STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065231	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UNIVERSITY PARK CARE CENTER	945 DESERT FLOWER BLVD PUEBLO, CO 81001

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 observations, record review and interviews, the facility failed to ensure infection control practices were established and maintained to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of Coronavirus (COVID-19) and other communicable diseases, and infections. Specifically, the facility failed to: -Cohort staff to reduce working on both positive and negative COVID-19 units; and, -Follow proper hand hygiene when donning (put on) and doffing (removing) personal protective equipment (PPE). Findings include: I. Facility policies/Professional references A. Policies The policy regarding cohorting of staff on COVID units was requested on 6/24/2020. The facility provided the states public health department COVID-19 guidance, last revised 5/6/2020. The state health department COVID-19 Interim Expanded Testing and Cohorting Public Health Strategy to Prevent [DIAGNOSES REDACTED]-CoV-2 Transmission in Nursing Home, Skilled-Nursing Facilities, and Assisted Living Residences, provided by the NHA on 6/24/2020 at 12:10 p.m. read in pertinent part: Strategies for Cohorting Residents and Designating Staff- General considerations: Cohorting refers to moving residents according to COVID-19 infectious status. This might include establishing a specific area for COVID-19 positive residents (designated COVID-19 care unit), moving residents between rooms, or establishing new roommate pairs. Cohorting residents also requires designating staff, with complete separation between staff working in designated COVID-19 care units (consistently across multiple shifts). The Hand Hygiene policy and procedure, last revised 5/7/2020, provided by the nursing home administrator (NHA) on 6/24/2020 at 12:10 p.m. read in pertinent part: When to perform hand hygiene with alcohol based hand rub (ABHR) and with soap and water; .before applying gloves, after removal of gloves, prior to removal of face shields/eye protection and/or respirator during the doffing of PPE process. B. Reference According to the Centers for Disease Control and Prevention (CDC), last updated 5/19/2020, retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html included the following recommendations for cohorting of staff. Assign dedicated HCP (heath care professional) to work only on the COVID-19 care unit. At a minimum this should include the primary nursing assistance (NAs) and the nurses assigned to care for these residents. HCP working on the COVID-19 care unit should ideally have a restroom, break room, and work area that are separate from the HCP working in other areas of the facility. II. Failure to cohort staff working on both positive and negative COVID-19 units A. Observations On 6/15/2020 at 1:24 p.m. licensed practical nurse (LPN) #1 was observed entering the closed double doors to the COVID-19 positive wing of the facility. The LPN returned approximately five minutes later to her medication cart, which was located on the COVID-19 negative wing of the facility. The LPN was interviewed at that time, and stated she was the nurse for the COVID-19 wing of the building and she had been over there passing pills. On 6/16/2020 at 11:20 a.m. LPN #1 was observed entering the COVID-19 wing of the facility, the LPN was observed passing medications to several of the residents on the COVID-19 wing. After approximately ten minutes the LPN left the COVID-19 wing of the unit, and returned to her medication cart which was located in a COVID-19 negative wing of the facility. On 6/16/2020 at 11:58 a.m. certified nurse aide (CNA) #1 was observed entering the COVID-19 wing of the facility. She was interviewed at that time and stated that she was helping the residents who needed meal assistance on the COVID-19 unit. The CNA was observed assisting three separate COVID-19 positive residents with their meal. The CNA was observed leaving the COVID-19 wing of the facility at 1:29 p.m. The CNA was observed returning to the COVID-19 negative wing of the facility. B. Interviews CNA #1 was interviewed on 6/16/2020 at 9:19 a.m. She said she had worked on the COVID-19 unit yesterday (6/15/2020), but was scheduled for the COVID-19 negative wing of the facility. The CNA said she helped with breakfast on the COVID-19 positive unit this morning. She said she sat with a few of the residents and provided them meal assistance. The CNA said she was working on the COVID-19 negative wing of the facility, and there were less residents who needed meal assistance on that wing on the facility. CNA #2 was interviewed on 6/16/2020 at 11:25 a.m. She said she was the only CNA on the COVID-19 positive wing of the facility. She said several residents needed meal assistance so CNA #1 had been helping with meals. LPN #1 was interviewed on 6/16/2020 at 12:22 p.m. She said she was only working on the COVID-19 positive wing of the facility. The LPN said she was told she needed to leave her cart on the other side of the barrier doors, but she was unsure why. The LPN said she had to go between the COVID-19 positive and negative wing of the facility to get medications from her cart. The LPN said when she was not passing medication or assisting the residents on the COVID-19 positive wing, she stayed on the COVID-19 negative wing of the facility where her medication cart was located. The director of nursing (DON) was interviewed on 6/16/2020 1:43 p.m. She said she was unaware of any CNAs going onto the COVID-19 positive wing of the facility to assist with meals. The DON said the number of residents had just increased on the COVID-19 positive wing, and she would look into the staffing to ensure there were enough staff to ensure staff were cohorting as much as possible. The DON said she was unaware the nurse cart for the COVID-19 positive unit was not located in the actual unit. The DON said she would immediately move the cart and educate the nurses on keeping the cart on the unit. III. Failure to follow proper hand hygiene when donning and doffing PPE A. Observations On 6/16/2020 at 11:15 a.m. Two plastic shoe [MEDICATION NAME] were observed hanging on the wall of the COVID-19 positive unit. Each opening of the [MEDICATION NAME] had brown paper bags with used N95 masks labeled with staff members' names. On 6/16/2020 at 11:20 a.m. LPN #1 was observed entering the COVID-19 positive unit, while she was putting on a cloth gown. The LPN placed blue plastic coverings over the arms of the gown. The LPN was observed donning gloves, the LPN did not perform hand hygiene prior to donning the gloves. -At 11:30 a.m. the LPN was observed doffing her gloves, gown and arm coverings. The LPN did not perform hand hygiene, and was observed exiting the COVID-19 positive unit and going to her medication cart located on the COVID-19 negative unit. On 6/16/2020 at 11:58 a.m. CNA #1 was observed entering the COVID-19 positive unit. The CNA was observed doffing the N95 mask she was wearing, and donning the N95 mask with her name. The CNA did not perform hand hygiene at any time while donning and doffing the new masks. On 6/16/2020 at 12:23 p.m. Occupational therapist (OT) #1 was observed entering the COVID-19 positive wing of the facility. The OT doffed the N95 he was wearing and donned a N95 from a bag hanging from the wall with his name. The OT did not perform hand hygiene at any time during the donning and doffing of the N95 masks. - At 12:27 the OT was observed donning a pair of gloves without performing hand hygiene. On 6/16/2020 at 12:25 p.m. LPN #1 was observed entering the COVID-19 positive unit wearing a cloth gown. The LPN was observed placing blue plastic covers over the sleeves of the gown, and donning a pair of gloves. The LPN did not perform hand hygiene. On 6/16/2020 at 1:00 p.m. Certified occupational therapy assistant (COTA) #1 was observed entering the COVID-19 positive unit. The COTA was observed doffing the N95 she was wearing and donning the N95 mask from the holder with her name. The COTA did not perform hand hygiene at any time. B. Interviews CNA #2 was interviewed on 6/16/2020 at 12:15 p.m. She said each staff member stored their N95 mask on the show holder that hung on the wall. The CNA said the same mask was worn for several days, and she had been wearing her current N95 for at least six days. The CNA said there were no ABHR dispensers in the hallway or near any of the PPE, and the only hand washing sinks available were in resident rooms or in the locked shower room. The DON was interviewed on 6/16/2020 at 1:43 p.m. The DON said staff should be washing their hands when they are changing their PPE, including gloves. The DON said she was unaware the staff were changing their N95 masks when they were on the COVID-19 positive unit. The DON said she

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 -** Some	(continued... from page 1) would educate the staff about not changing their masks. The DON said anytime a staff member touched or changed their masks they would need to hand hygiene before and after. The DON said she was aware of the lack of hand hygiene on the COVID-19 positive unit and she would look into getting more ABHR stands on the unit so staff would have easier access.