STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065308	A. BUILDING _____ B. WING _____	05/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WHEATRIDGE MANOR CARE CENTER	2920 FENTON ST WHEAT RIDGE, CO 80214

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.** Based on observations, interviews and record review, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary environment and to help prevent the development and transmission of communicable diseases and infections such as Coronavirus disease (COVID-19). Specifically, the facility failed to: -Ensure proper hand hygiene procedures were followed; -Ensure employee/visitor screening forms were completed thoroughly to include a temperature and signs and symptoms of COVID-19; -Ensure staff and residents wore facial coverings to cover the nose and mouth; and, -Ensure the proper PPE (personal protective equipment) was donned prior to entering a room of a readmitted resident, who was on droplet precautions for 14 days. Findings include: I. Professional references According to the Colorado Department of Public Health and Environment, COVID-19 Preparation and Rapid Response: Checklist for Long-Term Care Facilities, All staff should be screened at the beginning of their shift for fever (take temperature) or symptoms (cough, shortness of breath, difficulty breathing, fever, chills, rigors, myalgia, headache, sore throat, new olfactory (smell) and taste disorders; consider also rhinorrhea, diarrhea, nausea or vomiting). Any staff member with identified illness (as identified above) should immediately use a facemask, cloth face covering, or a tissue for source control and leave the facility. They should be excluded from work based on return to work criteria. When possible, all long-term care facility residents, whether they have COVID-19 symptoms or not, should cover their noses and mouths when staff are in their room. Residents can use tissues for this. They could also use cloth, non-medical masks when those are available. According to the Centers for Disease Control (CDC) website, Preparing for COVID-19: Long-term Care Facilities, Nursing Homes 5/7/2020 retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html Patients may remove their cloth face covering when in their rooms but should put them back on when leaving their room or when others enter their room. Health care professional (HCP) should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE (personal protective equipment), including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process. HCP should perform hand hygiene by using ABHR (alcohol based hand rub) with 60-95% alcohol or washing hands with soap and water for at least 20 seconds. II. Failed to ensure proper hand hygiene procedures were followed A. Observations During a continuous observation on 5/14/2020 beginning at 9:50 a.m. the following was observed: -A housekeeper was observed cleaning a room. She grabbed the trash can and tied off the trash bag. She donned gloves. She did not use hand hygiene prior to donning gloves. -A staff member was observed wheeling a resident out of her room. She grabbed a visibly dirty towel from underneath the resident with her bare hands. She placed it on the back of the resident's wheelchair. She then began wheeling the resident down the hallway. She did not use hand hygiene. -A certified nurse aide (CNA) was observed inside a resident's room. She, wearing gloves, emptied the resident's urinal. She doffed the gloves, grabbed the trash and left the resident's room. She did not use hand hygiene after doffing the gloves. She entered another resident's room. She used the sink in the resident's room to wash her hands. She scrubbed her hands with soap for seven seconds, rinsed and dried her hands. -A nurse entered a resident's room to give medications. She used the resident's sink to wash her hands. She did not wet her hands with water and obtained soap. She scrubbed her hands for 11 seconds. -At 10:24 a.m. a therapist was observed leaving a resident's room. She obtained hand sanitizer and rubbed it in for six seconds. -At 10:29 a.m. two housekeepers and a CNA were observed in a resident's room. The CNA was observed making the bed. She used the sink in the resident's room to wash her hands. She scrubbed her hands with soap for 10 seconds. One of the housekeepers was observed doffing her gloves. She held a trash bag tied off with trash inside. She placed it on the ground and was observed moving around the resident's personal items to clean a surface. She did not perform hand hygiene after doffing her gloves. She was observed washing her hands. She scrubbed her hands with soap for eight seconds. She donned gloves and swept the floor. She picked up the trash and tied off the bag. She doffed her gloves. She did not perform hand hygiene after doffing her gloves. Both housekeepers were observed cleaning the bathroom with gloves on. They both doffed their gloves and donned new gloves. They did not perform hand hygiene in between gloves changes. A CNA entered the room. She used the sink to wash her hands. She scrubbed her hand with soap for six seconds. -At 11:03 a.m. the director of nursing (DON) was observed adjusting and touching the outside of her surgical mask in the dining room. She did not perform hand hygiene after touching her surgical mask. -At 11:06 a.m., a CNA was observed taking a cart of lunch trays from the dining room to resident rooms. She entered one room and delivered the tray. She did not offer the resident hand hygiene. She left the room and did not perform hand hygiene. B. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 5/14/2020 at 11:23 a.m. She said staff should offer every resident hand hygiene prior to all meals. She said staff should perform hand hygiene prior to entering a resident room and when leaving a resident room. She said proper hand washing included scrubbing hands with soap and rubbing in ABHR for 20 seconds. Housekeeper #1 was interviewed on 5/14/2020 at 11:51 a.m. She said proper hand washing included wetting hands prior to obtaining soap. She said soap should be scrubbed onto hands and forearms for 20 seconds. She said staff should perform hand hygiene in between gloves changes. The DON was interviewed on 5/14/2020 at 12:15 p.m. She said each resident should be offered hand hygiene prior to meals. She said proper handwashing technique required hands and forearms to be wet with water prior to obtaining soap. She said staff should scrub their hands and forearms for 20 seconds. She said ABHR should be rubbed in for 20 seconds. She said hand hygiene should be completed after touching a surgical mask or facial covering. III. Failed to ensure employee/visitor screening forms were completed thoroughly to include a temperature and signs and symptoms of COVID-19 A. Record review The screening forms from 5/3/2020 to 5/10/2020 were reviewed on 5/12/2020. -18 screening forms were missing a temperature; -11 screening forms were missing answers to signs and symptoms of COVID-19; and -Four screening forms were missing an answer of exposure to someone or a facility with documented or suspected COVID-19. B. Staff interviews Receptionist #1 was interviewed on 5/14/2020 at 11:56 a.m. She said she worked at the front desk and was responsible to ensure everyone who entered the facility completed a screening form. She said each person should have their temperature taken and fill out a screening form to indicate if they had any symptoms of COVID-19 or were exposed to COVID-19. She said she filed the completed forms in a binder kept at the front desk. She said she kept them in the binder until it was full and then took them to the nursing home administrator (NHA) office. She said she did not know if anyone reviewed the screening forms. The DON was interviewed on 5/14/2020 at 12:15 p.m. She said the receptionist was responsible to ensure a screening form and temperature was taken for every staff member or ancillary service that entered the facility. She said the facility was restricting all other visitors. She said the charge nurse on the south unit was responsible for screening staff after hours. She said each person should have their temperature taken and answer the questions on the screening form. She said the screening form asked questions if the person is experiencing different signs and symptoms of COVID-19 and if they have come in contact with anyone or any facility with known or suspected COVID-19. She said the individual should not be allowed in the facility unless the form is filled out completely, and the individual should not have a temperature and should not have answered yes to any signs and symptoms of COVID-19. She said the nursing home administrator (NHA) reviewed the screening forms. The NHA was interviewed on 5/14/2020 at 12:37

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

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) p.m. She said she was responsible for reviewing the screening forms. She said she tried to review the screening forms twice per day. She said each form should indicate a temperature, answers to signs and symptoms of COVID-19 and exposure to COVID-19. IV. Failed to ensure staff and residents wore facial coverings to cover the nose and mouth A. Observations During a continuous observation on 5/14/2020 beginning at 9:50 a.m. the following was observed: -A female resident was observed in the hallway. She was wearing a cloth facial covering hooked around her ears and tucked underneath her nose. Staff members walked past the resident and did not remind the resident to wear the facial covering over her nose and mouth. -At 10:13 a.m. two residents were observed sitting in the dining room. Both residents were wearing their facial coverings tucked under their chins. Staff did not provide a reminder to the residents to wear their facial coverings over the nose and mouth. -At 11:00 a.m. a therapist was observed providing treatment to a resident who was under droplet precaution isolation. The resident and the therapist were ambulating across the room. The therapist was holding a gait belt around the resident's waist and came in direct contact with the resident. The resident was not wearing a facial covering. -At 11:17 a.m. one dietary staff member working in the kitchen preparing lunch trays for residents was observed with a surgical mask tucked underneath her chin. Another dietary staff member was observed with a surgical mask tucked underneath her nose. The DON and other nursing staff members were observed in the dining room and in contact with both dietary staff members. They did not remind the dietary staff to wear the surgical mask to cover their nose and mouth. B. Staff interviews The DON was interviewed on 5/14/2020 at 12:15 p.m. She said surgical masks and facial coverings should be worn to cover the nose and the mouth. She said wearing them below the nose or the chin does not protect the individual from aerosolized germs. She said residents should wear facial coverings when staff entered their rooms. V. Failed to ensure the proper PPE was donned prior to entering a room of a readmitted resident, who was on droplet precautions and ensure the resident wore a facial covering while being treated A. Observations On 5/14/2020 at 10:00 a.m. physical therapist (PT) #1 and occupational therapist (OT) #1 approached an isolation cart in the hallway outside a resident's room. Both staff members donned PPE prior to entering the resident's room. OT #1 did not put on protective eyewear. They were observed performing therapy with the resident for 30 minutes in his room. The resident was not wearing a facial covering. PT #1 and OT #1 did not remind the resident to wear a facial covering during the 30 minute therapy session. B. Staff interviews PT #1 and OT #1 were interviewed on 5/14/2020 at 10:35 a.m. PT #1 said the facility had provided training regarding the donning and doffing of PPE for isolation rooms for residents admitted or readmitted to the facility from the community. She said the residents were placed in isolation for two weeks as a preventative measure due to COVID-19 . She said staff should don a mask, gloves, gown and goggles or a face shield prior to entering an isolation room. OT #1 said she should have donned full PPE prior to entering the resident's room. She said she did not know why she did not don protective eyewear prior to entering the resident's room. PT #1 and OT #1 were interviewed on 5/14/2020 at 10:35 a.m. They said staff must wear surgical masks while working with the residents in their rooms. They said the residents were not required to wear a facial covering while staff were in their rooms. They said the residents were only required to wear facial coverings in the hallways or if they leave the building to go out into the community. The DON was interviewed on 5/14/2020 at 12:15 p.m. She said all new admissions to the facility were placed in isolation with droplet precautions. She said staff should don gloves, mask, gown, and goggles or face shield prior to entering the resident's room. VII. Failure to perform hand hygiene for staff and residents A. Observations On 5/14/2020 at 11:10 a.m. certified nurse aide (CNA) #1 pushed a cart of resident lunch trays from the dining room to a resident hallway. She walked into three different resident rooms to deliver lunch trays. CNA #1 did not perform hand hygiene between serving each resident's food tray. CNA #1 did not offer the residents hand hygiene prior to or upon receiving their meals from her. During continuous observation on 5/14/2020 beginning at 11:30 a.m., 10 residents were observed eating at 10 tables in the dining room. The residents had their meals served by the dietary staff and the director of nursing (DON). Staff did not offer hand hygiene to the residents prior to the meal. B. Interviews CNA #1 was interviewed on 5/14/2020 at 11:15 a.m. She said staff should wash their hands in the dining room before taking a cart with food trays on it. CNA #1 said she was never instructed to perform hand hygiene in between serving residents their food trays. CNA #1 said she did not need to offer to wash the resident's hands because they are independent and they can wash their own hands if they want to. Dietary aide (DA) #1 was interviewed on 5/14/2020 at 11:50 a.m. She said staff should offer every resident hand hygiene before being served their meal. The director of nursing (DON) was interviewed on 5/14/2020 at 12:20 p.m. She said staff were trained to wash their hands or use hand sanitizer between serving each resident their food. The DON said staff should offer hand hygiene to each resident before they ate their meal. VI. Failure to ensure residents wore a facial coverings in a common area A. Observations During continuous observations on 5/14/2020 beginning at 10:40 a.m. 10 residents were observed at 10 tables in the dining room. Five residents did not have on masks. Two wore their masks under their nose. B. Staff Interviews The DON was interviewed on 5/14/2020 at 10:55 a.m. She said the residents came early to the dining room to get a spot for lunch at one of the 10 tables. The DON said even if they were an hour early in the dining room they were not required to wear facial coverings while waiting to eat.