STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065361	A. BUILDING _____ B. WING _____	05/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKSIDE INN	1297 S PERRY ST CASTLE ROCK, CO 80104

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 new admissions were placed on isolation for the required 14 days; -Ensure residents and staff followed guidelines for facial coverings to prevent the spread of infections; -Ensure staff and residents observed social distancing guidelines; -Ensure disinfectant was not left out in common areas unattended; and, -Ensure housekeeping staff observed proper dwell time for disinfectants when cleaning. Findings include: I. Professional references According to the Centers for Medicare and Medicaid Services (CMS) COVID-19 Long-Term Care Facility Guidance April 2, 2020, if possible, isolate all admitted residents (including readmissions) in their room for 14 days if their COVID-19 status is unknown. According to the Centers for Disease Control (CDC) website, Preparing for COVID-19: Long-term Care Facilities, Nursing Homes https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html (Retrieved 4/29/2020) cloth face coverings are not considered personal protective equipment (PPE) because their capability to protect healthcare personnel (HCP) is unknown. HCP who enter the room of a patient with known or suspected COVID-19 should adhere to standard precautions and use of respirator, gown, gloves and eye protection. When available, respirators should be prioritized for situations where respiratory protection is most important and the care of patients with pathogens requiring airborne precautions. The PPE recommended when caring for a patient with known or suspected COVID-19 includes: Put on an N95 respirator (or higher level of respirator) or facemask (if a respirator is not available) before entry into the patient room or care area. Cloth face coverings are NOT PPE and should not be worn for the care of patients with known or suspected COVID-19). 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. II. Failure to ensure residents admitted from a COVID-19 positive facility were placed on isolation for the required 14 days A. Observations During continuous observations conducted at the facility beginning at 9:31 a.m., the following was observed: -On the B wing, the signage on the door to the wing indicated that the wing was used as an isolation/quarantine unit. -A resident room was observed with a sign on the door with a triangle and an exclamation point inside the triangle. Housekeeper #1 said the sign meant the resident was in quarantine because she was a recent admission to the facility. A staff member was observed entering the resident's room. Another staff member was observed in the room with the resident. The resident was observed coughing and blowing her nose into a tissue. The resident did not have a facial covering on. Both staff members wore surgical masks. They did not don any other PPE. B. Record review The resident admission and discharge record from 4/20/2020 to 5/4/2020 indicated the following: -Resident #1 was admitted to the facility from an acute care hospital on [DATE], 11 days prior; -Resident #2 was admitted to the facility from an acute care hospital on [DATE], nine days prior; and -Resident #4 was admitted to the facility from an acute care hospital on [DATE], two days prior. C. Staff interviews CNA #1 was interviewed on 5/4/2020 at 10:41 a.m. She said the sign on the outside of the residents rooms with a triangle and exclamation mark indicated the resident was on quarantine. She said if a resident was a new admission and had a negative COVID-19 test, then they were placed on quarantine. She said facility staff was required to wear a mask when entering the room. She said they did not don any other forms of PPE. She said for residents who did not have a COVID-19 test, they were placed on droplet isolation. She said the staff were required to don full PPE prior to entering the room. She said residents were placed on either quarantine or isolation for 14 days following their admission to the facility. The DON was interviewed on 5/4/2020 at 11:03 a.m. She said when the facility received a new admission, the resident was placed on droplet precaution isolation for 14 days. She said if the new admission had a negative COVID-19 test completed at the hospital, then the resident was placed on quarantine. She said for residents under quarantine, the staff and residents were expected to wear a surgical mask inside and outside of the room. She said the resident was able to go to the therapy gym as long as they wore a surgical mask. She confirmed the guidance from CMS on 4/2/2020 indicated when possible to place any new admissions coming from a COVID-19 positive facility under isolation for 14 days. She confirmed COVID-19 was [MEDICAL CONDITION] that was transmitted by droplets. She confirmed COVID-19 required droplet precautions for isolation. She confirmed a negative test could be obtained and a resident still tested positive and showed symptoms 14 days after potential exposure. She said she would place isolation carts outside each resident who had been admitted to the facility in the past 14 days and provide education to the staff immediately. III. Failure to ensure residents and staff followed guidelines for facial covering to prevent the spread of infections A. Observations During continuous observations conducted at the facility beginning at 9:31 a.m., the following was observed: On the E wing: -Licensed practical nurse (LPN) #1 was observed standing at the medication cart in the hallway. The surgical mask was pulled down with his nose exposed. -A male resident was sitting in a wheelchair in the hallway with a bandana around his neck. It was not pulled up to cover his mouth and nose. Staff were observed in the hallway and did not direct the resident to pull the bandana up to cover his nose and mouth. -A female resident sitting in her wheelchair in the hallway. She did not have on a mask or facial covering. On the F wing: -Two residents were observed sitting in the hallway in their wheelchairs without facial coverings. A staff member was observed leaning down to speak with one of the residents in close proximity. The staff member did not offer to get the resident a facial covering. -A resident was observed walking down the hallway using a four wheel walker. She walked up to the nurse at the medication cart, spoke with the nurse and then returned to her room. She did not have on a facial covering. The nurse did not offer the resident a facial covering when she moved about through the hallway. -A certified nurse aide (CNA) was observed providing direct care to a resident in the resident's room. The resident did not have on a facial covering while the CNA was in the room providing care. On the A wing: -A CNA was observed entering a resident's room and had direct contact with the resident. The resident did not don a facial covering and the CNA did not offer the resident a facial covering. -A CNA was observed pushing a linen cart with a surgical mask tucked down with her nose exposed. -A male resident was observed doing individual activities sitting in his wheelchair at the end of the hallway. The resident did not have a facial covering. A staff member interacted with the resident and did not offer the resident a facial covering. -A female resident was observed sitting in her wheelchair in the hallway. She did not have on a facial covering. Staff were observed passing by the resident and did not offer the resident a facial covering. On the B wing: -The signage on the door to the wing indicated that the wing was used as an isolation/quarantine unit. -A resident was observed sitting in the hallway in a wheelchair. She had direct contact with the housekeeper. The resident did not have on a facial covering. The facility staff did not offer or provide a reminder to the resident for a facial covering. On the secured unit: -A group activity was observed in the dining area with 11 residents present. All residents were not wearing facial coverings. The facility staff did not offer the residents facial coverings or hand hygiene throughout the activity. -Two residents were observed in one common area sitting down, one resident in a chair and the other laying down on a couch. Both residents did not have facial coverings. Two staff members entered the room to wash their hands. The staff did not offer the resident's facial coverings. -A resident was observed walking down

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 -** Many	(continued... from page 1) the hallway. She did not have on a facial covering. B. Staff interviews LPN #1 was interviewed on 5/4/2020 at 10:20 a.m. He said masks should be worn by all staff. He said the masks should be worn covering the mouth and nose. He said the facility did not provide a mask to residents unless they were leaving the facility to go to an appointment. He said the facility did not require residents to wear masks when they were moving freely about the units. Registered nurse (RN) #1 was interviewed on 5/4/2020 at 10:04 a.m. She said the facility expectation was for staff to wear surgical masks. She said the facility did not provide facial coverings to residents. She said the staff on the secured unit had not attempted to give the residents facial coverings. The DON was interviewed on 5/4/2020 at 11:03 a.m. She said surgical masks and other facial coverings should be worn covering the nose and mouth. She said the facility provided surgical masks to residents when they left the facility for an outside appointment. She said they did not issue the residents facial coverings to be worn in the facility, while out of their rooms. IV. Ensure social distancing guidelines were followed A. Observations During continuous observations conducted at the facility beginning at 9:31 a.m., the following was observed: -Two nurses were observed sitting at the nursing station, charting. They were both sitting at a desk three feet apart, not observing social distancing guidelines. -The chairs placed on the outside of the nursing station were placed three feet apart. The chairs were not placed to ensure social distancing guidelines were followed. On the secured unit: -Upon entering the secured unit, group activity was observed in the dining area. At four tables, there were two residents who were sitting two feet apart from one another and three residents at one table sitting less than a foot apart in distance. The activities assistant was sitting at the table with three residents less than a foot apart from the residents. -The seating throughout the dining area did not observe social distancing guidelines of six to eight feet apart. -Two common areas were observed on the secured unit. Seating in the common areas were not positioned to allow for the observance of social distancing. The seating was next to each other. Two residents were observed in one common area sitting down, one resident in a chair and the other laying down on a couch. They were not observing social distancing as the chair and couch were not positioned six to eight feet apart. -A resident was observed walking down the hallway. She joined the activity and was seated less than a foot away from another resident by the activity staff member. She was not offered hand hygiene before participating in the activity. B. Staff interviews RN #1 was interviewed on 5/4/2020 at 10:04 a.m. She said the expectation at the facility was that residents and staff would observe social distancing guidelines. She said social distancing guidelines indicated staff and residents should remain six to eight feet apart as much as possible. She said the resident's seated in the dining area, participating in an activity, should be seated six to eight feet apart. She said it was difficult with that population to allow for social distancing. She confirmed the residents were not seated to observe social distancing guidelines. The activity assistant was interviewed on 5/4/2020 at 10:07 a.m. She said they tried to keep the tables as far apart as possible but it was hard to comply with social distancing guidelines. She confirmed two tables in the area did not have any residents seated at them and could have been used in an attempt to comply with social distancing guidelines. The DON was interviewed on 5/4/2020 at 11:03 a.m. She said social distancing guidelines of six to eight feet should be followed while at the facility. She said the secured unit provided a challenge to comply with social distancing guidelines. She said the facility did change the table placement in the dining area. She confirmed the common areas of the secured unit were not set up to observe social distancing guidelines. She said residents should be seated as far apart as possible to observe social distancing. V. Ensure disinfectant was not left out in the common areas unattended A. Observations During continuous observations conducted at the facility beginning at 9:31 a.m., the F wing was observed with one spray bottle hand marked as a 10% bleach solution hanging on the hydration cart with an additional three unmarked spray bottles with liquid. B. Staff interviews LPN #1 was interviewed on 5/4/2020 at 10:20 a.m. He said some residents moved freely throughout the wing. He said some residents had cognitive impairment. He confirmed each of the bottles hanging on the hydration cart were cleaning agents. He said it was not safe for the disinfectants to be out in the open in resident areas. He said the cleaning agents should be kept locked up in the housekeeping cart. He said he would ensure the cleaning agents were locked up as soon as possible. The DON and NHA were interviewed on 5/4/2020 at 11:03 a.m. The DON said the disinfectant should not be left in public areas. She said the disinfectant should be locked up or with a staff member present to ensure residents did not ingest it by accident. VI. Ensure housekeeping staff observed proper dwell time for disinfectants when cleaning A. Manufacturer instructions The Waxie Solution Station 730 HP Disinfectant cleaner product specifications sheet revealed the contact time for the disinfectant for [MEDICAL CONDITION] and bacteria ranged between one minute, five minutes, and 10 minutes. B. Observations During a continuous observation throughout the facility on 5/4/2020 beginning at 9:31 a.m., a housekeeper #1 was observed spraying disinfectant directly onto a rag and immediately wiping down the handrails and other surfaces on the B wing hallway. She said she was using the Waxie 730 disinfectant. She said the disinfectant should be sprayed onto a surface, left wet for three minutes and then wiped with a rag. She then continued to spray the disinfectant onto the rag and immediately wiped down surfaces on the hallway. C. Staff interviews The environmental services director (ESD) was interviewed on 5/4/2020 at 11:06 a.m. He said the Waxie 730 disinfectant was used to disinfect resident and common areas throughout the facility. He said the disinfectant should be sprayed onto a surface, left wet for 10 minutes and wiped down with a dry rag. He said the housekeeper was not following proper disinfection technique for that product by spraying it onto the rag and immediately wiping down the surface. He said he would provide the entire housekeeping staff education immediately.