STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065166	A. BUILDING _____ B. WING _____	08/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FORT COLLINS HEALTH CARE CENTER	1000 S LEMAY AVE FORT COLLINS, CO 80524

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, record review, and interviews the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection such as coronavirus (COVID-19) in three of five halls and one of one smoking area observed for infection control practices. Specifically, the facility failed to: -Ensure proper personal protective equipment (PPE) isolation techniques were followed for new admission/readmission isolation rooms 105, 107, 200, 202, and 204; -Ensure proper hand hygiene and cleaning of face shields/goggles was performed during donning and doffing of PPE; and, -Ensure social distancing was maintained in the facility and the smoking area. Findings include I. Isolation/PPE usage, hand hygiene, and social distancing A. The Centers for Disease Control (CDC) references According to the CDC guidance, Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19, dated 3/20/2020, retrieved online 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. - Face masks should be extended under the chin. - Both your mouth and nose should be protected . Accessed on 8/13/2020. The CDC (2020) Coronavirus Infection Control Recommendations, retrieved from :https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html, revealed in part, Healthcare professionals (HCP) should continue to adhere to Standard and Transmission-Based Precautions, including use of eye protection and/or an N95 or equivalent or higher-level respirator based on anticipated exposures and suspected or confirmed diagnoses. Universal use of a facemask for source control is recommended for HCP. Accessed on 8/13/2020. The CDC (2020) Hand Hygiene, retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/hand-hygiene.html, revealed in part, Hand hygiene is an important part of the U.S. response to the international emergence of COVID-19. [MEDICATION NAME] hand hygiene, which includes the use of alcohol-based hand rub (ABHR) or handwashing, is a simple yet effective way to prevent the spread of pathogens and infections in healthcare settings. CDC recommendations reflect this important role. The exact contribution of hand hygiene to the reduction of direct and indirect spread of coronaviruses between people is currently unknown. However, hand washing mechanically removes pathogens, and laboratory data demonstrate that ABHR formulations in the range of alcohol concentrations recommended by CDC, inactivate [DIAGNOSES REDACTED]-CoV-2. ABHR effectively reduces the number of pathogens that may be present on the hands of healthcare providers after brief interactions with patients or the care environment. The CDC recommends using ABHR with greater than 60% [MEDICATION NAME] or 70% [MEDICATION NAME] in healthcare settings. Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and are effective in the absence of a sink. Accessed on 8/13/2020. According to the CDC guidance Key Strategies to Prepare for COVID-19 in Long-term Care Facilities (LTCFs), last updated 5/12/2020, retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-strategies.html. Enforce social distancing among residents. Ensure all residents wear a cloth face covering for source control whenever they leave their room or are around others .This approach is recommended because of the high risk of unrecognized infection among residents. Recent experience suggests that a substantial proportion of residents could have COVID-19 without reporting symptoms or before symptoms develop. Accessed on 8/13/2020 B. Facility policy and procedure The Infection Prevention Strategies and Guidance for COVID-19 policy and procedure, dated 8/5/2020, provided by the nursing home administrator (NHA) on 8/10/2020 at 1:04 p.m., read in pertinent part: The center should ensure that all staff is using appropriate PPE when they are interacting with residents to the extent PPE is available. Staff should perform hand hygiene, which includes washing hands with soap and water or using an alcohol-based hand sanitizer that contains 60 to 95% alcohol for at least 20 seconds, as appropriate. Conservation strategies should be followed by the center, as necessary, to provide care to the residents and protection for staff. As of May 14 (2020), full PPE is recommended in the following areas: admission units, observation units, and dedicated areas where residents with suspected or confirmed COVID-19 are located. Resident Use of Face Masks When possible, whether COVID-19 symptoms are present or not, residents should cover their nose and mouth whenever staff is in their room. Remind and/or assist residents with frequent hand hygiene and social distancing. How to Re-Use Eye Protection (Goggles and Face Shields) -Perform hand hygiene. -Apply a clean pair of gloves. -Carefully wipe the inside of the face shield or goggles, followed by the outside of the face shield or goggles using a clean cloth saturated with neutral detergent solution or cleaner wipe. -Carefully wipe the outside of the face shield or goggles using a wipe or clean cloth saturated with environmental protection agency (EPA)-registered hospital disinfectant solution. -Utilize cleaning solutions and ensure dwell time is met. -Fully dry (place eye protection on clean paper towel on a clean surface). -Once the face shield or goggles are dry, wipe the outside of face shield or goggles with clean water or alcohol to remove residue. -Remove gloves and perform hand hygiene. C. Manufacturer's instructions Review of the manufacturer's instructions for the Sani-Cloth Germicidal Disinfecting Surface Wipe read in pertinent part: Kills bacteria [MEDICAL CONDITION] within two minutes of surface contact (dwell time). For use on hard surfaces and materials such as stainless steel, plastic, and glass. -Protective gloves should be worn when handling the product. -For the disinfectant wipe to work properly, the surface of the item must be wet for the duration of the specified dwell time. D. Staff education Review of the staff education conducted 7/1, 7/7, 7/16 and 7/28/2020 included COVID use of masks, eye protection, isolation, and social distancing. Not all staff attended the in-services. The infection control preventionist (ICP) was interviewed on 8/11/2020 at 9:30 a.m She said she was unaware of what education the staff had prior to 7/1/2020 before her assuming the role of ICP. She said she had not completed any staff education on proper cleaning of face shields or goggles. E. Observations and staff interviews room [ROOM NUMBER] was observed on 8/10/2020 at 11:12 a.m. There were two residents talking to each other in the doorway. One resident was in the hallway with a mask and the other resident was in the room without a mask. They were talking to each other less than six feet apart. -At 11:21 a.m., certified nurse aide (CNA) #1 was seen preparing to enter isolation room [ROOM NUMBER]. She donned full PPE but did not perform hand hygiene prior to applying gloves. The N95 mask she donned had both straps around her neck which was not on correctly. The resident did not wear a mask while CNA #1 was in the room. -At 11:23 a.m., an unknown nurse was seen in isolation room [ROOM NUMBER] interacting with the resident who was not wearing a mask. -At 11:27 a.m., CNA #1 exited isolation room [ROOM NUMBER], removed the gown at the door and carried it to a bin in the hallway to dispose of it. There were no bins in the resident room to dispose of PPE that had been worn. She did not clean the face shield or perform hand hygiene. She exited the 200 hall, wearing the face shield and walked through the building to the 500 hall where she entered non-isolation room [ROOM NUMBER]. She did not perform hand hygiene before entering the resident's room. -At 11:28 a.m., RN #2 entered resident isolation room [ROOM NUMBER]. She left the residents room without her gloves and gown. She took off her N95 mask and put on her surgical mask. She did not clean her face shield upon exit. -At 11:31 a.m., the social services director (SSD) was observed entering isolation room [ROOM NUMBER]. Before entering the residents room, she was talking on her cell phone while at the isolation cart. She put on her N95 mask and

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) placed her surgical mask into a brown bag. She put her gown on and dropped her phone on the isolation cart. She tied the back of her gown and put on her face shield. No sanitizing was observed throughout this process. -At 11:35 a.m., the SSD was seen exiting isolation room [ROOM NUMBER] wearing a disposable gown. She removed the gown in the hallway and disposed of it in a bin located in the hall. The resident's room did not contain bins for disposal of used PPE. She placed her face shield on top of an isolation cart, with the outside of the shield on the cart. She opened all three drawers of the isolation cart and moved the water pitcher on top of the cart. She obtained her surgical mask from a brown paper bag and placed it on the face shield. She then removed her N95 mask and placed it on the face shield as well before placing it in the paper bag. She then carried the face shield to an isolation cart on the 100 hall and placed it on top of that cart with the outside of the shield lying on the cart. She cleaned it using a disinfectant wipe using her bare hands and waving it in the air. -At 11:41 a.m., CNA #1 was observed entering isolation room [ROOM NUMBER]. She put on a gown and gloves and took the residents clothes into the resident's room. At 11:58 a.m., CNA #1 left the room and pulled her N95 mask off with her whole fist scrunching up the mask. She placed the mask into her pocket. She changed her mask out with her surgical mask. She did not clean her face shield upon exiting the residents room. -At 11:43 a.m., the occupational therapist (OT) was seen in the hallway of the 200 hall wearing a cloth gown. He was preparing to enter isolation room [ROOM NUMBER]. He removed his surgical mask, placed it in a brown paper bag. He swiped his nose with his bare hand, donned an N95 mask and did not perform hand hygiene prior to donning gloves. His face shield was lying on top of an isolation cart. He did not clean the face shield before entering the room and the resident did not wear a mask while the OT worked with him in the room. -At 11:51 a.m., registered nurse (RN) #2 was seen preparing to enter isolation room [ROOM NUMBER]. She donned full PPE and after she donned gloves she picked up the brown paper bag that contained her N95 mask. The bag slipped from her hands and landed on the floor. She picked it up, removed the N95 mask, placed her face shield on top of the isolation cart, applied the N95 mask then the face shield. She did not clean the face shield. At 11:56 a.m., she exited the room wearing the gown and discarded it in the bin in the hallway. She removed the face shield and placed it with the outer surface down, onto the top of the isolation cart. She removed the N95 mask, placed it in the bag and reapplied the face shield. She did not clean the face shield and exited the hall to the 100 hall nurses station. -At 11:59 a.m., the housekeeper (HSK) entered isolation room [ROOM NUMBER] with a mop wearing only a surgical mask and a face shield. The ICP was seen at this time placing droplet isolation signs on the doors of the isolation rooms on the 200 hall. She told the HSK she needed to wear full PPE when entering the isolation rooms. The HSK and the housekeeping supervisor (HKS) were interviewed at 12:00 p.m. immediately after the observation. The HSK said she had no idea the resident in room [ROOM NUMBER] was in isolation. She said the housekeeping staff were usually made aware of any resident in isolation by a sign on the door to their room, but when she entered room [ROOM NUMBER] there was no sign indicating the resident was in isolation. The HKS said the housekeeping department was an outside contracted company and there was a lack of communication between her department and the facility. She said they were not always informed of which residents were in isolation and there was usually an isolation sign on the door. She said her staff were to wear full PPE when entering those rooms. -At 12:02 p.m., the OT exited isolation room [ROOM NUMBER] wearing full PPE. He removed the cloth gown and placed it in a bin in the hallway. He removed his gloves and the face shield. He dispensed a large amount of alcohol based hand rub (ABHR) into the palm of his hand and used his bare hands to apply it to both sides of the face shield. He did not allow the ABHR to dry and placed the shield back on his head. He exited the 200 hall and walked onto the 100 hall to the nurse's station where he removed the face shield and used tissues to dry both sides of it. He then used a disinfectant wipe to clean the shield with his bare hands. He did not allow the shield to dry before placing it back on his head. -At 12:08 p.m., the resident in isolation room [ROOM NUMBER] was seen halfway out of her doorway approximately two feet conversing with a therapist, she was not wearing a mask. -From 12:13 p.m. to 12:22 p.m., CNA #1 was seen delivering lunch trays to the isolation rooms on the 100 and 200 halls. She did not perform hand hygiene, don gloves and removed her surgical mask and placed it in a pocket of her uniform. She retrieved her N95 mask from another pocket, applied it with both straps around her neck which was incorrectly applied and entered the isolation rooms repeating the same process at each room. When exiting the rooms she removed the N95 mask, placed it in a pocket of her uniform top or pants and reapplied the surgical mask that she kept in another pocket. She did not perform hand hygiene or clean her face shield after delivering the meals to the rooms. When she delivered the lunch meal to room [ROOM NUMBER] she placed the food containers on top of the isolation cart outside his room. She did not perform hand hygiene or wear gloves and entered the room touching the resident's wheelchair and his arm to assist him into the wheelchair. She did not perform hand hygiene or clean the face shield when she exited the room and hall to deliver room [ROOM NUMBER]s meal. -At 12:34 p.m., CNA #1 removed her required N95 mask inside isolation room [ROOM NUMBER] and placed it in a pocket of her uniform. She applied her surgical mask that she obtained from a pocket of her uniform. She did not perform hand hygiene or clean her face shield and walked down the hall into non-isolation room [ROOM NUMBER]. -At 1:37 p.m., the smoking area with two residents observed in wheelchairs sitting next to the divider wall and walkway not weaing masks. They were sitting next to each other less than six feet apart. -At 1:45 p.m., CNA #2 approached isolation room [ROOM NUMBER] to escort him to the smoking area. She was carrying a metal box that contained smoking materials. She did not don PPE other than her surgical mask and goggles. The resident was wearing a cloth gown and a cloth mask that was below his nose. She did not have the resident perform hand hygiene. She placed the metal box on his lap while she pushed his wheelchair outside. When they got out to the smoking area there were two other residents and another staff member. One of the residents did not practice social distancing, he would approach staff and residents randomly with his mask off of his face. CNA #2 sat next to the resident while he smoked. CNA #2 escorted the resident back inside at 2:04 p.m. and again placed the metal box on his lap. She nor the resident performed hand hygiene prior to reentering the building. When he arrived at his room she retrieved the box from him and placed it under her arm and exited the hall. She did not perform hand hygiene or clean the box. CNA #2 said she was unaware of the process she needed to follow when an isolation resident was escorted to the smoking area. The NHA was interviewed at 3:10 p.m. She said when a resident was admitted or readmitted from the hospital they were quarantined for the required 14 days. If they were a smoker they were to be offered cessation products and if they insisted on smoking, the resident and the staff member, escorting them to the smoking area, were to wear full PPE and were to be the only ones in the smoking area at the time. She said the resident should perform hand hygiene when leaving their room and when reentering the building. -At 2:13 p.m., the resident in isolation room [ROOM NUMBER] exited his room in his wheelchair wearing a cloth gown and a cloth mask that was below his nose in the hallway. He propelled himself off the 200 hall and down the 100 hall. The OT passed him in the hallway, spoke to him and walked on. The therapy program manager (TPM) approached him. She was wearing a surgical mask and a face shield. She talked with him and escorted him to the SSD's office. She did not perform hand hygiene or don gloves before touching the handles of his wheelchair. At 2:16 p.m., the SSD escorted the resident into her office, pushing his wheelchair with her bare hands. She did not don any PPE other than her surgical mask and face shield. After the resident was inside her office, she shut the door. -At 2:30 p.m., the speech therapist (ST) exited an isolation room on the 200 hall and placed her goggles on top of an isolation cart. She used her bare hands to clean them with an alcohol prep pad, wiping the outside then the inside of the goggles and placing them back on the unprotected surface of the isolation cart. -At 2:38 p.m., the physical therapist (PT) exited isolation room [ROOM NUMBER] wearing a cloth gown, gloves, an N95 mask, and a face shield. He disposed of the gown he was wearing in a bin in the hallway. He cleaned the face shield with a disinfecting wipe and waved it in the air then hung it on a clip that held the brown paper bags of N95 masks. He retrieved his surgical mask that he had clipped with the paper bags. -At 3:25 p.m., three residents in wheelchairs were observed in the smoking area seated approximately a foot apart, they were not wearing masks as they were smoked and conversed. -At 3:28 p.m., the ST had exited isolation room [ROOM NUMBER] wearing full PPE. She disposed of the gown and gloves in the bin in the hallway. She placed her goggles on top of an isolation cart. She did not perform hand hygiene, removed the N95 mask and applied her surgical mask. She used the same disinfecting wipe to clean her goggles and ink pen. The wipe fell on top of the isolation cart and she picked it up and continued to clean the goggles with it and then placed the goggles back on the unprotected surface of the cart before placing them on her face. -At 3:35 p.m., the PT exited isolation room [ROOM NUMBER] wearing full PPE. The top strap of his N95 mask was broken and caused the mask to gape on his face. He doffed the used PPE and discarded it in the bin in the hallway. He cleaned the face shield and waved it in the air and did not leave it wet for the recommended two minute dwell (surface contact) time of the wipe. He had again clipped his surgical mask on the string that held the paper bags prior to entering the isolation room. On 8/11/2020 at 8:17 a.m., the SSD exited isolation room [ROOM NUMBER] wearing full PPE. She disposed of the PPE the bins in the hallway. She removed the face shield, exited the hall onto the 100 hall. She placed her face shield on top of the isolation cart outside room [ROOM NUMBER] with the outside of the shield down. She swiped both sides of the shield with a

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