| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065266 | A. BUILDING _____ B. WING _____ | 07/01/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| GARDEN TERRACE ALZHEIMER'S CENTER OF EXCELLENCE | 1600 S POTOMAC ST AURORA, CO 80012 |

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) |
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| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observations, record review and interviews, the facility failed to maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections, including COVID-19. Specifically, the facility failed to: -Ensure staff used appropriate personal protective equipment (PPE) when working with newly admitted residents with an unknown infection status for COVID-19; -Ensure quarantined residents practiced social distancing and did not congregate in common areas; -Encourage quarantined residents to use source control measures when receiving care; and, -Consistently collect staff and visitor screening information prior to allowing entrance to the facility. Findings include: I. Infection prevention A. Professional standards According to the Centers for Disease Control and Prevention (CDC) Preparing for COVID-19 in Nursing Homes, revised 6/25/2020, retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, .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 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 . According to the CDC's Preparing for COVID-19 in Nursing Homes, revised 6/25/2020, retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-strategies.html .Ensure all residents wear a cloth face covering for source control whenever they leave their room .Implement aggressive social distancing measures (remain at least 6 feet apart from others .Remind residents to practice social distancing, wear a cloth face covering (if tolerated, and perform hand hygiene . B. Facility policies The facility policy for Coronavirus (COVID-19) ([DIAGNOSES REDACTED]-CoV-2), last revised 6/25/2020, revealed: -Residents under isolation precautions will need to be served meals in their rooms. -All residents should be encouraged to stay in their rooms and if a resident needs to leave his or her room for any reason, the resident should wear a cloth face covering or a face mask if tolerated. -Residents in yellow status (in this case, those under observation for symptoms following admission to the facility) undergo 14 days observation before being transferred to the COVID-19 negative areas of the facility. All recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of an N95 or higher level respirator .eye protection (i.e. googles or a disposable face shield .), gloves and gown. C. Observations 6/29/2020 The quarantine unit for new admissions was observed at approximately 5:00 p.m. There were six residents seated in a common area outside of the nurses' station. Clinical staff in the area were observed to wear N95/KN95 respirators with no other per PPE. The residents were seated at least six feet apart and wore masks. Resident #5 was seated in a wheelchair next to a bench in the common area. He became restless as he waited for dinner to be served. An unidentified certified nurse aide (CNA) helped the resident to his feet and, with the use of a gait belt, began walking the resident up and down the hall. The CNA wore an N95/KN95 respirator but did not have on other PPE, including goggles. The CNA stopped Resident #5 to help him reposition his mask that had slipped below his chin. Resident #5 spoke directly into the CNA's face that was only several inches away as she helped him with the mask. The CNA did not wash or sanitize her hands as she continued to ambulate the resident. Resident #5 was returned to his wheelchair and each of the six residents were served meals while seated in the common area. 6/30/2020 Another observation of the quarantine unit was completed at 12:15 p.m. Staff continued to wear N95/KN95 respirators only as care was provided to residents in the common area. Resident #4 was seated on a small bench and Resident #5 was positioned in his wheelchair. Each resident wore a mask, however, Resident #5's mask had slid underneath his chin. The two were within two feet of each other as they talked while waiting for the lunch meal to arrive. Several staff were in the area but did not immediately redirect the two to follow social distancing guidelines while having properly adjusted masks. Eight minutes later, LPN #2 and a CNA prompted the two residents to be seated a safe distance apart. The CNA, who was wearing only an N95/KN95 helped Resident #5 physically adjust his mask. Registered nurse (RN) #1 said all of the residents on the unit were newly admitted to the facility. He said the COVID-19 status of the residents was unknown At 5:15 p.m., six residents were seated in the common area outside of the nurses' station on the quarantine unit. Resident #5 was seated in his wheelchair, within several feet of the entrance way to Resident #10's room. Resident #10 moved his wheelchair to the entrance to the room and was not wearing a mask. Resident #5's mask had slipped below his chin as he asked questions and spoke with staff and other residents alike. Staff at the nurses' station responded to Resident #1 who was seated nearby but did not prompt Resident #5 or Resident #10 to practice safe social distancing and did not remind them to wear or adjust their masks. When the meal was served, Resident #5 and Resident #10 ate their meals while being seated within several feet of each other. 7/1/2020 Between 9 a.m. and 9:15 a.m., Resident #5 attempted to rise from his wheelchair several times. CNA #4, who was wearing an N95/KN95 respirator and goggles, retrieved a gait belt and began ambulating with Resident #5. CNA #4 and Resident #5. Resident #7 was seated in a wheelchair on the other side of the bench from where Resident #5 was previously positioned. Resident #7 was wearing an oxygen cannula and the mask he wore had slipped under his chin. On two occasions, Resident #7 was observed to cough as CNA #4 and Resident #5 passed within two feet. D. Interviews Registered nurse (RN) #1 and LPN #2 were interviewed on 6/30/2020 at 12:25 p.m. The RN said the COVID-19 status of each resident on the unit was unknown because they were newly admitted to the facility. He and LPN #2 found COVID-19 tests for a few of the residents that were completed at the hospital prior to admission. RN #1 acknowledged the tests did not resolve the resident's COVID-19 status because they were completed five to seven days before admission. LPN #2 said it was difficult to keep the residents on the unit apart or to have them wear masks because they had dementia. The LPN said, because the residents were newly admitted , staff had to treat them as if they were infected. The RN said staff wore N95 respirators at all times. He said staff don faceshields, gowns and gloves when providing care in resident rooms. He said residents being repositioned, assisted with eating or having their masks/oxygen repositioned could be considered care and was being done in the common area as well. CNA #4 was interviewed on 7/1/2020 at 9:12 a.m. The CNA said staff started wearing goggles, in addition to their respirator when providing care, yesterday (6/30/2020). She said gowns, face shields and gloves were used for care such as hygiene, toileting and dressing, provided in resident rooms. The nursing home administrator (NHA) and director of nursing (DON) were interviewed on 7/1/2020 at 10 a.m. The NHA said he believed facility policy was in line with CDC (and other professional) requirements. The NHA said, based on a review of admission guidance and facility policy, staff needed re-education to ensure PPE was being used appropriately in the quarantine unit. The NHA said staff should use full PPE when providing care (such as transferring, repositioning, feeding, masks and oxygen) and agreed care was being provided in the common area. The NHA said residents should be encouraged to use masks or other means of source control and should practice safe social distancing of at least six feet. The NHA said, he did recognize the importance of strategies such as resident engagement in order to keep residents with cognitive impairment at a safe distance from each other within a limited space. III. Screening A. Professional standards According to the CDC Interim |

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<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 1)<br>Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings, last revised 4/12/2020, retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html Screen all healthcare personnel (HCP) at the beginning of their shift for fever and symptoms consistent with COVID-19. Actively take their temperature and document absence of symptoms consistent with COVID-19. If they are ill, have them keep their cloth face covering or facemask on and leave the workplace. According to the CDPHE COVID-19 Preparation and Rapid Response Checklist for Long Term Care Facilities, updated 5/13/2020, Restrict all volunteers and non-essential healthcare personnel from entering the facility .All essential visitors must be screened when entering the building, to include fever, any respiratory symptoms or other symptoms of infection, and potential exposure to COVID-19. B. Facility policy The Infection Prevention and Control policy related to Visitors, Vendors, and Contractors During Outbreak and/or Pandemic, revised 4/20/20, revealed: All visitors, vendors, and contractors will be screened for COVID-19 symptoms in accordance with CDC, CMS and local and state guidelines. This screening will include a temperature check. C. Observation On 6/30/2020 at 2:00 p.m., the social services assistant (SSA) was observed screening staff as they entered the building for the afternoon/evening shift. The SSA measured and documented the temperature of one particular staff member and allowed her to pass into the building without screening for other symptoms consistent with COVID-19. The SSA did not ask the staff about being symptomatic and did not document having visually inspected the staff for symptoms. D. Record review A review of employee and visitor screening logs for June 2020 revealed: -The temperature of the central supply clerk was not recorded prior to starting work on 6/5/2020 and 6/22/2020. -On 6/13/2020 a visitor from a hospice agency was screened through the main entrance. The temperature of the visitor was not recorded. -On 6/19/2020 four visitors entered through the main entrance. The temperature of one of the visitors was not recorded. The name of the screener or the reason for the visit for each of the four visitors was also not recorded. Two of the entries were not dated, did not include a symptom/contact screen but were written in the same handwriting as the other two entries (verified with the administrator in training). A suggested reason for the visit was written next to one of the names as deliver. E. Interviews The SSA was interviewed on 6/30/20 at 11:49 a.m. The SSA said she was responsible to screen staff from 9 a.m. to 5 p.m. two days per week. She said the process she was trained to follow included meeting staff at the back entrance (employee entrance) for screening. She was supposed to remind staff to sanitize their hands and then take their temperature. The SSA said she was supposed to ask questions listed on the sheet and record the temperature measurement and question answers on the screening log. She said each staff have their own sheet that is kept in a binder. The SSA said she was supposed to notify administration if anyone had a temperature over 100 degrees. She said staff temperatures were also measured when coming off duty as well. The day receptionist was interviewed on 6/30/2020 at 2:33 p.m. She said she was responsible for screening anyone coming through the front entrance Monday through Friday. The day receptionist said everyone received training to screen from the administrator in training (AIT). She said visitors to the facility were limited and included state health surveyors, hospice/[MEDICATION NAME] care staff, suppliers, laboratory and x-ray technicians and physicians. The day receptionist said screeners were supposed to record everyone's temperature and answers to the screening questions on the screening log. The DON was interviewed on 6/30/2020 at 4:53 p.m. The DON said the AIT was responsible for providing oversight for the screening process and logs. She said she was usually at the facility during the day to deal with issues and was available for the night supervisor to call and discuss abnormal screenings such as temperature measurements above 99.5 degrees. She said the staff and visitor screening logs should be completed entirely without omissions. The DON said she followed up with staff whenever she discovered any missing information. The DON said all visitors/vendors should be screened even though they were not coming all the way into the building. The AIT was interviewed 6/30/20 at 5:22 p.m. The AIT said the facility recognized the screening process needed to be followed more closely when there was an outbreak of COVID-19 in April 2020. The AIT said there was someone available to screen staff and visitors entering the building between 5:30 a.m. and 11 p.m. She said there were a number of staff designated to do screening during various time slots. The AIT said she did daily audits of the screening logs. She said a time clock report was sent each day that she compared to the screening logs. The AIT said she did re-education with staff whenever any discrepancies were discovered. She said she monitored the screening logs for temperatures between 99.5 and 100 degrees and for those over 100 degrees. She said she also looked for measurements under 96 degrees. She said the screeners were responsible to calibrate the thermometers and ensure they were functioning properly. The AIT said the expectation was for staff and visitors to be screened thoroughly. She said the screen should include the date checking in, name, who they were with/reason for visit, temperature and any symptoms, travel or exposure. The AIT said the information on visitor logs was not as thorough. She said they do not always measure temperatures coming in or when leaving because they typically will not be coming back. The AIT said she was not aware the visitor log was missing information as described in the record review. She said she reviewed visitor logs about once per month. She said not discovering the missing information was a gap on her part. The AIT said missing information would make it difficult to track and identify issues. A follow up interview was held with the AIT on 7/1/2020 at 9:12 a.m. She said there were eleven staff who were trained to screen employees and visitors. The AIT said training was mostly verbal and there was little documentation of what was trained. She said the lack of a formal training tool may have led to potential mistakes in screening. At 9:57 am., the AIT said the CSC did not get screened on the two days in question. The AIT said the CSC had missed punches on her time clock. She did work these days, as evidenced by her outgoing temperature being recorded. The AIT said the missing entry did not come up on her report because the CSC did not clock in and was omitted from the audit tool. The AIT said she would re-educate staff and consider another method for auditing screening logs. |