STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065311	A. BUILDING _____ B. WING _____	**07/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UPTOWN HEALTH CARE CENTER	**745 EAST 18TH AVE DENVER, CO 80203**

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 -** Immediate jeopardy **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 prevent the spread of the novel Coronavirus (COVID-19) in three of three neighborhoods. Specifically: Observations, record review and interviews revealed the facility failed to conduct active screening of staff in a manner to prevent the spread of COVID-19. Staff reported self-screening and one staff member, who worked one-to-one with a resident, had no screening forms available for review. Both the staff member and the resident developed COVID-19. Further review of screening forms and staff interviews revealed no system to ensure all staff were screened, that screening forms were completed, and finally, that these forms were reviewed timely. Observations and interviews revealed additional infection control failures, including staff's failure to follow appropriate donning and doffing procedures for residents on isolation precautions. The above failures in infection control practices created an immediate jeopardy situation with the likelihood of serious harm to residents in three of three neighborhoods, staff, and others, if not corrected immediately. Findings include: I. Immediate jeopardy A. Findings of immediate jeopardy Observations, record review and interviews revealed the facility failed to conduct active screening of staff in a manner to prevent the spread of COVID-19. Staff reported self-screening and one staff member, who worked one-to-one with a resident, had no screening forms available for review. Both the staff member and the resident developed COVID-19. Further review of screening forms and staff interviews revealed no system to ensure all staff and visitors were screened, that screening forms were completed, and finally, that these forms were reviewed timely. Observations and interviews revealed additional infection control failures, including staff's failure to follow appropriate donning and doffing procedures for residents on isolation precautions. The above failures in infection control practices created an immediate jeopardy situation with the likelihood of serious harm to residents in three of three neighborhoods, staff, and others, if not corrected immediately. On 7/13/2020 at 5:52 p.m., the nursing home administrator (NHA), quality improvement coordinator (QIC), and director of nursing (DON) were notified the failures above created an immediate jeopardy situation that placed all residents in the facility at risk for serious harm (COVID-19). B. Facility plan to remove immediate jeopardy On 7/14/20 at 2:13 p.m., the facility submitted an action plan to abate the immediate jeopardy. The abatement plan read: The community was not following CDC guidance regarding thorough screening of employees consistently as well as donning and doffing PPE. Immediate action and ongoing monitoring Admission hold for new residents Fourteen day isolation hold for any hospital readmissions Employee reeducation on donning and doffing of PPE Dedicated staff to man front entrance for staff screenings during day hours. Identified staff to receive more education for staff screening off hours, after doors locked. QI(C), NHA, and DON reeducation for staff on proper donning and doffing of PPE. QI(C) to perform daily review of all employee COVID-19 entrance screening forms. QI(C) to perform daily virtual facility tours for compliance. Corporate call to facility on 7/14/20 to reiterate compliance. Facility to return to weekly staff and resident COVID-19 testing. C. Removal of immediate jeopardy On 7/14/20 at 3:05 p.m. the NHA, QIC, regional consultant (RC), and DON were informed that the immediate jeopardy had been abated, based on the facility's implementation of the above plan. However, deficient practice remained at F level (widespread with the potential for more than minimal harm). II. The facility failed to conduct active screening of staff in a manner to prevent the spread of COVID-19. A. Professional references 1. The Centers for Disease Control and Prevention (CDC) updated 6/25/2020, retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, reads: Actively screen everyone for fever and symptoms of COVID-19 before they enter the healthcare facility. Screen all healthcare personnel at the beginning of their shift. Actively take their temperature and document the absence of symptoms consistent with COVID-19. 2. The Centers for Medicare and Medicaid Services (CMS) (4/2/2020) COVID-19 Long-Term Care Facility Guidance. Retrieved from: https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf. It read in pertinent part, Long-term care facilities should immediately implement symptom screening for all. Facilities should limit access points and ensure that all accessible entrances have a screening station. B. Screening process On 7/13/2020, observations of the facility's screening area for all healthcare personnel and other visitors who entered the facility revealed the screening area was located at the receptionist's office at the facility's main entrance and secured with a keypad code. Staff could access the building using the code and, thereafter, enter the facility for screening. Visitors pushed the doorbell and allowed, selectively, entrance into the screening area. 1. Observations and interviews a. Interviews and observations revealed deficiencies in the facility's screening process. On 7/13/20 at 8:55 a.m., the survey team entered the facility. The receptionist (REC) #1 asked the team to complete a screening questionnaire, stating, go ahead and screen yourselves and then someone will take your temperature. The social services assistant (SSA) took the team members' temperatures; neither REC #1 nor the SSA reviewed the team's responses on the questionnaires prior to the team entering the building. In addition, no education was provided and the bottle of hand sanitizer located at the screening desk was empty. At approximately 9:00 a.m., the NHA entered the facility for the first time that day and did not complete the screening process. She walked past the screening area and down the hallway. At 5:40 p.m., REC #1 was interviewed regarding the staff screening process. She said she normally worked the second shift of the day, but was covering another receptionist on this day. She said all staff enter through the front door and she has them fill out the screening form. She then takes the staff's temperature, and makes sure it is accurate. She said if a temperature was above 99 degrees Fahrenheit, she contacts administration. She said management would handle the screening process from there. When asked how she documented that she had contacted administration for any staff screenings that had occurred, she said it had not yet come up for discussion. She said she checked to make sure the staff name was on the form, the date, and that the temperature was documented accurately. She said she looked to make sure the rest of the screening form was completed with checkmarks, but she did not look at the responses specifically, just that they were completed. b. Staff interviews confirmed the deficiencies in the facility's screening process. In multiple interviews, staff reported they often self-screened prior to starting their shifts. Cook #2 was interviewed on 7/13/20 at 5:35 p.m. She said she always entered the facility through the front door. She said that if staff was present, she would have them watch her screen herself in the morning. However, she said she could not wait around in the morning because she had to start cooking; therefore, she often completed the screening form herself and took her own temperature. Licensed practical nurse (LPN) #2 was interviewed on 7/14/2020 at 12:45 p.m. She said she works the morning shift and every morning when she comes in, she checks her own temperature, answers all the questions, and sanitizes her hands. She said she usually is in the screening area by herself. Certified nurse aide (CNA) #4 was interviewed at the same time as LPN #2. He said all CNAs check and record their own temperature prior to the morning shift. He said they have been doing it for months, ever since the facility started to screen staff prior to their shift. He said no one was usually there to screen them; they all completed the screening themselves. CNA #1 was interviewed on 7/14/2020 at 12:33 p.m. She said, with regard to self-screening in the morning, We fill (out) the paper (form), check our own

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 -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) temperature, preferably confirming it with another nurse or CNA who is in line for screening. There is usually a line of people waiting and we confirm each other's temperature. 2. Record review revealed additional deficiencies in the facility's screening process. a. Review of the screening form, last updated 5/28/20, titled Respiratory Disease Screening, revealed the instructions read, Must be completed with any person entering (the) building. It further read, if a person had a new onset of fever, coughing, or shortness of breath/difficulty breathing, the person must speak to management prior to entering the community. If the person had two of the following symptoms, the person must speak to management prior to entering: Sore throat, congestion, runny nose, nausea/vomiting/diarrhea, new loss of sense of taste and/or smell, chills/shaking with chills, headache, fatigue, or muscle/body aches. The bottom of the form asked if the person had washed their hands or used alcohol-based hand rub (ABHR) on entry, and if they did not, please ask them to do so. The form did not include a space to document who provided the screening, the time the screening was completed, or any follow up conducted if the person had symptoms. b. Staff daily screening sheets from 6/1/2020 to 7/13/2020 were reviewed and many were found incomplete. Of the several hundred staff screening forms reviewed, approximately half were either incomplete, had responses which should have triggered additional screening questions, or indicated no under the bottom of the form where it asked if the person had washed their hands or used ABHR. Sixty-seven (67) staff screening forms reviewed were undated, eight screening forms had no recorded temperature, and more than half had no additional signature to indicate the temperature had been witnessed by another staff member. C. Potential adverse outcome related to the facility's screening deficiencies 1. Resident #7 and CNA #5 Resident #7 was admitted to the secured memory unit of the facility on 2/1/19. The resident's care plan was updated on 10/11/19 to include he should have one-to-one staff monitoring to ensure safety of others until such time as risk was mitigated. The record revealed CNA #5 had worked as a one-to-one aide with Resident #7 on 6/4/2020, 6/5/2020 and 6/6/2020. A nurse progress note, dated 6/9/2020, read Resident #7's oxygen saturation level had decreased to 68 percent on room air. He was transported to the hospital and subsequently tested positive for COVID-19. The facility tested all staff and residents on 6/12/2020 and confirmed that CNA #5 was positive for COVID-19 on 6/15/2020. According to the facility's line listing, seven residents and two staff members had positive results. 2. CNA #5's screening forms could not be located in the facility's records for 6/4/2020, 6/5/2020 and 6/6/2020. The facility could not confirm that the CNA had completed a screening prior to working on these dates. 3. The DON was interviewed on 7/13/2020 at 9:36 a.m. She said the facility had educated staff that they needed to have another staff person witness them take their temperature. She said if another staff member was not at the door when the staff member completed the screening at the start of their shift, he or she needed to get someone to witness their temperature. She said that all staff utilized the entrance where the screening area was located. She said that, usually, if any staff member had a temperature over 99 degrees, the staff member would bring that to the attention of the administration. 4. The NHA and DON were interviewed together on 7/13/2020 at 3:10 p.m. The DON said that based on the facility's investigation of the outbreak, it was identified that CNA #5 was likely patient zero, the initial person who was positive in the facility. D. Action taken to address the facility's screening deficiencies on and after notification of immediate jeopardy on 7/13/2020 at 5:52 p.m. 1. On 7/13/2020 at 5:52 p.m., the NHA, QIC, and DON were interviewed regarding the screening failures identified above. The NHA said the facility had not been able to locate daily screening documentation for the identified staff member (CNA #5) who most likely brought COVID-19 to the facility in early June. They were going to continue to look for it, but the search had been unsuccessful. The QIC said that he had reviewed the staff screening forms, as well, and would make sure that going forward, the forms would be filled out completely. 2. On 7/14/20 at 12:37 p.m., a meeting was held with the NHA, QIC, and DON. The QIC said an in-service education on the importance of staff screening was conducted the night of 7/13/20. Every staff member had been educated overnight. The QIC said he had provided this education himself. He said they had held a corporate call on the morning of 7/14/20 for all company facilities. All facilities were educated that either someone would be manning the facility front doors or the doors would be locked. Someone would have to unlock the facility door to allow staff to enter after hours. The QIC said they were going to reformat the facility's employee screening forms, as they had seen some of them filled out incorrectly. The NHA said they were considering putting answers to necessary follow-up questions on the back of the form to show that concerns had been reviewed. Staff would not be permitted to go to the floor until concerns were noted. Dedicated staff were educated on the full staff screening process. After hours, all registered nurses (RNs) would be educated, as they would be the staff doing the off-hour staff screenings. The QIC said he had reviewed all of the staff screening forms and would be reviewing them each day. He said he would also be doing virtual tours each day to address any concerns. III. Additional infection control failures - Failure to properly apply mask and failure to follow appropriate donning and doffing procedures for residents on isolation precautions. A. Professional references and facility policies 1. Professional references The Centers for Disease Control and Prevention, Preparing for COVID-19 in Nursing Homes, retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html (updated 6/25/2020) read, in pertinent part: 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 (health care providers) should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable 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 . Residents with known or suspected COVID-19 should be cared for using all recommended PPE (personal protective equipment), which includes use of N95 or higher level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front sides of the face), gloves, and gown. The Centers for Disease Control, How to Safely Wear and Take off a Cloth Face covering, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/diy-cloth-face-coverings.html reads in pertinent part, put (the mask) over your nose and mouth and secure it under your chin. 2. Facility policy A copy of the Personal Protective Equipment policy, dated 4/2020, was provided by the DON on 7/14/2020, read in part, Protocol for removing and reprocessing eye protection. Outside of goggles or face shield are contaminated! If your hands get contaminated during google or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer. Remove goggles or face shield from the back by lifting headband or ear pieces. If the item is reusable, place it in a designated receptacle for reprocessing. A copy of the Coronavirus Disease -Infection Prevention and Control Measures, dated 4/2020, was provided by the DON on 7/14/2020. It read in part, For a resident with a known or suspected COVID-19: Staff wear gloves, isolation gown, eye protection and an N95 or higher level respirator if available (a facemask is an acceptable alternative if a respirator is not available); and resident is placed in a private room with a dedicated bathroom (if available) and close the door; or resident cohorted per national, state, or local public health authority recommendations. B. Improper use of PPE 1. Mask The dietary manager (DM) was observed on 7/13/20 at 1:20 p.m., in the first floor common area. Two residents were observed in close proximity, wearing surgical masks. The DM had her surgical mask positioned below her nose. 2. Isolation room interviews and observations a. Isolation room [ROOM NUMBER] on 7/13/2020 CNA #2 was interviewed on 7/13/2020 at 9:42 a.m. She said the resident in room [ROOM NUMBER] was admitted two days ago and he was on quarantine because he was new to the facility. She further stated, if you do not touch the resident, you need only to wear gloves and a mask when in his room, nothing else. CNA #1 was observed at 9:45 a.m. entering room [ROOM NUMBER] with a breakfast tray. The sign on the door to the room read Droplet precautions. The CNA did not wear any PPE when she entered the room except for gloves and a surgical mask. After delivering the tray, she removed her gloves in the hallway, threw them into trash at the nurses' station and sanitized her hands. The DON was interviewed on 7/13/2020 at 10:40 a.m. She confirmed the newly admitted resident in room [ROOM NUMBER] was on droplet precautions. She said this meant nurses and CNAs should always wear a facemask, gloves, and a face shield; a gown should only be worn when providing direct resident care and touching the resident. She said she was following guidelines from the CDC found on a printed flyer, which she said did not mention the use of a gown with residents in isolation. In addition, she said resident in room [ROOM NUMBER] had two negative COVID-19 tests prior to admission. CNA #1 was interviewed 7/13/2020 at 1:02 p.m. She, too, acknowledged the resident in room [ROOM NUMBER] was admitted recently and was on isolation precautions. She said, since she did not touch the resident, she did not need to wear anything but gloves. She said she was aware the sign on the door read Droplet precautions, and she said other PPE were necessary only when staff provided direct care to the resident. LPN #1 was interviewed on 7/13/2020 at 1:20 p.m. He said the resident in room [ROOM NUMBER] was on droplet isolation precautions because he was newly admitted to the facility and his COVID-19

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) status was unknown. He said for droplet precautions, everyone entering the room should wear a gown, N95 mask or equivalent, gloves, and face shield. He said isolation precautions were followed for two consecutive weeks. CNA #2 was present during the interview with LPN #1. She said the DON instructed her not to wear full PPE, rather, only gloves, when in an isolation room. She said this was the practice followed earlier on the fourth floor when there was an outbreak of COVID-19. b. Isolation room [ROOM NUMBER] on 7/14/2020 The DON was interviewed on 7/14/2020 at 11:05 a.m. She said there was confusion on what PPE to wear for new admitted residents, but said she clarified for all staff members (during survey) that full PPE should be worn at all times when entering an isolation room, including gown, even though it had not been mentioned in the CDC flyer. CNA #1 was observed leaving room [ROOM NUMBER] on 7/14/2020 at 12:33 p.m. CNA #1 was wearing a surgical mask, face shield, gown, and gloves. She took all the PPE off in the room and hung the face shield on the wall on a hook outside the room. She did not sanitize her hands after removing PPE and she did not clean the face shield prior to hanging it on the hook outside the room. She said the face shield was not labeled and she just hoped no one would take it. At 1:05 p.m., room [ROOM NUMBER] was updated with a new sign that read to wear full PPE when entering the room - gown, gloves, face shield and N95 mask. CNA #3 was observed entering room [ROOM NUMBER] at 1:30 p.m When she approached the room, she was already wearing a N95 mask on top of a surgical mask. CNA #3 donned gloves first, then a gown and a face shield that was on the hook outside the door and delivered a lunch tray to the resident. As the CNA exited the room, the DON approached her and said she would walk the CNA through what PPE needed to be taken off first. The DON read the sign on the wall that she just posted, and told the CNA what to take off first. There was no hand sanitizer in the room and DON went to get it. Upon doffing the face shield, the CNA placed the shield back on the hook outside the room without cleaning. The DON was interviewed about the face shield left unsanitized on the hook outside room [ROOM NUMBER]. She confirmed that face shields were not assigned to individual staff members, not labeled, and not cleaned prior to hanging them on the wall outside the room. She also said a N95 mask should not be worn on top of the surgical mask. She acknowledged that PPE donning and doffing was not done correctly and stated she would work on it more. Regarding resident in isolation room [ROOM NUMBER], the DON said that she could not locate the test results showing the resident was tested for COVID prior to admission and, therefore, his COVID-19 status was unknown. C. Actions taken on and after the facility was notified of immediate jeopardy 1. On 7/13/2020 at 5:52 p.m., the NHA, QIC, and DON were interviewed about PPE use and care. The DON said that they had been using the CDC (Center for Disease Control) guidelines for everybody in the facility. The DON said that all staff had been educated on the use of gowns, and that they were to be worn at all times in isolation rooms. She said they had N95 masks, gowns, gloves, and face protection for any staff member going into the new resident admit room. 2. On 7/14/20 at 12:37 p.m., a meeting was held with the NHA, QIC, and DON on PPE use and care. The QIC said staff restrictions would be in place for resident isolation rooms. The QIC said the readmission process for residents would not change. He said all residents returning from the hospital would be on 14 days of isolation. He said there had been some readmission confusion, and they had thought they could relax precautions. All staff was now educated on PPE usage. The DON said all donning signs now included the N95 mask. She said she also looked at the resident vital signs every day. She said she looked at every resident with a temperature above 99 Fahrenheit. She said she would reeducate staff on ensuring temperatures were retaken due to any concerns with temperatures outside normal parameters.