STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065373	A. BUILDING _____ B. WING _____	10/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEAR CREEK SENIOR LIVING	**1685 S 21ST ST COLORADO SPRINGS, CO 80904**

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, interviews and record review the facility failed to implement an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the possible development and transmission of Coronavirus (COVID-19) communicable diseases and infections for two out of four units. Specifically, the facility failed to: -Ensure laundry staff wore appropriate personal protective equipment (PPE) when handling potentially contaminated clothing/linens; -Actively screen and document nursing personal working on the isolation unit; -Ensure staff working on the isolation unit wore the appropriate PPE (N95) and encourage residents to wear face coverings during interactions with staff; -Ensure staff on the isolation unit performed appropriate hand hygiene before and after glove use; -Ensure staff on the isolation unit offered hand hygiene to residents prior to meal service; and, -Ensure visitors COVID-19 screening assessments were thoroughly completed and temperatures documented prior to entrance to the facility. Findings include I. Laundry staff's failure to use proper PPE when handling potentially contaminated clothings/linens Observation and staff interview Housekeeper (HSK) was in the laundry room on 9/30/2020 at 10:01 a.m. She had googles on her face. She wore her face mask below her chin and had latex gloves on her hands. She was not wearing a gown as she took linens from the laundry bin and put them into the washing machine. She identified the two bins as one from the skilled side of the facility and the other from isolation precaution rooms. She was unable to tell which linen was from the isolation precaution room separate from those which were not from the isolation room. She identified the bags containing the linen from both the isolation rooms and non-isolation rooms as trash bags. She said she knew to bag dirty linen from isolation precaution rooms in a sugar bag but the process was hindered because nursing staff on the isolation precaution unit bagged the dirty linens and she only picked them up to wash. She said she exited the building through a side door and went around from the outside to avoid going into the isolation precaution unit. She said when she arrived at the unit's back door, nursing staff had already bagged the dirty linens and sat them at the door where she picked them up and returned to the laundry unit. She said she was required to wear full PPE when she came in contact with dirty linens from isolation based precaution rooms. She however acknowledged she was not wearing her gown and that she had her mask below her chin while she put the dirty linens into the washing machine. Certified nurse aide (CNA) #2 was interviewed on 9/30/2020 at 11:15 a.m. She said when residents from the isolation based precaution rooms needed their linens washed, she picked them up from the individual resident's rooms, bagged them and put the bag containing the potentially contaminated linens out by the doorway. She said she went on the radio to announce that the laundry department needed to pick up the laundry. She identified the bag she used bagging dirty linens from the isolation unit as a regular trash bag. She said she took the job as a CNA at the facility two weeks prior and had not received any training relating to COVID-19 or how she was not supposed to bag a potentially contaminated linens from the isolation unit a trash bag. She added that the facility scarcely had sugar bags available hence she had been using a regular trash bag. She said she had knowledge of how to care for residents who tested positive or were symptomatic of COVID-19 from the facility she worked prior to joining the facility. She accessed the four isolation carts on the isolation unit and acknowledged there was no sugar bag in either of them. Registered nurse (RN) #1 was interviewed on 9/30/2020 at 11:22 a.m. She said when nursing staff picked up dirty linens from residents on isolation based precaution, they placed them in a sugar bag. She said nursing staff wore their gowns, N95 masks, gloves and google when they collected the linens and when the bags were picked up. She said nursing staff took care to ensure that the bag did not make contact with their body. She said sugar bags were designed to dissolve when placed in the washing machine and as such it protected laundry staff from the potential risk of exposure. She said trash bags were not to be used in the place of sugar bags as it made it impossible to identify linens from isolation rooms separately from those not in isolation. She said she would bring the observation to the attention of the facility's administration. The maintenance director (MDR) was interviewed on 9/30/2020 at 11:44 a.m. He said when housekeeping/laundry staff were newly hired, they were provided education on how to operate machines utilized for cleaning purposes. He said they were trained on all appropriate chemicals to be used at different stages of cleaning. He said when dirty linens were collected from residents on isolation precaution rooms, they were placed and secured in a sugar bag. He said sugar bags were readily available in the isolation carts which were stationed at every resident's door who tested positive or were suspected of having symptoms consistent with COVID-19. He said laundry/housekeeping staff who picked up the dirty linens from the isolation based precaution unit wore full PPE. He described full PPE in the context of handling potentially contaminated linens from residents who were positive or suspected of having COVID-19 as a gown, N95 mask google and gloves. He said the aforementioned practice was repeated when housekeeping/laundry staff sorted the linens in the laundry room. He said the trash bag was not to be used for collecting potentially contaminated linens. He checked with the nursing staff in the isolation unit and acknowledged that there were no sugar bags in the isolation carts. He said he did not have a documented record of training provided to housekeeping staff on how to handle potentially contaminated linens and use of PPE during the laundry process. He said he would educate his staff based on the identified concerns going forward. II. Screening concerns A. Professional reference According to the Centers for Disease Control and Prevention (CDC) updated 6/25/2020, retrieved on 10/2/2020 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, included the following recommendations: Actively screen everyone for fever and symptoms of COVID-19 before they enter the healthcare facility. B. Observation On 9/30/2020 at 2:15 p.m. CNA #1 accessed the isolation unit through a back door which provided direct access to the isolation unit. She approached CNA #2 and was debriefed about the events which took place in the early hours of the morning. The debriefing was centered around resident care. Immediately afterwards, CNA #1 took to the floor and started caring for residents. She did not complete the staff checklist for COVID-19. C. Record review The COVID-19 screening Checklist for visitors and staff was provided by the nursing home administrator. The undated document read On March 13,2020, CMS and CDC updated guidance on restricting all Long Term Care (LTC) visitors and non-essential healthcare personnel, except for certain [MEDICATION NAME] care situations. All individuals (staff, other health care workers, family, visitors, government officials, e.t.c) entering the building must be asked the following questions: The visitor sign-in COVID-19 assessment form (not dated) revealed each visitor should answer yes or no to two questions. (1) have you washed your hands or used an alcohol based hand rub prior to entering the facility? (2) do you have any of the following respiratory symptoms: cough, shortness of breath, fever, repeated shaking chills, headache, new loss of taste or smell, diarrhea, chills, muscle pain, sore throat or vomiting ? The checklist directed that if an individual answered YES to any of the aforementioned questions, the individual should not visit the facility until they have been symptom free for at least three days. -The checklist also had a designated portion for recording the temperatures of health care providers (HCP) e.g agency staff, regional or corporate staff, health care workers such as hospice, EMS, [MEDICAL TREATMENT] technicians that provide care to residents. The checklist directed that if an individual recorded a temperature over 100.4, the individual should not visit the facility until they have been symptom free for at least three days. In addition, the form also revealed each visitor should answer yes or no to whether or not the individual completing the form had worked at

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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One of the two visitors also did not complete the temperature portion of the checklist. -Four visitors who were at the facility on 9/4/2020 failed to answer one or multiple yes or no questions asked on the checklist. Two of the four visitors also did not complete the temperature portion of the checklist. -Nine visitors who were at the facility on 9/6/2020 through 9/11/2020 failed to answer one or multiple yes or no questions asked on the checklist. -Three visitors who were at the facility on 9/11/2020 through 9/13/2020 failed to complete the temperature portion of the checklist. -Two visitors were at the facility but did not record their names nor the name of the resident they visited. They also did not record the date they visited the facility. D. Interview RN #1was interviewed on 9/30/2020 at 4:20 p.m. The RN said she was an agency nurse and had worked a couple of times on the isolation unit. She said staff came into the isolation unit using a separate rear entrance that led them straight into the isolation unit. She said she was not screened into the facility. She said she had never completed a checklist at the main entrance or on the isolation unit prior to resuming her shift. She said she was not provided any education or informed about the need to undergo a screening prior to working the floor. She said when she came on shift, she relieved the nurse who worked the previous shift and immediately started caring for residents. She said she had not received any training about COVID-19 from the facility. CNA #1 was interviewed on 9/30/2020 at 2:30 p.m. She said she was an agency nurse. She said she was not aware there was a screening process into the facility. The nursing home administrator was interviewed on 10/1/2020 at 9:12 a.m. He said the screening checklist for visitors and staff was one of the guidance put out by CDC and CMS to ensure anyone visiting the facility was screened by asking the questions contained within the checklist. He acknowledged some of the checklists were not thoroughly completed. He said no one reviewed the visitors checklists to identify any parameter that might be a red flag. He acknowledged that not documenting the temperatures of the individuals who had access to residents at the facility could potentially result in exposing and cross-contaminating residents if those individuals whose temperatures were missed were positive for COVID-19. He said the process for screening nursing staff into the isolation unit was that the outgoing nurse screened the incoming nurse. He said he did not realize that the information was not communicated to the nurses who worked on the isolation unit. He acknowledged there was no document which recorded the screening of staff in the isolation unit. The NHA said Without having a record of the screening, I was unable to tell if a nurse reported on the job with symptoms that would have warranted they ' d be sent back home. He said, most of the nurses who worked on the isolation unit were agency nurses. He said he did not have evidence of a training on COVID-19 provided to those individuals before they worked the floor. He added that he did not have evidence which addressed the need for nursing staff to actively screen for COVID-19 symptoms before they came into the facility. He said he would educate nursing staff on the isolation unit on the importance of screening going forward. III. Failure to ensure staff working on the isolation unit wore the appropriate PPE (N95) and encouraged residents to wear face coverings during interactions with staff. A. Professional reference According to the Centers for Disease Control and Prevention (CDC) updated 6/25/2020, retrieved on 10/2/2020 from ttps://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, included the following recommendations: 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. Observation On 9/30/2020 at 11:35 p.m. The isolation based precaution unit was observed. Certified nurse (CNA) #2 conducted routine checks and performed direct care on all the six residents who were on the unit. Before entering the rooms, CNA #2 had a full PPE on, however, she failed to advise /encourage the residents she cared for to put their face masks on or protect their faces by any means. None of the six residents protected their faces when they received care from CNA #2. On 9/30/2020 at 4:12 p.m., CNA #1 was observed in room [ROOM NUMBER] when she responded to a call light. There was an isolation cart outside the room and a sign on the door that read droplet precautions. She entered the room wearing a disposable gown, gloves, surgical mask and eye protection. The resident in the room was positive for COVID-19. CNA #1 failed to wear a N95 mask which was required in a COVID-19 positive room. The resident she was caring for had no face mask and was not protecting her face by any means. CNA #1 was also observed as she repeated the foregoing in room [ROOM NUMBER], #193 and #194. The residents in the later rooms also tested positive for COVID-19. IV. Hand hygiene issues A. Professional reference The Centers for Disease Control and Prevention (CDC) Hand Hygiene Guidance, retrieved from: https://www.cdc.gov/handhygiene/providers/guidelin.html (updated 1/30/2020, retrieved on 10/2/2020), read in part, Multiple opportunities for hand hygiene may occur during a single care episode. Following are the clinical indications for hand hygiene: Use an alcohol-based hand sanitizer immediately before touching a patient, before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids or contaminated surfaces, and immediately after glove removal. Wash with soap and water when hands are visibly soiled, after caring for a person with known or suspected infectious diarrhea, and after known or suspected exposure to spores. When using alcohol-based hand sanitizer, put the product on hands and rub hands together. Cover all surfaces until hands feel dry. This should take around 20 seconds. When cleaning hands with soap and water, wet hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Avoid using hot water, to prevent drying of skin. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times. B. Observation On 9/30/2020 at 11:35 p.m. The isolation based precaution unit was observed. Certified nurse (CNA) #2 conducted routine checks and performed direct care on all the six residents who were on the unit. CNA #2 began caring for the resident in room [ROOM NUMBER]. The residents on the unit were cohorted and nursing staff used the same gown, N95 and google when they cared for the residents. They were required to change gloves between each resident. CNA #2 did not perform hand hygiene before she donned a new pair of gloves going into room [ROOM NUMBER] and after she discarded a used pair of gloves. Two of the isolation rooms (#191 and #193) had double occupancy. CNA #2 failed to replace her gloves and perform hand hygiene between caring for the two residents who occupied the rooms. CNA #2 spent approximately 15 minutes before she exited the rooms on each visit. Upon exiting the room, she did not perform hand hygiene before walking off to the nurse station. On 9/30/2020 at 12:50, CNA #2 served the first room tray on the isolation unit in room [ROOM NUMBER]. The meal was a sandwich (considered a finger food). The CNA failed to perform hand hygiene prior to handling the meal tray. She did not offer hand hygiene to the resident prior to serving the meals. The CNA neither performed nor offered hand hygiene to the other five residents who lived on the unit. On 9/30/2020 at 12:55 p.m., RN #1 was observed while she prepared medication and nutrition supplement at her med-cart. RN #1 repeatedly opened and closed the med-cart with a bunch of keys. She kept the bunch of keys in her pocket after each use. RN #1 served the nutrition supplement and administered the pills which she poured in small sized disposable cups to an unidentified resident residing in room [ROOM NUMBER]. RN #1 held the cups containing the nutrition supplements and pills around the mouth piece and administered the same to the resident. She did not perform any type of hand hygiene the entirety of the observation. By failing to perform hand hygiene in-between going in and out of several residents room and also handling of medication and nutrition supplement cup around the mouth piece, the RN had potentially cross-contaminated the cup containing the resident's medication and nutritional supplement with whatever contaminant might have been on her hands from handling med-cart keys, touching her clothes and likewise touching door knobs. V. Secondary entrance to the facility observation and interviews On 9/29/2020 at 1:00 p.m., the nursing home administrator (NHA) said staff entered the facility using the shipping entrance located at the back of the facility. The staff had to walk from this entrance, to the nurse's station on the long-term care portion of the facility, to be assessed for COVID-19. He said this door required a code to enter the facility. On 9/20/2020 at 1:55 p.m., the NHA walked with the surveyor from the shipping entrance to the nurse's station. There was no COVID-19 assessment station at this entrance. The walk consisted of two short hallways from the shipping entrance to the closed fire doors leading onto the long-term care portion of the facility. From the closed fire doors, a staff member had to walk past six occupied resident rooms to emerge

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She said the nurse took her temperature and reviewed the form for completion and accuracy. On 9/30/2020 11:20 a.m., at CNA #5 said she entered the facility at the shipping entrance door. She walked through the hall leading from the fire doors, passed resident rooms, to the nurse's station before she was assessed on the long-term portion of the facility. On 9/30/2020 at 4:26 p.m., observations of resident rooms, on the hallway from the fire doors to the common area, located on the long-term care portion of the facility. -door to room [ROOM NUMBER] was open. -door to room [ROOM NUMBER] was open. -door to room [ROOM NUMBER] was open with the resident in the room with a staff member. The staff member wore the appropriate personal protection equipment (PPE). The door was signed for droplet isolation. -door to room [ROOM NUMBER] was open. -door to room [ROOM NUMBER] was open with the resident in the room. The door was signed for droplet isolation. -door to room [ROOM NUMBER] was partially open. On 9/30/2020 at 4:29 p.m., CNA #3 said she entered the facility at the shipping entrance and walked past several resident rooms on the long-term portion of the facility, to the nurse's station to be assessed. She said she completed the employee screening form and a nurse took her temperature and documented it on the form. She said the nurse reviewed the form for completeness. On 9/30/2020 at 5:23 p.m., the director of nursing (DON) said staff entered the facility at the shipping entrance located at the back of the facility and walked onto the long-term portion of the facility. She said staff wore a surgical mask and eye protection when they entered the facility. She said staff had to walk down a hallway, past resident rooms before they were assessed by a nurse at the nurse's station. She said she reviewed the employee assessment forms on a daily basis. -The DON said she preferred the staff enter the facility at the side entrance directly onto the long-term care portion of the facility. This entrance was near the nurse's station and did not require the staff to walk past resident rooms. She said she was unsure why the staff used the shipping entrance, instead of the side entrance. On 10/1/2020 at 10:30 a.m., the NHA said staff used the shipping entrance at the back of the facility to limit the number of entrance doors available for staff. He said staff wore surgical masks and eye protection when they entered the facility. He said staff had to walk past resident rooms before they were assessed at the nurse's station. He said the staff had been using the shipping entrance since 3/2020. VI. Additional interviews CNA #2 was interviewed on 9/30/2020 at 1:38 p.m. She said when she served meals to the residents, she would sanitize or offer hand hygiene to the residents prior to serving them. She said she would sanitize her own hands on the way out of the resident's room. She acknowledged she did not offer or perform hand hygiene with the resident prior to serving the meal. She said I did not want to act like I was always 100 percent (%) with hand hygiene because I was being observed because the truth is I am not always 100 %). She said she was afraid of accessing the residents bathroom to wash her hands because of the risk of exposing herself. She said she would ensure to perform and offer residents hand hygiene to residents going forward. On 9/30/2020 at 3:07 p.m., RN #1 was interviewed, she said she was an agency nurse. She said she did not receive hand hygiene training at the facility. RN #1 said she knew from her experience from haven practiced nursing for several years to wash her hands for 20 seconds when visibly soiled and also to use alcohol based hand rub (ABHR) till it was dry. She added that she was required to perform hand hygiene in between caring for residents, after toilet use, and when in contact with frequently touched surfaces. She agreed she did perform hand hygiene while she performed the activities described above. She said she did not know to perform hand hygiene when she did not make contact with the residents. She acknowledged however, that she had touched door handles when she opened and closed the doors leading into the residents rooms, and that she had held keys and touched her clothes multiple times which had now contaminated her hands and thus, necessitating that she performed hand hygiene. She said she would make amends going forward. Administrative interviews The director of nursing (DON)/ infection preventionist (IP) was interviewed on 9/30/2020 at 2:22 p.m. via telephone (phone number omitted). She went through an overview of the required steps of meal delivery. She said staff must knock on doors, announce themselves, encourage the resident to wear a face mask when staff was present, and ensure the meal card matched the meal and name of the resident to whom the room tray was delivered. The DON said residents should have received hand hygiene at time of meal delivery. She said residents should have been offered hand hygiene or had their hands wiped with sani-wipe to ensure that their hands were clean and free of contaminants when they ate their meal. She said staff should ensure to perform hand hygiene during meal delivery as needed and in-between residents. She said she would relay the concerns to the facility administration to ensure necessary training was provided. She said all residents in the isolation unit had a bin in their rooms for biohazard and a bin for linens. She said the dirty linens were collected in a dissolvable sugarbag. She said there was a bigger biohazard bin in the corner of the hallway which was used whenever laundry needed to be picked up. She said staff used the radio to communicate with the laundry department and informed them that an outside laundry (delineating the laundry was from an isolation unit) was ready for pick up. She said the laundry staff exited the building and walked around to avoid having direct contact with the isolation unit when they picked up the dirty linens from the isolation unit. She said the bags which contained the dirty linens from the isolation sat by the doorway so that laundry staff do not have to go into the isolation unit. She said laundry staff were to wear full personal protective equipment which included a gown, N95 mask, google and gloves. She said all staff caring for residents who tested positive for COVID-19 were to wear N95, face shield/ google, gown and gloves. She said when she called the agency staffer to request for nurses, she let the staffer know and to inform the agency nurse that they had an active case of COVID-19 in the building. She said she was at the facility the week before the survey and she left some N95 for whichever agency staff came in the facility. She said she left instructions with the on floor nurse (did not recall the name) to provide the agency nurse with N95. She said she was unsure whether the nurse acted as instructed. She clarified that seasoned or agency staff were not to wear surgical masks when they cared for residents who tested positive for COVID-19. She said the facility did not maintain a training/ inservices record on COVID-19 for the agency and seasoned nurses who cared for residents on the isolation unit because they wanted to avoid gathering of people in the same room. She said the assistant director of nursing (ADON) who was also the staff development coordinator (SDC) left in July, 2020. She had been unable to keep up with the task. She said nursing staff who worked in the COVID-19 unit should be screening themselves because they left through the back door; outgoing staff should be screening the incoming nursing staff and documenting in the COVID-19 screening form. She said it was important to have a log which recorded the temperatures and other symptoms of nursing staff who accessed the facility to ensure they did not record high on any of parameters which would warrant that the nursing staff be sent back home to prevent infecting or re-infecting residents. She said it was the duty of the nursing home administrator (NHA) to review the visitors checklist for the same reasons stated above. The NHA was interviewed on 10/1/2020 at 9:19 a.m. He said the facility had an abundance of N95 (did not know the exact figure). He said his understanding was that staff who had not been fit tested for N95 were not to use them. He said when nursing staff attended to a resident on isolation based precaution, they wore full PPE (gown, N95 mask, google and gloves). He said nursing staff who do not have N95 masks used the surgical face. He said nursing staff in the isolation unit screened themselves (outgoing shifts screened incoming shift). He said he was not aware that staff have not been following the procedure of having to screen themselves and completing the COVID-19 screening checklists. He acknowledged there was no COVID-19 checklist available in the isolation unit which documented the staff temperature and other required parameters to monitor for COVID-19. He said agency staff accessed PPE at the facility except for N95. He said he thought agency staff came in with their own N95. He said he was not able to guarantee the sanitary status of the N95 brought in by agency staff. He said it was important for staff to use N95 and advise residents to protect their faces when staff provided direct care to prevent staff from infecting residents and vice versa. The NHA was interviewed on 10/1/2020 at 11:44 a.m. He acknowledged he reviewed the visitors COVID-19 checklist. He said the problem with the checklist completed by visitors was that staff who was assigned the duty of screening visitors into the facility was not carefully reviewing to ensure the checklist was completely filled out to include documenting temperatures and answering all the yes and no questions as identified above. He said the consequence of the oversight was the potential of having an exposed person access the facility and infecting residents who were already vulnerable. He said he had been auditing employee COVID-19 checklists but had not audited the visitors checklist until survey. He listed home health, hospice, and oxygen delivery personnel as part the visitors who completed the checklists which were missing the identified information. The NHA said he had no evidence of training for the agency nurses before they were on the floor providing

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 3) care. He said hand hygiene and isolation precaution measures were universal practice which he expected they (agency and seasoned staff) should have known. He acknowledged the four rooms on the isolation unit shared only one alcohol based hand rub (ABHR) dispenser. He said the lack of ABHR dispensers in individual resident rooms contributed to the missed opportunity for hand hygiene. He said his plan going forward was to train seasoned nursing staff and to do away with agency staff.