| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065380 | A. BUILDING _____ B. WING _____ | 06/25/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| COLORADO STATE VETERANS HOME AT FITZSIMONS | 1919 QUENTIN ST AURORA, CO 80045 |

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** - Many | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to consistently implement an infection prevention program regarding the COVID-19 virus to help prevent the spread of it. Specifically, the facility failed to: -Ensure the admission screening process for staff and visitors was followed thoroughly; -Have certified nurse aide (CNA) #1 and licensed practical nurse (LPN) #1 don protective barriers over their N95 masks when they provided care to both residents in isolation precautions for the COVID-19 virus; -Ensure staff perform hand hygiene prior to assisting other residents and prior to food service, and -Have CNA #4 disinfect their face shield immediately upon exiting resident isolation room.<br>Findings include: I. Screening A. Facility policy Facility policy on using personal protective equipment (PPE), provided by the nursing home administrator (NHA) on 6/24/2020 at 1:35 p.m. Revision on 6/9/2020. It stated in pertinent part: -How to put on (Don) PPE gear: 1. Identify and gather the proper PPE to don. 2. Perform hand hygiene using hand sanitizer. 3. Put on isolation gown. 4. Put on NIOSH-approved N95 filtering facepiece respirator or higher. 5. Put on face shield or goggles. When wearing an N95 respirator or half facepiece [MEDICATION NAME] respirator, select the proper eye protection to ensure that the respirator does not interfere with the correct positioning of the eye protection, and the eye protection does not affect the fit or seal of the respirator. Face shields provide full face coverage. 6. Put on gloves. 7. Healthcare personnel may now enter patient room. -How to take off (Doff) PPE gear: 1. Remove gloves. 2. Remove gown. 3. Healthcare personnel may now exit patient room. 4. Perform hand hygiene. 5. Remove face shield or goggles. Carefully remove face shield or goggles by grabbing the strap and pulling upwards and away from the head. Do not touch the front of the face shield or goggles. 6. Remove and discard respirator. 7. Perform hand hygiene after removing the respirator/face mask and before putting it on again if your workplace is [MEDICATION NAME] reuse. B. Inservice Facility in-service education on using personal protective equipment, provided by the NHA on 6/24/2020 at 1:35 p.m., dated 6/16/2020. It stated in pertinent part: -Please wear face shields in the rooms at all times with presumptive COVID positive, and COVID positive residents. Remember to clean your face shields upon exiting the presumptive positive, and positive rooms. C. Observations On 6/22/2020 at 4:10 p.m. three surveyors entered the facility, and were immediately welcomed with a screening area that contained multiple hand sanitizer stations, tables with screening forms to be completed by the individual, clean/dirty pen holders, and additional surgical masks. The posted directions stated for the individual to fill out the form, and then proceed to the reception desk inside the front lobby. The surveyors completed the form, handed it to the receptionist, who then took the temperature of each individual. The receptionist did not look at the form that was handed to them. Each surveyor had noted that they had been around other facilities with COVID-19 outbreaks, but was not asked about this by the screener. The forms were turned over on her desk, into a stack, without stringent review. This process was repeated on admission to the facility on [DATE]. The infection control preventionist (ICP) was interviewed on 6/23/2020 at 12:40 p.m. She said that everyone entered the facility through the front desk. She said the individual would fill out the screening form, put on a mask if they did not already have one on, and would go to the front desk to have their temperature taken. She said anything 100 degrees Fahrenheit or above would be a temperature. She said the screener needed to check for responses to the questions that might need further questioning. She said if there were any questions about the responses on the screening form, they were educated to contact her or the director of nursing (DON). They would then assess if the individual was appropriate for entrance. The receptionist (REC) was interviewed on 6/23/2020 at 1:20 p.m. She said that she took the screening forms to make sure they were filled out. If there were any responses on the form that needed further review, she would contact the DON or ICP to let them know. She said any temperature over 99 degrees Fahrenheit, and she would contact management. She said she had not paid as close of attention to the screening questions that asked if the individual had been at risk for exposure. She said there was only staff entering the facility, and there had not been any concern with outside individuals entering. At 3:28 p.m. the REC said she did not know who was looking at the screening forms each day for compliance, since the forms were staying at the front desk. She said that she believed the infection control preventionist (ICP) was looking at them daily. She stated that she had not asked the surveyors any additional questions regarding the screening process because she felt that experts were already complying with isolation processes. The director of nursing (DON) was interviewed on 6/23/2020 at 1:45 p.m. She said they had identified that some of the staff would benefit from in-servicing, to empower them to always feel comfortable asking anyone entering the building any question necessary. D. Staff interviews On 6/22/2020 at 4:45 p.m. the nursing home administrator (NHA) said that only a handful of the facility staff had been fit tested for N95 masks. The rest of the staff would instead wear face shields over their N95 masks when entering an isolation room. On 6/23/2020 at 12:40 p.m. the infection control preventionist (ICP) said that any resident that came back from the hospital was treated as a positive, and they would be isolated. They are put on isolation, and the staff entering the room would be required to wear a face shield, the N95 mask, and practice donning and doffing. The ICP said they do testing, and educate on handwashing. Those residents who test positive or come back from the hospital are treated on isolation the same way. A return from the hospital was for 14 days, and for those individuals that were tested positive, it was also 14 days. She said that even if a resident tested on ce negative at the hospital, they were keeping them on 14 days isolation to be safe. She said the isolation carts had gowns, gloves, face shields, and N95 masks. She said staff used to wear a surgical mask over their N95 masks, but now they must wear the face shield. She said that staff doff at the door to the isolation room, where the bins were located. They must wash their hands. She said the only thing the staff member should have on as they are exiting the room was the face shield and N95 mask. She said that they must doff right at the door. The staff could then use the sanitizing wipes right outside the resident door, and toss the wipe in the bin at the door. The face shield they could wear again. The staff member could wear the face shield during the day after sanitizing it, or they could place it in a paper bag with their name on it, and place it in a cabinet on the unit. She said the face shield should be sanitized before entering the facility hallways. The DON and NHA were interviewed on 6/24/2020 at 11:05 a.m. They said that they had educated staff working in isolation rooms to don and doff PPE numerous times during the COVID-19 outbreak. They said the expectation was that a face shield would be worn with the N95 mask prior to entering an isolation room. The staff member would doff their gown and gloves prior to exiting the room. Since the bins were just inside the resident room, the staff member would doff the face shield as they were exiting, wiping it down with a sanitizer wipe. The wipe would be discarded inside the room, in the bin. They would then be allowed to continue to wear the face shield, or store it in the designated cupboard on the unit, that had a bag with their name on it. The staff would not doff or sanitize the face shield as they walked down the hallway, towards the cupboard. II. Improper PPE and disinfection A. Professional reference According to the Centers for Disease Control (CDC): Recommended Guidance for Extended Use and Limited Reuse of N95 Filtering Facepiece Respirators in Healthcare Settings, (2/27/20), https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html, (7/6/2020). It read in pertinent part to: -Discard the N95 respirators following close contact with, or exit from, the care area of any patient co-infected with an infectious disease requiring contact precautions. - Consider use of a cleanable face shield (preferred) over an N95 |

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** - Many | (continued... from page 1)<br>respirator to reduce surface contamination. B. Resident #1 1. Resident status Resident #1, less than [AGE] years of age, was admitted on [DATE]. The June 2020 computerized physician orders [REDACTED]. He required set-up for meals, and extensive assist with transfers, bed mobility and toileting. 2. Observation An observation on 6/22/2020 at 4:49 p.m. revealed, Resident #1 resided in the Constitution left hall of the facility (one of four halls located on the second floor), there was an isolation cart outside of his room. LPN #1 wore an N95 mask as he approached Resident #1's isolation cart. LPN #1 donned a gown and gloves, did not don any type of barrier over his N95 mask, and entered Resident #1's room. LPN #1 exited Resident #1's room wearing only his N95 mask. He walked away from Resident #1's room to a common dining area of the unit. He picked up a tray of food from a mobile cart (located in the dining area) which carried multiple trays of food. He placed the plate of food, from the tray, on a table in front of Resident #4 who sat in the common dining area. LPN #1 went from helping Resident #1 who was in an isolation room without the proper PPE to assisting other residents. An observation on 6/22/2020 at 4:54 p.m. revealed, CNA #1 wore an N95 mask as he approached Resident #1's isolation cart. CNA #1 donned a gown and gloves, did not don any type of barrier over his N95 mask, and entered Resident #1's room. CNA #1 exited Resident #1's room wearing only his N95 mask. He walked away from Resident #1's room to a common dining area of the unit. He picked up a tray of food from a mobile cart (located in the dining area) which carried multiple trays of food. CNA#1 continued to the common area to assist Resident #5 with their food and to help cut up the food for Resident #4. CNA #1 was not observed performing hand hygiene. An observation on 6/22/2020 at 5:01 p.m. revealed LPN #1 cut up Resident #5's food and began to assist him with eating. LPN #1 was not observed performing hand hygiene. These observations show staff going from an isolated room with improper PPE on and then into the common areas to assist other residents. 3. Record review According to the June 2020 CPOs, a 6/13/2020 order placed Resident #1 on droplet isolation precautions for 14 days due to a possible exposure to the COVID-19 virus. The care plan, initiated on 3/18/2020, identified Resident #1 would practice social distancing to prevent the spread of the COVID-19 virus. Interventions included he was encouraged to stay in his room. The facility was in process of updating care plans to reflect his placement on isolation precautions due to recent exposure to a provider who was diagnosed as positive for the COVID-19 virus. 4. Staff interviews LPN #1 was interviewed on 6/22/2020 at 4:35 p.m. He said he wore the same N95 mask throughout his entire shift. He provided care to residents in his unit who were in isolation precautions for the COVID-19 virus, such as with Resident #1, and residents who were not in isolation for [MEDICAL CONDITION]. Resident #1 was in a 14-day isolation period due to he came into close contact with a psychiatric provider who tested positive for the COVID-19 virus. He did not identify the need to cover his N95 mask when he provided care to both residents in isolation and residents not in isolation. LPN #1 was interviewed a second time on 6/22/2020 at 4:52 p.m. He said the facility had not told to him to cover his N95 mask when he would go into resident rooms who were on isolation; such as with Resident #1. CNA #1 was interviewed on 6/22/2020 at 5:00 p.m. He said the facility had not told to him to cover his N95 mask when he would go into resident rooms who were on isolation; such as with Resident #1. C. Resident #2 1. Resident status Resident #2, less than [AGE] years of age, was admitted on [DATE]. The June 2020 CPO revealed [DIAGNOSES REDACTED]. According to the 3/18/2020 MDS assessment he had no cognitive deficits with a BIMS score of 15 out of 15. He required extensive assistance with toileting and personal hygiene. 2. Observation An observation on 6/23/2020 at 12:12 p.m. revealed, Resident #2 resided in the Patriot left hall of the facility (one of four halls located on the first floor), there was an isolation cart outside of his room, and his room was next to a resident's room who was not in isolation precautions. CNA #2 wore an N95 mask and carried a face shield in her hand (which she retrieved from a clear bag located on top of a nearby desk in the hallway of the unit) as she approached Resident #2's isolation cart. CNA #2 donned the face shield, a gown, gloves, and entered Resident #2's room. CNA #2 exited Resident #2's room wearing only her N95 mask and the face shield. She removed the face shield while outside of Resident #2's room, grabbed a antimicrobial wipe from the cylindrical container which sat on top of the isolation cart outside of Resident #2's room, and proceeded to wipe the face shield with the wipe as she stood by the isolation cart. She then placed the face shield back into the clear bag in which it was stored, and placed the bag on top of the nearby desk. This desk was observed to be a work area for direct care staff and an area by which some residents would pass if going to either the dining room or to exit the unit. This would not be an appropriate area for reusable PPE. An observation on 6/23/2020 at 12:25 p.m. revealed CNA #2 wore an N95 mask and carried a face shield in her hand (which she retrieved from a clear bag located on top of a nearby desk in the hallway of the unit) as she approached Resident #2's isolation cart. CNA #2 donned the face shield, a gown, gloves, and entered Resident #2's room. CNA #2 exited Resident #2's room wearing only her N95 mask and the face shield. She removed the face shield while outside of Resident #2's room, grabbed a antimicrobial wipe from the cylindrical container which sat on top of the isolation cart outside of Resident #2's room, and proceeded to wipe the face shield with the wipe as she stood by the isolation cart. She then placed the face shield back into the clear bag in which it was stored, and placed the bag on top of the nearby desk. This desk was observed to be a work area for direct care staff and an area by which some residents would pass if going to either the dining room or to exit the unit. 3. Record review According to the June 2020 CPO Resident #2 had a 6/5/2020 order to receive treatment for [REDACTED]. The care plan, initiated on 6/5/2020, it identified he had complications with impaired gas exchange, pneumonia consistent for COVID-19 infection; he returned from the hospital on [DATE]. Interventions included staff to maintain standard, contact, and droplet precautions plus eye protection during all care activities around residents with suspected or confirmed coronavirus infection for seven days after the onset of illness or until symptoms subside, whichever was longer. According to the Colorado Department of Public Health and Environment (CDPHE's) Laboratory Service Division (LSD) Resident #2 tested positive for the COVID-19 virus on 6/20/2020. According to the 6/23/2020 progress note Resident #2 remained on isolation due to a positive COVID-19 test. 4. Staff interviews CNA #2 was interviewed on 6/23/2020 at 12:35 p.m. She said no one told her she could not wipe the face shield outside the residents ' rooms; the wipes she used were outside of their rooms. She was not told where to store the face shield. RN #1 was interviewed on 6/23/2020 at 12:38 p.m. He said Resident #2 was in isolation because he was COVID-19 positive. Staff had their own face shields they wore in his room and would disinfect the face shields outside of his room. D. Resident #3 1. Resident status Resident #3, less than [AGE] years of age, was admitted on [DATE]. The June 2020 CPO revealed [DIAGNOSES REDACTED]. He requires extensive assistance for mobility, transfers, and toileting. 2. Observation An observation on 6/23/2020 at 1:40 p.m. revealed Resident #3 resided in the Patriot left hall of the facility (one of four halls located on the first floor, and the same hall where Resident #2 resided), and there was an isolation cart outside of his room. CNA #2 and CNA #3 wore N95 masks and carried a face shield in their hands as they approached Resident #3's isolation cart. CNA #2 and CNA #3 donned their face shields, a gown, gloves, and entered Resident #3's room. CNA #2 and CNA #3 exited Resident #3's room wearing only their N95 masks and face shields. They removed their face shields while outside of Resident #3's room, grabbed a antimicrobial wipe from the cylindrical container which sat on top of the isolation cart outside of Resident #3's room, and proceeded to wipe their face shields with the wipe as they stood by the isolation cart. They placed the face shields into a clear bag (located at the nurse's station) and placed the bag on a shelf at the nurse's station. 3. Record review According to CDPHE's LSD Resident #3 tested positive for the COVID-19 virus on 5/29/2020. According to the 6/20/2020 progress note Resident #3 was on contact isolation precautions due to a positive COVID-19 test. According to the June 2020 CPOs he had a 6/16/2020 order to receive physical and occupational therapy evaluations, and treatments, for deconditioning related to COVID-19 pneumonia. The care plan, initiated on 5/29/2020 and revised on 6/9/2020, identified he was positive for COVID-19 on 5/29/2020 and was sent to the hospital for worsening symptoms on 6/4/2020. Interventions included staff to maintain standard, contact, and droplet precautions plus eye protection during all care activities around residents with suspected or confirmed coronavirus infection for seven days after the onset of illness or until symptoms subside, whichever was longer. 4. Staff interviews CNA #2 and CNA #3 were interviewed on 6/23/2020 at 2:10 p.m. They said they were to use the wipes outside of the residents' rooms to clean the face shields and store them in plastic bags for future use. E. Additional observations and interviews CNA #4 was observed at 4:33 p.m. on 6/22/2020 as she donned and doffed her personal protective equipment (PPE) when entering and exiting the room of a COVID positive resident who was on isolation precautions. She donned a gown, gloves, N95 mask with a surgical mask over the top of it and a face shield prior to entering the room. When she exited the room, she walked into the hallway while still wearing her face shield. She donned a new set of gloves once in the hallway, however, sanitized her face shield at a counter top in the common area of the unit. She walked past several other resident rooms who were not on isolation precautions to get to the area where she sanitized her face shield. CNA #5 was interviewed on 6/23/2020 at 1:23 p.m. She said that each isolation room has sanitizer wipes on the isolation cart located outside the door. She said that face shields should be removed and sanitized immediately after exiting the room and then stored in bags labeled with the name of the staff person. RN #2 was observed at 2:23 p.m. on 6/23/2020 as she donned PPE prior to entering the room of a resident |

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| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | (continued... from page 2)<br>who had recently been discharged from the hospital. She donned a gown, gloves and an N95 mask with a surgical mask over the top. She wore her own glasses and no other protective eye wear or face shield. She was interviewed prior to entering the room. She said that the resident was a readmit and had tested negative at the hospital, therefore, full isolation precautions were not in place to care for the resident. The DON was interviewed on 6/23/2020 at 4:25 p.m. She said staff had their own face shields for added protection of their N95 masks; when they entered isolation rooms. Staff were to disinfect their face shields while still in the resident's isolation rooms; not outside their rooms. Staff could also cover their N95 masks with a surgical mask and then doff the surgical mask in the resident's isolation room; prior to exit of their room. Resident #1 was exposed to a provider who was COVID-19 positive but asymptomatic, and Resident #2 and Resident #3 tested positive for COVID-19; all were on isolation precautions which staff were to follow. |