STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065121	A. BUILDING _____ B. WING _____	05/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PAVILION AT VILLA PUEBLO, THE	855 HUNTER DR 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observations, record review and staff interviews, the facility failed to ensure food was stored, prepared, and served under sanitary conditions in one of one kitchens. Specifically, the facility failed to ensure proper washing and sanitizing of kitchen utensils. Findings include: I. Improper dishwashing sanitation A. Professional references According to the Colorado Retail Food Establishment Rules and Regulations (effective 1/1/19) pp. 146-148, After being cleaned, equipment food contact surfaces and utensils shall be sanitized in: Hot water manual operations by immersion for at least 30 seconds. Hot water mechanical operations by being cycled through equipment that is set up as specified under surface temperature of 71oC (160oF) as measured by an irreversible registering temperature indicator; and Chemical manual or mechanical operations, including the application of sanitizing chemicals by immersion, manual swabbing, brushing, or pressure spraying methods, using a solution as specified. Contact times shall be consistent with those on EPA-registered label use instructions. B. Observation On 5/4/2020 at 11:50 a.m., dietary aide (DA) #2 was observed doing dishes in the kitchen. DA #2 said she checked the sanitation in the dishwasher every morning. She said the dishwasher was a high temperature machine but it had been having issues with a heat booster so they had made the dishwasher a low temperature and sanitation machine. DA #2 proceeded to run a sanitation test strip in the machine. She compared it to the sanitation level on the bottle. She said it was at zero. The DA #2 ran another cycle of the dishwasher. The DA #2 observed the water temperature during the rinse cycle. She said the water temperature was 110 degree Fahrenheit. She checked the parts per million with the sanitation strip with the same result of zero. The DA #2 said the water temperature should be 120 degree F or higher. C. Staff interview The dietary manager was interviewed on 5/4/2020 at 11:50 a.m. He said the dishwasher had been having issues with the heater booster. He said it had been changed to low temperature and sanitation while the part was coming in. He instructed DA #2 to wash all kitchen service wear in the three compartment sink immediately. He said he would call the ECO lab tech in immediately to see what was going on. The eco lab technician was interviewed on 5/4/2020 at 1:12 p.m. He said the line was blocked and not allowing the sanitizer to go through. He said the water temperature was low and he raised the temperature. He said the booster was on back order and it should be coming in soon. He said he would monitor the dishwashing machine weekly and monitor the machine daily. The DM was interviewed again on 5/4/2020 at 1:17 p.m. He said he was having dietary staff monitor the dishwasher machine every two hours to ensure all levels were still adequate.
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, record review and interviews the failed to maintain infection prevention and control designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections such as Coronavirus disease (COVID-19) for five (#1, #11, #10, #8 and #9) of 11 sample residents. Specifically, the facility: -Failed to ensure necessary PPE was worn at all times by staff. -Failed to ensure residents had face covering while staff were assisting them in their rooms. -Failed to ensure residents' who left their rooms performed hand hygiene, and wore a cloth face covering. -Failed to follow proper housekeeping protocols to prevent cross contamination, and maintain proper cleaning standards and procedures; and, -Failed to ensure proper sanitizing of kitchen utensils. Findings include: I. CDC recommended guidelines The Center for Disease Control (CDC), Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings (4/28/2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#minimize, (Update April 13, 2020) Patients may remove their cloth face covering when in their rooms but should put them back on when leaving their room or when others (e.g., HCP, visitors) enter the room. Screening for symptoms and appropriate triage, evaluation, and isolation of individuals who report symptoms should still occur. Healthcare personnel As part of source control efforts, HCP should wear a facemask at all times while they are in the healthcare facility. When available, facemasks are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. If there are anticipated shortages of facemasks, facemasks should be prioritized for HCP and then for patients with symptoms of COVID-19 (as supply allows). Cloth face coverings should NOT be worn instead of a respirator or facemask if more than source control is required. HCP should have received job-specific training on PPE and demonstrated competency with selection and proper use (e.g., putting on and removing without self-contamination). II. Lack of using necessary PPE A. Observations On 5/4/2020 at 9:40 a.m., the business office manager (BOM) was observed walking in the halls. As she walked down the halls her cloth mask was below the bridge of her nose with her nostrils exposed or not covered by the mask. She said the cloth mask did not have a metal bracket which would hold the mask on the bridge of her nose. She said she was provided training to use the same face mask. She said she should have a mask on all the time. She said she had not noticed it dropping below the bridge of her nose. On 5/4/2020 at 10:02 a.m., dietary aide (DA) #1 was observed exiting the dining room without a face mask on. She was observed to walk down toward the end of the hall and state, I'll be right back I forgot my mask. On 5/4/2020 at 10:12 a.m., certified nurse aide was observed wearing a cloth mask with her nose exposed. She said she had received training on how to properly wear PPE. She said she had to wear the mask below her nose because she had asthma and it was hard for her to breathe with the mask on. She said staff were given the option of wearing a cloth mask or a surgical mask. On 5/4/2020 at 10:23 a.m., registered nurse (RN) #1 was observed in Resident #4's room provides care. Resident #4 did not have a mask while RN #1 was providing care. The resident did not have a face cover or a tissue over his. She said residents had to wear a mask when they left the facility for an appointment and they did not need one while they were in their room. She also said she did not have a surgical mask on, only a cloth face mask. On 5/4/2020 at 10:31 a.m., CNA #3 and CNA #5 were observed in Resident #5's room provides care. Resident #5 did not have a face cover. CNA #3 said the only training she received was to make sure the resident had a face mask on when she left the facility. She said residents did not have to have a mask on in their rooms. She said she did not receive training for residents to have face covering while cares were being provided. On 5/4/2020 at 9:50 a.m., Resident #1, #11, #10, #8 and #9 were observed in the common area and halls not wearing masks. B. Staff interviews The director of nursing (DON) and assistant director of nursing (ADON) were interviewed on 5/4/2020 at 12:52 p.m. The DON and ADON were told of the observations above. The ADON said staff who work with residents needed to wear a surgical mask and should be wearing them while they are in the facility. The ADON said staff should be wearing their masks on the bridge of their nose and covering their mouth. The DON said they received guidance from their cooperation that it was okay for staff to wear cloth masks due to the shortness of masks, which would extend their supply. The DON and ADON both stated residents ' were not required to wear a mask while care was being provided. The ADON said the only time a

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) resident required a mask, was when they had an outside appointment. The ADON said they have tried to put masks on residents ' when they are outside of their rooms. She said the long term care unit was difficult because they refuse to wear their mask. She said we do not document the residents ' refusal to wear their mask. The DON said she will provide more education to the staff on wearing a surgical mask at all times and to have the residents wear a face covering while staff was in their room and place masks on residents ' who are outside their rooms. II. Improper housekeeping protocols A. Facility policies and procedures The Infection Control Policies and Procedures policy, revised 8/2012, was provided on 5/5/2020 at 3:03 p.m. by the ADON. To provide general guidelines for infection control program are to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections. B. Observations of improper housekeeping protocols On 5/4/2020 at 10:55 a.m., Housekeeper (HSK) #1 was observed cleaning room # S-52. Housekeeper HSK#2 put on gloves, and grabbed a rag, cleaner, and toilet brush and caddie. She placed the caddie on the floor next to the restroom. KSK #2 then grabbed a broom and dustpan from her cart. HSK #2 moved the resident ' s dresser and proceeded to sweep behind the dresser. She then moved the resident ' s bed and swept behind the bed. She exited the resident ' s room and proceeded to ring out the mop on her cart. She grabbed the mop and mopped behind the dresser and then behind the bed. She exited the resident ' s room and placed the mop back in the mop bucket. She did not change her gloves or utilize hand sanitizer. She reentered the resident ' s room and picked up the fall mat from underneath the roommates bed. She placed the mat next to the door and proceeded to sweep behind and underneath the resident ' s bed. She then swept the fall mat. She swept all of the trash into her dustpan and dumped the dustpan into her trash can. She sprayed a rag with the disinfectant and proceeded to wipe the resident ' s dresser and bedside table. She cleaned all areas with the same rag without spraying additional disinfectant on the rag. She exited the resident ' s room and placed the rag in a plastic bag on the side of her cart. She changed her gloves but did not utilize hand sanitizer. She put on a new pair of gloves and grabbed the mop. She rang the mop out and proceeded to enter the residents ' room and proceed to mop the floor behind and underneath the bed. She then exited the residents ' room and placed the mop back onto her cart. She then grabbed a rag from the top of her cart and grabbed a disinfectant from the caddie next to the restroom. She sprayed the sink, handrails, the top of the commode and the base of the commode. She did not allow for recommended dwell time on all items in the restroom. She wiped the sink, handrails, commode and toilet seat. She exited the restroom and placed the rag into the plastic bag on her cart. She removed her gloves and grabbed the mop and reentered the residents ' room. She proceeded to mop the floor in the restroom. She closed the door with her ungloved hands and finished mopping the restroom. She placed the mop back in the bucket on her cart and placed a wet sign next to the residents ' room. She did not wash or sanitize her hands after completing the cleaning of the room. C. Interviews The housekeeping supervisor (HSKS) was interviewed 5/4/2020 at 11:49 a.m. The LHSKM was told of the observation above. He said the housekeepers are supposed to go from clean to dirty, which was starting from the window working out towards the door with the restroom being the last task. He said it was his expectations the housekeeper would have followed facility procedure when cleaning the residents' rooms. He said she thought the dwell time for the disinfectant was three to five minutes. He said the housekeeper should have sprayed the restroom with the disinfectant and allowed for the dwell time. He said the housekeepers were to go into the room and cleaned the entire room. He said they were to wash and sanitize their hands after every task especially coming out of the restroom. He said mopping is the last task which should be done. He said a negative outcome for not following cleaning procedures and lack of dwell time would be cross contamination.