STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065322	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JULIA TEMPLE HEALTHCARE CENTER	3401 S LAFAYETTE ST ENGLEWOOD, CO 80113

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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 observation, interviews and record review, the facility failed to ensure infection control procedures were followed to prevent the possible cross-contamination of Coronavirus disease (COVID-19) during resident room cleaning, and proper infection control procedures during resident communication and meal service. Specifically, the facility failed to ensure: -Follow proper protocol for use of personal protection to ensure compliance with recommended standards for respiratory hygiene and cough etiquette were provided to residents; -Proper infection control procedures were followed to prevent cross-contamination during resident room cleaning by housekeepers; -Followed social distancing; and -Staff performed hand hygiene during snack service. Findings include: I. Face masks use A. Professional reference The Center for Disease Control (2020), Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings , retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html. It read in pertinent part, 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-health care personnel, visitors) enter the room. Screening for symptoms and appropriate triage, evaluation, and isolation of individuals who report symptoms should still occur. B. Observation 1. Sage unit On 6/30/2020 at 11:45 a.m., 11 residents were observed out of their rooms and co-mingling in the hallway of the Sage unit (secured unit). The residents were not wearing face masks and did not observe the recommended six feet for social distancing. Facility staff did not offer to/encourage all 11 residents to maintain social distance. 2. Larkspur Unit 6/30/2020 --At 11:35 a.m., observations of the common area showed approximately 17 of the residents were not wearing masks.The residents were not encouraged to wear a mask. --At 11:39 a.m., the residents were not encouraged to social distance from each other.The residents were sitting on the sofas right next to each other. Some residents were holding hands. --At 11:46 a.m., the residents were assisted to the dining room for lunch. --At 11:55 a.m., a male and a female resident were observed about three feet from each other at the table and eating their lunch.They were not encouraged to social distance from each other. --At 11:59 a.m., a staff member passed out Fingerbowl moist hand wipes to each resident. --At 12:05 p.m., the residents were not aided to use the hand wipes before the meal. --At 12:20 p.m., an unidentified certified nurse aide (CNA) moved around to different tables in the dining room and offered eating assistance to different residents.The CNA wore the same gloves in between each resident and did not do hand hygiene. Record Review According to the material safety data sheets (MSDS) submitted by the dining service manager (DSM) on 7/1/2020 at 3:00 p.m.,the moist towelettes given to the residents had a main ingredient of 90-100 % water and a mild soap product. There was no alcohol base in the wipes. 3. [MEDICATION NAME] Unit 6/30/2020 --At 12:30 p.m.,15 residents were sitting right next to each other in the common area around the television. They were not wearing masks or encouraged to wear masks. Some of the residents were holding hands. --At 12:40 p.m.,three residents walked up to some of the other residents and touched them. The staff did not encourage residents to use social distancing.--At 12:50 p.m., an unidentified resident walked around the unit and got within two or three inches of other residents' faces. C. Interview and observation The certified nurse aide (CNA) #2 was interviewed on 6/30/2020 at 1:02 p.m She said she had been trained on the need to use face masks when in and about the facility and especially when in close contact with residents. She said she was not made aware or received any training to offer face masks to residents. She said many of the residents on the Sage unit were known to refuse face masks in the past and she was not trained to offer the residents masks to wear. She was observed as she offered face masks to all the residents after the interview was conducted , and the residents accepted the face mask and appreciated the offer. D. Additional staff interviews CNA #3 was interviewed on 6/30/2020 at 1:15 p.m. She said she was not made aware the residents needed a face covering when they were out of their rooms. She said she would ensure to offer face masks to the residents going forward. Certified nurse aide #1(CNA#1) was interviewed on 7/1/2020 at 3:50 p.m. He said he had been working at the facility for five years. He included that the residents were supposed to wear masks when they were out of their rooms. He indicated that the residents always refused the masks and would take them off. He offered that social distancing was not possible with this population of residents because they could not understand the direction nor comply. He was not aware of any interventions used for the residents when they refused to wear the mask. He stated that the staff had to perform hand hygiene for the residents because they could not do it on their own. The assistant director of nursing (ADON) was interviewed on 7/1/2020 at 4:07 p.m She said the Sage unit housed many residents who have cognitive impairment. She said it was a struggle getting the residents to wear face coverings. She said the staff would be trained on the need to keep redirecting, re-offering and encouraging residents to wear their masks going forward. II. Residents room cleaning A. Professional reference The Center for Disease Control and Prevention (2020) Environmental Cleaning Procedures-Best Practices for Environmental Cleaning in Healthcare Facilities, retrieved from: https://www.cdc.gov/hai/prevent/resource-limited/cleaning-procedures.html It read in pertinent part, Clean patient areas and patient zones before patient toilets. Follow proper procedures for effective uses of mops, cloths, and solutions. According to the Colorado Department of Public Health and Environment COVID-19 Preparation and Rapid Response Checklist for Long Term Care Facilities (LTCF's) (2020) Environmental Cleaning and Disinfection, retrieved from: https://COVID19.colorado.gov/ltcf, read in pertinent part, Validate environmental services staff members ' processes (1) Follow label instructions on the hospital grade disinfectant; (2) Validate disinfection procedures. B. Disinfectant product information According to Using Cloroxpro clorox germicidal bleach against [DIAGNOSES REDACTED]-CoV-2 provided by the housekeeping manager (HKM) on 7/1/2020 at 3:36 p.m. the instructions for use of, product name above, documented contact time to kill [DIAGNOSES REDACTED]-CoV-2 as five minutes. C. Observation 1. Sage Unit On 6/30/2020 at approximately 11:52 a.m. Housekeeper (HK) #3 was observed as she cleaned rooms #308 and #309 on the Sage unit. She entered room [ROOM NUMBER] which was a double-occupancy resident room. Both residents were served room trays and were eating at the time of the observation. HK #3 had sanitized her hands and donned gloves. She wiped down the surfaces on each resident's side of the room using the same cleaning cloths, she then retrieved a dust mop from the cleaning cart in the hallway. HK #3 dust mopped the floor, starting in the bathroom, then the bedroom areas, swept the dust and particles from the floor to the doorway, used a dustpan to pick up the debris, emptied the dustpan into the trash on her cart, and returned the dust mop to the cart. HK #3 then retrieved a wet mop with a replaceable cleaning cover from the cart and mopped the residents' bathroom floor. She removed the cover from the mop head that she had just used to mop the bathroom floor, touching the soiled surface with her gloved hands, returned the mop cover to her cart, got a cleaning cloth, and wiped down the bedside tables which had the residents' noon meals sitting on them. As she wiped down the table, she picked up and replaced the residents water pitcher, disposable food packs, glass of apple juice and a small carton of supplement with a straw inside. After cleaning and mopping the rest of the residents' room, HK #3 returned to the cleaning cart in the hallway, disposed of her gloves, sanitized her hands and donned new gloves, and moved towards room [ROOM NUMBER]. During the cleaning process, HK #3 had worn the same pair of gloves to clean the entire room, potentially cross-contaminating the residents' room with her soiled gloves after handling the mop cover used on the bathroom floor. By dust-mopping the entire floor starting in the

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) bathroom, she had potentially cross-contaminated the flooring in the residents' bedroom area with whatever might have been on the bathroom floor. In addition, by touching the residents food packs, cups and juice cans, she had potentially cross contaminated the residents meals with whatever contaminant that was retained on her soiled gloves. While in room [ROOM NUMBER], HK #3 knocked on the bathroom door and was alerted to the presence of a resident in the toilet. She then proceeded to spray a Clorox liquid solution onto the washing hand basin and immediately wiped it off. She left the room to take some mop heads from her cleaning cart which she parked at approximately 10 feet away from the room. She retrieved three mop heads which sat in a bucket containing Clorox liquid solution. The mop heads dripped across the hallway from the liquid they were sitting in as they were transferred with HK #3 bare hands. After she was done cleaning the toilet and the residents room, She took the mop heads that were contaminated, and without bagging them, she walked several feet the hallway to place the mop heads in her cart. The mop heads had remnant from the liquid solution that had dripped across the hallway as she returned them to her cleaning cart. At the time, several residents were in the hallway were exposed to whatever contaminant that was dripping from the unbagged mop heads. 2. [MEDICATION NAME] Unit Observation --At 12:53 p.m., housekeeper #2 (Hk#2) moved her cleaning cart up to room [ROOM NUMBER] --At 12:55 p.m., HK #2 took a spray bottle and a toilet brush from the cleaning cart and entered room [ROOM NUMBER]. --At 12:56p.m., HK #2 sprayed the toilet and sink area in the bathroom. --At 12:57 p.m., HK #2 changed her gloves, however, she failed to perform hand hygiene prior to donning a clean pair of gloves. --At 12:58 p.m., HK #2 took the broom from the cleaning cart and swept the residents room. --At 1:02 p.m., HK #2 finished sweeping the room and returned the broom to the cart. --At 1:04 p.m., HK#2 changed her gloves, however, she failed to perform hand hygiene. --At 1:06 p.m., HK #2 took a clean rag from the cart and dipped it in a cleaning solution. --At 1:07 p.m., HK #2 wiped down the tables and the door handles in the residents room. --At 1:08 p.m., HK #2 used the same rag to wipe off the toilet and sink area in the bathroom. --At 1:09 p.m., HK #2 took off her gloves. She did not perform hand hygiene. She put on new gloves. --At 1:10 p.m., HK #2 dipped a clean mop head into the cleaning solution and then placed it on the end of the mop handle. --At 1:11 p.m., HK #2 mopped the bathroom floor. --At 1:13 p.m., HK #2 changed the mop head and replaced it with a clean one. She failed to perform hand hygiene. --At 1:15 p.m., HK #2 mopped the rest of the residents' room. --At 1: 17 p.m., HK #2 took the used mophead and placed it in a bag on the cart. --At 1: 18 p.m., HK#2 took off her gloves. She did not perform hand hygiene. D. Interview HK #3 was interviewed on 6/30/2020 at 1:14 p.m. She said she did not know to wait until residents were done eating before cleaning their room. She said I guess it ' s a common sense situation, I will take that into consideration going forward. She said she had no idea what the contact time was for the disinfectant she was using. She said her cleaning cart was parked approximately 10 feet away from the the room (#308) because she was trying to leave enough room for the residents who liked to wander around. She said she would make sure to have her cart by the door way going forward. She said she should have bagged the contaminated mop heads before taking it out and allowing it to drip all over the hallway. Housekeeper #1 (HK#1) was interviewed on 7/1/2020 at 3:10 p.m. She said she received her infection control training from the housekeeping manager (HKM). She said some of her training was done on the computer, some of the training was done in person with her supervisor. She indicated that the facility had a new product called Oxivir tb which had a dwell time of one minute on surfaces. She included the spray comet cleaner was used for the bathrooms and it had a dwell time of 10 minutes. She said the hand hygiene protocol for cleaning a room was to change gloves in between cleaning tasks and perform hand hygiene. The HKM was interviewed on 7/1/2020 at 3:15 p.m He said housekeeping staff were last trained on cleaning procedures approximately one month ago. He said the housekeeping staff should start cleaning from the cleanest areas to dirtiest areas, and use different rags to clean each resident's area and the entire room He said, Not following the proper cleaning procedures, touching residents' personal belongings with contaminated gloves and not using the cleaning products correctly can increase the spread of infections. The HKM said that not following the manufacturer's recommended dwell time may not provide appropriate disinfection.The HKM stated the housekeeping staff should always have the cleaning carts by the door of the room being cleaned. He said he would provide more training with the housekeepers going forward. The HKM said he expected the housekeepers to change their gloves in between each cleaning task and perform hand hygiene. He included the staff received monthly training on infection control which included hand hygiene. He said all the high touch areas in the facility were sanitized daily. III. Hand hygiene A. Professional reference The Centers for Disease and Prevention (2020) Hand Hygiene in Healthcare Settings, retrieved from:https://www.cdc.gov/handhygiene/providers/index.html. It included the following recommendations, 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 1. Sage unit On 7/1/2020 at 2:19 p.m. CNA #4 was observed as he served snacks to the residents on the Sage unit. The snacks offered were finger foods like cookies, peanut butter and jelly sandwiches. CNA #4 started serving in room [ROOM NUMBER] of the unit. Prior to going into the room, CNA #4 was observed as he removed a pair of gloves from his pocket, he did not perform hand hygiene before donning the gloves. He proceeded to open the room door and served snacks to the residents occupying the room. Before serving the snacks to the residents, CNA #4 did not offer handwashing or any type of hand hygiene to the residents. CNA #4 proceeded to room [ROOM NUMBER] after leaving room [ROOM NUMBER], he had doffed his gloves and was no longer wearing gloves when he went into room [ROOM NUMBER]. While in front of room [ROOM NUMBER], CNA #4 took the snacks from the tray which sat on a cart, opened the resident ' s door, greeted the residents, placed the snacks on the table and left the room. CNA #4 did not offer hand hygiene to the residents in the room and did not perform hand hygiene after leaving the room. CNA #4 was observed as he repeated the sequence explained above in rooms #313, #317 and #320. CNA #4 was observed as he served snacks to 13 other residents who sat across the hallway of the Sage unit. The residents had touched their chair arm rests and surrounding surfaces and objects such as books, dolls, seating surfaces In addition, three of the residents who propelled themselves on a wheelchair and had made contact with the wheels which had been potentially contaminated by the surrounding floor were served the snacks without being offered hand hygiene. CNA #4 also did not perform hand hygiene between serving the residents. 2. Larkspur unit 7/1/2020 --At 2:20 p.m., observations revealed that 10 residents sat on the sofas in the common area. --At 2:22 p.m., the residents were not encouraged to wear masks. --At 2:25 p.m., the residents sat next to each other on the sofas. --At 2:28p.m., the residents were not encouraged to social distance. --At 2:30 p.m., staff passed out snacks to the residents in the common area. --At 2: 35 p.m., the residents were not offered hand hygiene before they were given the snack. B. [MEDICATION NAME] Unit --At 2:43 p.m., snacks were passed to the residents in the common area. The residents were not offered hand hygiene. C. Interview CNA #4 was interviewed on 7/1/2020 at 2:37 p.m. He said after the regular noon meal service, he served nourishments in the form of drinks and snacks to the residents. He said when he served the drinks and snacks to the residents, he would ensure residents were sitting upright and then he would ask the residents their preference of drinks and snacks. He said he would sanitize or offer hand hygiene to the residents prior to serving them and that he would perform hand hygiene on the way out. He agreed he did not perform hand hygiene prior to serving the snacks, after doffing his gloves, and in-between residents (see observations above). He said he will ensure to perform hand hygiene when serving nourishments and offer residents hand hygiene going forward. Registered nurse (RN) #1 was interviewed on 7/1/2020 at 2:53 p.m. He reported an overview of the required steps of meal delivery. He said the steps were: staff must knock on doors, announce themselves, encourage the resident to wear a face mask when staff were present and ensure the meal card matched the meal and name of the resident delivered. RN #1 did not include resident hand hygiene when reviewing the meal delivery steps. He said the residents should have received hand hygiene, at time of meal delivery. He said residents should have been offered hand hygiene at meal delivery to ensure that their hands were clean and free of contaminants when they ate their meal. He said staff should ensure to perform hand hygiene at every step of meal delivery and in-between residents. He said he would relay the concerns to the facility administration to ensure necessary training was provided.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) The dining service manager (DSM) was interviewed on 7/1/2020 at 2:55 p.m. She said the towelette wipes were not used very often for the residents to do hand hygiene. She included she was just using the wipes until the supply had run out.She said the hand wipes contained a mild soap solution and no alcohol ingredients. She said the hand hygiene for the residents should be done with a wet towel and soap and water.She offered the residents from the [MEDICATION NAME] and Larkspur units needed assistance to wash their hands. The ADON was interviewed on 7/1/2020 at 4:07 p.m She said hand hygiene must be conducted before resident meals. She said hand hygiene was offered differently to residents based on their cognition. She said nursing staff was required to either utilize wash cloths or hand sanitizer. She said staff had all been trained to offer hand hygiene at time of meal delivery to ensure residents ate their meal with clean hands to decrease the risk of infections. She added that staff should perform hand hygiene when delivering meals to the residents. She said staff should not store gloves in their pockets because of the risk of contamination. She said gloves should be retrieved from the glove box at all times. She said she would provide increased training to staff on hand hygiene and glove use.