STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065250	A. BUILDING _____ B. WING _____	05/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SKYLINE RIDGE NURSING AND REHABILITATION CENTER	515 FAIRVIEW ST CANON CITY, CO 81212

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** - Some	**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 properly maintain an infection control program designed to prevent the spread of COVID-19 in two of six neighborhoods. Specifically, the facility failed to: -Follow proper housekeeping protocols to prevent cross-contamination; -Maintain proper cleaning standards and procedures; -Ensure residents had face covering while out of their rooms; and -Ensure residents practiced social distancing. Findings include: I. Improper housekeeping protocols A. Facility policies and procedures The Infection Control Policies and Procedures policy, revised 3/16/2020, was provided on 5/6/2020 at 10:14 a.m. by the director of nursing (DON). The goals of the infection control program are to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections. B. Observations of improper housekeeping protocols On 5/6/2020 at 10:11 a.m., housekeeper (HSK) #1 was observed cleaning room [ROOM NUMBER]. HSK #1 put on a pair of gloves, and grabbed a rag and cleaner. HSK #1 proceeded to spray the door knob and dresser drawers behind the door. HSK #1 entered the restroom and proceeded to spray the sink, toilet tank and base of the commode. He exited the residents' room and placed the spray bottle of disinfectant into his cart and removed his gloves. HSK #1 threw the gloves into the trash can. HSK #1 sprayed hand sanitizer on his hands and immediately put on his gloves. He placed a rag into a red bucket on his cart and proceeded to wring out the rag in the bucket. HSK #1 reentered the residents' room and began to wipe the door knob and the dresser drawers behind the door. He then went over to the residents' bedside table and wiped the table and then grabbed the bed remote control and wiped it with the rag. He then wiped the top of the dresser drawer next to the residents' bed. HSK #1 then went to the roommate's side moving his wheelchair with his glove. He proceeded to wipe the small dresser next to the resident's bed. He placed the wheel chair next to the resident's bed with his gloved hands. HSK #1 exited the resident's room and placed the dirty rag into the plastic bag on his cart. The dwell time from start to finish was approximately seven minutes. He removed his gloves and threw them into the trash can. He sanitized his hands and immediately put on his gloves. HSK #1 then grabbed a clean rag and immersed it into the red bucket. He wrung out the rag and proceeded to reenter the residents' restroom. He wiped the sink, towel bars and then wiped the toilet tank and lid. HSK #1 then washed the inside of the toilet bowl with his gloved hand using the toilet water. HSK #1 did not flush the commode prior to washing the restroom. HSK #1 then wrung out the rag in the toilet bowl and exited the restroom. HSK #1 grabbed three microfiber towels from his mop bucket. He wrung all three out with his gloved hands and dropped one on each side of the residents' room and then dropped the last one in the restroom. He went to his cart and grabbed the mop handle and proceeded to walk into the restroom. HSK #1 placed the mop onto the micro fiber towel and mopped the bathroom floor. He exited the restroom and pulled the microfiber mop and placed it on the floor next to the door. He then went to the roommate's bed area and placed the mop handle onto the micro fiber on the floor. He used his gloved hand and moved the resident's front wheel walker away from the bed and mopped next to and under the resident's bed. He again moved the front wheel walker with his gloved hand and finished mopping the far side of the room's floor. He walked over to the door pulling off the micro fiber with his gloved hand and placed it next to the door. HSK #1 placed the last microfiber on the mop handle. He proceeded to move the resident's wheelchair with his gloved hand so he could mop next to the resident's bed. He replaced the wheel chair next to the resident's bed with his gloved hand. He finished mopping the room. He pulled off the microfiber mop head and grabbed the other two microfiber mop heads off the floor. He placed them into the plastic bag on his cart with his gloved hand. He removed his gloves and threw them into the trash. He sanitized his hands and then placed the wet floor sign on the floor outside of room [ROOM NUMBER]. He then went across the hall and started to clean the next room. HSK #1 did not wash his hands after cleaning room [ROOM NUMBER]. C. Staff interviews HSK #1 was interviewed on 5/6/2020 at 10:32 a.m. He said he starts cleaning the room by spraying all frequently touched surfaces starting at the door and working his way into the restroom and then out of the room. He said the spray was AirX 75 which had a dwell time of one minute. He said he used this for the frequently touched objects in the residents' rooms. He said he then will use the Virex II 256 for the tables and restroom. He said the dwell time was 10 minutes but he would leave it a little wet. He said, I was told I can clean three rooms before I have to wash my hands with soap and water. The housekeeping manager (HSKM) was interviewed 5/6/2020 at 11:37a.m. The HSKM was told of the observation above. She said the housekeepers are supposed to start on the right side of the room allowing for adequate dwell time. She said they would work their way into the restroom again allowing for dwell time. She said staff should wash their hands after cleaning the restroom and sanitize their hands after other cleaning tasks and change their gloves. She said the Virexill 256 was an issue because it had a dwell time of 10 minutes. She said staff would try to leave it wet but it dries before the 10 minutes. She said it was an ongoing problem especially with trying to follow recommended dwell time. She said it was her expectation that staff would be washing their hands after cleaning the restroom especially after cleaning the toilet bowl. She said a negative outcome would be cross contamination from room to room. II. Failure to ensure residents had face coverings while out of their rooms; and ensure social distancing was followed in secured dining rooms. A. Professional standard The Center for Disease Control (CDC), Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings (4/28/2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#minimize, (revised 4/13/2020) includes: Patients may remove their cloth face covering when in their rooms but should put them back on when leaving their room or when others (e.g., HCP, visitors) enter the room. Screening for symptoms and appropriate triage, evaluation, and isolation of individuals who report symptoms should still occur. B. Observations On 5/6/2020 from 9:40 a.m. to 10:15 a.m., continuous observation of the secured unit revealed all residents who were out of their rooms were not wearing masks and were not following six feet social distancing. On 4/29/2020 at 11:45 a.m. the residents were being seated in the secured unit dining room. There were approximately five residents seated at various tables in the dining room. There was one table with three residents seated at the table. The distance between the residents seated in the dining room were approximately two to three feet apart. The other three tables had two residents sitting at each table. The residents who were seated at the double tables were seated approximately three and a half feet apart. All residents in the dining room were not wearing face masks. Staff did not ask residents to put on a mask or encourage residents to social distance themselves while in the dining room. On 5/6/2020 at 9:46 a.m., four residents were in the hall on the secured unit. One resident was sitting in her wheelchair and two residents were wandering the halls. All residents did not have on any face masks. Staff did not ask residents' to put on masks or encourage residents to wear their masks or socially distance C. Staff interviews Registered nurse (RN) #1 was interviewed on 5/6/2020 at 9:49 a.m. She said the residents in the secured unit were difficult because they wouldn't wear their masks. She said they would refuse to wear their masks and would not keep six feet between them. She said they do not document residents' refusals. She said it would be her expectation they would have been redirected or asked to put their masks on. Certified nurse aide (CNA) #1 was interviewed on 5/6/2020 at 10:04 a.m. She said one resident prefers to wear a mask but all other residents don't wear masks when they are out of their rooms. She said the only time

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) residents on the secured unit would wear a mask would be when they are transported for a shower or an outside appointment. The nursing home administrator (NHA) and director of nursing (DON) were interviewed on 5/6/2020 at 12:22 p.m. They were told of the observations above on the secured unit. The DON said the residents were constantly being redirected to wear their mask because they would not keep them on. The DON said it would be her expectations that staff should have been redirecting and offering the residents to wear their masks and to keep six feet from each other.