STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065238	A. BUILDING _____ B. WING _____	07/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ELMS HAVEN CENTER	12080 BELLAIRE WAY THORNTON, CO 80241

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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 establish and maintain an infection control program designed to provide a safe, sanitary environment and to help prevent the development and transmission of communicable diseases and infections such as COVID-19 in nine of nine resident hallways. Specifically, the facility failed to ensure: -Staff and vendors were actively screened for appropriate PPE usage upon entrance to the facility; -Staff covered reusable dishware from isolation rooms, in order to prevent cross-contamination; and, -Staff followed proper protocol for use of personal protective equipment (PPE) in isolation rooms, to ensure compliance with recommended standards. Findings include: I. Professional references According to the Centers for Disease Control and Prevention (CDC), Preparing for COVID-19: Long-term Care Facilities, Nursing Homes updated 4/14/2020, accessed on 7/25/2020, retrieved from 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 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. According to the CDC guidance, Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19, dated 6/3/2020, accessed on 8/3/2020 retrieved from https://www.cdc.gov/coronavirus/2019-ncov/downloads/A_FS_HCP_COVID19_PPE.pdf: -PPE must be donned correctly before entering the patient area. -PPE must remain in place and be worn correctly for the duration of work in potentially contaminated areas. PPE should not be adjusted during patient care. -Respirator/facemask should be extended under the chin. -Both your mouth and nose should be protected . Coronavirus (Covid-2019) (7/10/2020) accessed on 8/3/2020, retrieved from https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cleaning-disinfection.html. If possible, dedicate a lined trash can for the ill person. Use gloves when removing garbage bags, handling, and disposing of trash. Wash hands after handling or disposing of trash. II. Facility policies Infection Control Measures for Vendors policy, was provided by the DON on 7/27/2020, last revised on 7/10/2020, stated in pertinent part: All vendors must be screened immediately upon entering the facility, perform hand hygiene and apply mask and eye protection. Cleaning and Disinfecting policy, was provided by the DON on 7/27/2020, last revised on 7/14/2018, stated in pertinent part: Non-critical items are objects that do not come into contact with mucus membranes, but do come into contact with intact skin (e.g., blood pressure cuff, glucose meters, stethoscope, activity supplies, sensory manipulatives, craft supplies). These items require cleaning between patient use. Guidance for Gloves policy, was provided by the DON on 7/27/2020, last revised on 7/27/2020, stated in pertinent part: When should gloves be used: for delivering meal trays. III. Screening upon entrance to the facility Facility observations and staff interviews On 7/27/2020 at 1:39 p.m. an oxygen vendor was observed entering the 1100 isolation hallway, pushing two large oxygen concentrators. The vendor had sunglasses on, and a cotton face mask, which was not covering his nose. He quickly turned and pushed the two oxygen concentrators down the 1000 resident hallway, past the 100 hallway, into the lobby, and then outside. He was observed returning into the facility with two large oxygen concentrators, and passed the receptionist, towards the 700, 800, and 900 hallway. He continued to wear sunglasses and his cotton mask, which still did not cover his nose. He was not stopped at the receptionist desk. On 7/27/2020 at 1:50 p.m. licensed practical nurse (LPN) #1 was observed walking down the facility hallway, towards the 100 facility hallway. She had her regular eyeglasses on, and was holding her surgical mask. LPN #1 said she was a nurse on her way to the 1000, 1100, and 1200 hallways, and confirmed that she was supplied with a surgical mask that she was required to wear. She continued to walk away towards that facility unit, and was observed placing her surgical mask on her face as she walked. On 7/27/2020 at 1:55 p.m. the receptionist (REC) was interviewed about the screening process. She said that all staff and vendors were required to come into the facility through the front entrance. She said the front desk was occupied from 5:30 a.m. until 10 p.m., at which point the nurse on the 100-300 resident hallway was responsible for screening. She said the expectation upon entrance was that the person working at the front desk would ask the screening questions, and take the temperature. She said that upon entrance, individuals were expected to be wearing goggles and surgical masks. She said that she had screened LPN #1, and was not sure how she had entered down the resident hallways without wearing her mask. She said that the oxygen vendor coming into the facility had told her that his sunglasses were fine. She said she was not aware that this individual was being observed with his cotton mask below his nose, entering and exiting the facility multiple times. On 7/27/2020 at 2:00 p.m. the director of nursing (DON) was interviewed about the facility entrance screening process. She said that everyone entering the facility was aware that they had to wear goggles and masks. She said they kept extra goggles and masks at the front receptionist desk for those who might need one. She said she would be providing additional education to her staff, because they had all been educated on the use of PPE. IV. Isolation room PPE usage and potential cross-contamination On 7/27/2020 at 10:30 a.m. the DON said when staff went into isolation rooms, everything would be available to them in the isolation carts outside the resident rooms. She said they donned and doffed the PPE at the resident door. She said the staff were required to wear surgical masks throughout the facility. She said ongoing education had been provided, and competencies were completed regularly for compliance. Certified nurse aide (CNA) #1 was observed on 7/27/2020 at 12:10 p.m. to enter a residents room [ROOM NUMBER] who was in isolation for droplet precautions. She did not wear an isolation gown when she entered the room and she had no gloves on. Housekeeper was observed on 7/27/2020 at 12:15 p.m. to wear her surgical mask incorrectly. Her nose was not covered by the mask and she was in a residents room [ROOM NUMBER]. The resident laid in the bed. Maintenance assistance (MA) was observed on 7/27/2020 at 12:08 p.m. to leave an isolation room, walk down the hallway with his gown, gloves, goggles and N-95 mask on. He took off his gloves then he took off the disposable gown touching all parts of the gown with his bare hands and put them in the regular trash container. He walked away and did not wash his hands. He was interviewed immediately and said he had no specific training on how to put on or take off the personal protective equipment (PPE). CNA #3 was observed on 7/27/2020 at 12:50 p.m. to leave an isolation room, walk down the hallway with her gown, gloves, goggles and N95 mask on. She took off her gloves and gown and placed them in the trash container. There was no biohazard waste container in the isolation room, only a small trash can under the sink. She was interviewed immediately and she said she was not trained where to discard the gowns and gloves. Oxygen delivery person (ODP) was observed on 7/27/2020 at 1:40 p.m. to wear his mask incorrectly. His mask was below his nose and was exposed to air when he was in the resident areas of the facility. He walked past multiple residents in all areas of the facility. Registered nurse (RN) was observed on 7/29/2020 at 2:10 p.m. to leave an isolation room. He did not have on a gown and no gloves. He left the isolation hallway area and he took his N95 mask off with his bare hands and placed the N95 mask on top of the medication cart and put on his surgical mask. He did not wash his hands before he took

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) off the N95 mask. He was interviewed immediately and he said he did not wear the gown or gloves as he was not doing any personal care with the resident, however, he was giving the residents medications. He then took off the surgical mask and put the N95 mask back on and entered the isolation hallway to give medication to a resident. On 7/27/2020 at 2:21 p.m. an isolation cart was observed outside isolation room [ROOM NUMBER]. The signage on the resident ' s door stated that the room was on isolation for contact plus airborne precautions. A half-eaten lunch meal tray was observed resting on top of the isolation cart outside the room, uncovered. Numerous staff members were observed walking past the exposed meal tray without disposing of it. -At 2:23 p.m. certified nurse aide (CNA) #4 was observed going down the 100 hallway, getting dinner orders from the residents. She said she had seen the meal tray on the isolation cart, and had planned to pick it up once she got to that room. With bare hands, the CNA picked up the uncovered meal tray, and proceeded to take it to the kitchen. She was observed carrying the meal tray down the 100 hallway, past the nurses ' station, through a common dayroom, and placed the meal tray by the kitchen. She passed numerous staff and residents in the process. After she completed this task, she said that staff was not supposed to wear gloves in the hallway. She said that since the tray had come from an isolation room, perhaps she could have done something differently. On 7/28/2020 at 1:45 p.m. the dietary manager (DM) was interviewed about the meal service for the isolation room hallway. The DM said that they used a separate plastic wheeled cart to serve the meals on the 1100 isolation hallway. He said that after meal service was over, the staff would pick up the meal trays, put them on the cart, and wheel the cart to the kitchenette on the unit. The cart would be washed down and sanitized, and parked in the corner of the kitchenette. He said that the cart was not covered, and they did not cover the meal trays upon return to the kitchenette. This cart would have to pass the 1000 resident hallway upon its return to the kitchenette. CNA #2 was observed on 7/29/2020 at 2:30 p.m. to take blood pressures of multiple residents on the 100 hallway. She did not disinfect the blood pressure cuff in between residents nor wash her hands in between residents. V. Facility observations of infection control failure for resident rooms and meal service CNA #1 was observed on 7/27/2020 at 11:45 p.m. to deliver meal trays to residents in isolation rooms. The trays were delivered to the unit on a small cart and the food was on real dishware. CNA #1 wore a N95 mask, gown, goggles and gloves and entered one room She did not change her gloves nor wash her hands in between tray delivery. -At 12:35 p.m. CNA #1 picked up the meal trays and put them on the small cart and pushed it outside of the isolation unit. The cart was not covered and another CNA pushed the cart down the hallway with no isolation rooms and left it in the corner of the dishwash area of the kitchen. On 7/27/2020 at 12:00 p.m. two housekeepers were observed pushing a large empty trash bin to the entrance of the biohazard/soiled utility room near the 700, 800, and 900 resident room hallway and nurses ' station. Neither housekeeper was observed wearing gloves, and one of the two had his goggles hooked into his pant pocket, instead of wearing them. The housekeepers stopped filling the trash bin, exited the biohazard room, and left the facility unit. A few minutes later the male housekeeper returned to the biohazard room, pushing the trash bin. He now had gloves and goggles on, and proceeded to finish emptying the biohazard room trash. On 7/28/2020 at 12:40 p.m. a dietary staff member was observed pushing a large wheeled meal-tray cart towards the dietary department, after lunch service was completed. She did not have protective goggles on. The staff member noted she was being observed, and promptly placed her goggles onto her face. On 7/28/2020 at 12:43 p.m. a male nurse was observed standing at a medication cart on the 700 hallway. The nurse had his goggles on, but his surgical mask was observed hanging off of his right ear. His mouth and nose were not protected or covered. On 7/28/2020 at 1:05 p.m. a nurse was observed sitting in the secured unit nurses ' station, with a resident seated in a wheelchair beside her. The entrance to the nurses ' station was open. The resident did not have a mask on, while the nurse was working on her computer, who also was without a mask in use. Upon observation, the nurse put her surgical mask on, and told the resident she was going to go get her a mask, as well. Observations on 7/29/2020 at 10:28 a.m. revealed an isolation room door propped open with a small trash can that was overflowing with disposable gowns. The gowns touched the walls and door. Observations on 7/29/2020 at 10:57 a.m. in one of the isolation rooms on the 200 hallway revealed a small trash can overflowing of disposable gowns. Observations on 7/29/2020 at 11:10 a.m revealed the biohazard containers in the soiled utility room near the 200 hallway were touching the housekeeping cart. The biohazard containers near the 600 hallway were uncovered and full to the top with sharps containers creating a situation of possible cross-contamination. Infection preventionist (IP) was interviewed on 7/29/2020 at 12:10 p.m. she said PPE gear was taken off in the residents room and discarded there. She said a bin in the isolation room was labeled for disposable. She said face shields were disinfected and masks were changed from an N95 to a surgical mask. On 7/29/2020 at 1:43 p.m. the nursing home administrator (NHA) and DON said that they were very strict with their outside vendors. They expected them to follow the same PPE usage upon entrance to the facility, as the rest of their staff. The DON said that the receptionist kept extra goggles and masks for anyone in need of them, and that the dirty goggles were given to the infection control preventionist (IP) for sanitizing. The DON said that when staff doffed PPE while exiting an isolation room, there would be a bag in the room to put the gown in. The bag went to the biohazard room. The housekeeping staff was trained to use proper PPE. The NHA and DON said that upon admission to the facility, whether they were a readmission or a new admission, a resident must be on a 14 day isolation period. The NHA and DON said that the two [MEDICAL TREATMENT] residents were also in the isolation unit because they were going out of the facility on a regular basis. The NHA said that he would look into methods to improve cross-contamination prevention, such as using covers for meal delivery and pickup. The DON said the full PPE gear was worn in the isolation rooms. She said the gowns and gloves were discarded in the room when leaving the room. She said the facility will reeducate staff on the isolation units as soon as they talk to coorporate.