STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065221	A. BUILDING _____ B. WING _____	04/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SPRING CREEK HEALTH CARE CENTER	1000 E STUART ST FORT COLLINS, CO 80525

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.** Based on observations, staff interviews and record review the facility failed to properly prevent the potential spread and transmission of COVID-19 throughout the facility. Specifically, the facility failed to: - Ensure housekeeping staff were educated on proper hand hygiene; - Ensure staff were educated on the proper use of personal protective equipment (PPE) including the proper use of gloves when working with residents on isolation; - Ensure activity staff provided snacks in a manner that ensured the risk of infection was minimized; - Ensure communal activities, to include bingo and a parachute activity, were discontinued to minimize the risk of infection; and - Ensure unsupervised smokers followed social distance guidelines. Findings include: I. Education related to proper use of personal protective equipment Staff interviews The environmental services director (ESD) was interviewed on 4/9/2020 at 10:00 a.m. He stated he began his job approximately a month prior and the previous director would have completed the hand washing training for the staff. He said he had not performed staff education for hand washing. Housekeeper (HSK) #1 was interviewed on 4/9/2020 at 10:10a.m. with the ESD. She stated she had worked in housekeeping a long time and did not need hand washing training. Record review The housekeeping handwashing in-services records were reviewed and revealed, the last hand washing in services were performed on 12/4/2019 and 10/18/2019. II. Staff were educated on the use of PPE while providing cares for residents on isolation Observation On 4/9/2020 at approximately 9:30 a.m. the 600 hall was observed. There were six isolation carts outside of rooms. There were no gloves in any of the six isolation carts. Staff interviews On 4/9/2020 at 11:30 a.m. the infection control preventionist (ICP) reported she would not keep gloves on any cart because staff would take too many and she was afraid she would run out. Certified nurse aide (CNA) #1 said she would go to the nurses' station if she needed gloves. She said they were kept there and staff were to get them from the locked room at the nurses' station. CNA #1 said she would keep them in her pocket and pulled one out of her pocket to demonstrate. Licensed practical nurse (LPN) #1 said she brought her own gloves; however, she said she knew some of the rooms had gloves inside the rooms and occasionally, she said she would put her mask and gown on and enter the room to get gloves. Facility follow-up An email was received from the nursing home administrator(NHA) and the ICP on 4/10/2020. It read in pertinent part: We have had gloves on back order since mid March and did not come in until the end of month delivery. Now all orders have to be approved by the corporate office to order PPE. Staff have not been instructed to put gloves in their pockets. We have reeducated them on this practice. With the threat of PPE shortage we will set up glove stations for the units where gloves will be more easily accessible for each unit but still be easily accountable and able to be tracked. III. Provision of snacks from the activity director (AD) and activity assistant (AA) Observation and staff interviews On 4/9/2020 at 11:00a.m. the AD and AA were observed pushing a food cart with boxes of donuts down the hallway coming from the kitchen. The AD and AA had gloves on; while walking down the hall they stopped at resident rooms to offer each resident a donut. Resident's hands were not washed or offered any sanitizer prior to receiving a donut from the activity staff. On 4/9/20 at approximately 11:02 a.m. the nursing home administrator (NHA) was standing in the hall and called out to the AD and AA and said he would give them a bottle of hand sanitizer to offer to residents so they use hand sanitizer prior to receiving food. He was observed handing the AD a bottle of hand sanitizer which they placed on their cart. AD and AA were interviewed on 4/9/2020 at 11:20 a.m. Both stated they did not know they should sanitize the resident's hands prior to giving them donuts and said up to this point they had never heard that information. The AD said we give the residents soda daily and other snacks and have not done this until now. AD and AA were interviewed on 4/9/2020 at 11:25 a.m. The AD stated she had been conducting bingo in the dining room with only one resident at each table but was not conducting hallway bingo. The AD stated she had been conducting the parachute game with five residents in the communal area. She stated on 4/14/2020 there would be a group resident council in the dining room with 10 people. On 4/16/2020 at 12:40 p.m. during an online interview the NHA confirmed the resident council meeting did take place. IV. Failure to follow social distancing guidelines Observations On 4/9/2020 at 11:00 a.m. six residents were observed through the dining room windows sitting in the communal outdoor smoking area. The residents were talking together as they smoked. Two residents were standing 3-4 apart from one another as they talked and smoked together. One resident was in their wheelchair and another was standing 2 to the side as both smoked. There were two men sitting together on a park bench who had opposite shoulders and knees touching one another as they smoked. The residents were not observing social distancing as they smoked. There was no intervention by staff for social distancing reminders. Resident #1 and Resident #2 were interviewed on 4/9/2020 at 11:10a.m. Resident #1 and #2 were smoking and they were seated together on a park bench in the smoking area along with four other residents. Resident #1 stated staff told him about social distancing but he did not remember what they told him. Resident #2 did not remember any instructions from staff on social distancing. The health information manager (HIM) was interviewed on 4/9/20 at 11:10 a.m. She said that she had been educated on social distancing and knew that when she saw residents in the smoking area sitting too close they should be reminded of the importance of social distancing.

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.