA) #1 and #2 were interviewed on 3/31/2020 at 2:28 p.m. They said they received COVID-19 training and it included social distancing of six feet and wearing a mask all the time. They said some of the residents wore the masks and some did not. They felt for the most part the residents tried hard to keep social distancing and wearing the masks. They said that the residents got lonely so it was hard to keep them in their rooms. They said the residents continued to smoke in the foyer and that was the residents favorite activity and place to hang out. The nursing home administrator (NHA) was interviewed again on [DATE]20 at 10:05 a.m. He said that they had constant problems with residents congregating and had staff trained to intervene. He said the maintenance director painted colored dots on the ground to show the six feet apart for distancing. He said it was difficult to get the residents to adhere to the changes. The NHA said he was working with local and State health departments since last week. He said the first case of COVID positive was a staff member. He said that there were difficulties getting testing done and timely. He said they were at contingency level for personal protective equipment (PPE), so the goggles and gowns were being reused. The goggles were disinfected between uses on the same resident. The gowns were hung on the back of resident doors to make them last longer and changed when soiled or wet. The staff were issued masks at the beginning of the week and used from the start to the end of shift. He said all cases of COVID-19 were on the North side of the building and had not been present on the secured unit. He said the implementation of the staff wearing masks for the entirety of their shifts prevented the spread on the secured unit. The assistant director of nursing (ADON) who was the acting director of nursing (DON) during time of survey, was interviewed via email on 4/7/2020. She said, Staff were designated care providers of residents with positive COVID-19. (Due to) Staffing shortage a few IDT (interdisciplinary team) members completed CNA training and are assisting on the floor. The infection preventionist (IP) was interviewed via email on 4/7/2020. She said that the training provided to staff included, in pertinent part, Handwashing and PPE competency, Reviewed COVID-19 and Infection Control policy with staff. Staff demonstrated proper PPE donning/removing. General COVID-19 signs and symptoms, isolation protocol. Different precautions protocols. One employee is from an agency staff. Her hours are blocked and consistent so she is receiving the same types of training as all staff. Initial source was an employee, reported daily to the health dept (department). Surveillance is completed with new cases, and line listings sent to (State health department) with updates. Overall communication between staff, residents, and family on the ever changing nature of [MEDICAL CONDITION]. II. Disposal of dirty linen A. Observations On 3/31/2020 at 2:11 p.m. certified nurse aide (CNA) #2 was observed taking a red biohazardous waste linen bag to the laundry room, which was located downstairs. She wore gloves carrying the bag and pushed the elevator key for the first floor. She opened the door to the laundry room and deposited the bag into a bin labeled Biohazardous waste. Located outside the laundry depository was a hand sanitizer dispenser, filled with alcohol based hand rub (ABHR). She kept the gloves on and kept her arms elevated. She used her elbow to push the elevator key to the second floor. CNA #2 said that she would wash her hands once she got upstairs since there was no place in the laundry depository area. She went directly to the nurses station to wash her hands. B. Interview The nursing home administrator (NHA) was interviewed via telephone on 4/7/2020 at 4:00 p.m. He said there was ABHR available in that area and she (CNA#2) should have done hand hygiene before entering the elevator. III. Passing ice water A. Observation On 3/31/2020 at 2:28 p.m. CNA #1 was observed going downstairs in the elevator to fill up the ice chest. Once filled she put the chest into the nutrition room. She went to a room down the hallway that contained several rooms in isolation and returned with a cup. She filled up the cup with ice and water in the nutrition room. CNA #1 said that the ice chest was cleaned daily by the night shift staff. She said the cart was left in the nutrition room and not taken from room to room. She said straws were changed daily as well by the night shift staff. She said the cups and straws were changed by night shift staff. B. Interview The assistant director of nursing (ADON) who was the acting director of nursing (DON) during time of survey, was interviewed via email on 4/7/2020. She said, Ice chests are exchanged and cleaned daily, extra coolers available to switch out. (Staff development coordinator (SDC)) will re-educate staff tomorrow again, I will post on (computer program name) dashboard as well. Ice water is passed every shift. Ice cooler is placed in a separate room isolated away from residents and it is not taken room to room. Water pitchers and straws are changed daily. IV. Hand hygiene after doing resident cares A. Observation On 3/31/2020 at 2:35 p.m. observed CNAs #1 and #2 provide peri care to Resident #7. CNA #2 removed her gloves but did not perform hand hygiene, then assisted Resident #7 with her electronic device to contact her daughter. Certified nurse aide (CNA) #1 and #2 were interviewed at 2:28 p.m. They said they received hand hygiene training that consisted of return demonstration and computer tests. They said they needed to wash their hands before and after taking care of the residents. B. Interview The nursing home administrator (NHA) was interviewed via telephone on 4/7/2020 at 4:00 p.m. He said hand hygiene should have been performed prior to assisting with the electronic device. V. Disinfect the mechanical lift A. Observation On 3/31/2020 at 2:42 p.m. observed CNAs #1 and #2 transfer Resident #7 using the mechanical lift. CNA #1 put the lift in the storage area but did not clean it after use. B. Interview CNA #1 said she did not think the lift needed to be cleaned since the resident did not

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) touch it. The nursing home administrator (NHA) was interviewed via telephone on 4/7/2020 at 4:00 p.m. He said the facility had disinfecting wipes to clean the mechanical lift between VI. Disinfect the laboratory technician ' s case A. Observation and interview On 3/31/2020 at 2:51 p.m. observed the laboratory (lab) technician (tech) at a room carrying a bag filled with supplies wearing a mask and gloves. At 2:54 p.m. the same lab tech was observed to go into another resident room carrying the same bag. The lab tech said that he did not disinfect the bag going room to room but he did not set it down on surfaces in the room because he used a pad on the bedside tables to protect the bag from the residents ' belongings. The pad was reused and he put it in the bag to use in the next room. B. Additional interview The nursing home administrator (NHA) was interviewed via telephone on 4/7/2020 at 4:00 p.m. He said he would talk to the company that supplied the lab techs to instruct them on disinfecting the bag when going room to room. VII. Dispose of dirty linens and trash A. Observation On [DATE]20 at 9:37 a.m. observed two red bags labeled biohazard waste were outside the door of room [ROOM NUMBER] in the hallway in front of the gate to the downstairs area. At 9:43 a.m. a staff member collected the bags from the floor and disposed of them. Two activity assistants pushed a snack cart past the two red bags on the floor in the hallway. They said they did not know how long the bags had been on the floor. B. Interviews The nursing home administrator (NHA) was interviewed via telephone on 4/7/2020 at 4:00 p.m. He said the bags should be disposed of immediately and not set on the floor outside the residents room.