STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065015	A. BUILDING _____ B. WING _____	08/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MOUNTAIN VISTA HEALTH CENTER	4800 TABOR ST WHEAT RIDGE, CO 80033

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** - Few	**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 implement an effective infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection such as COVID-19 in two of four neighborhoods Specifically, the facility failed to: - Effectively quarantine residents who were newly admitted to the memory care unit; - Follow droplet precautions when entering rooms with residents under isolation; and, - Redirect and provide oversight for Resident #10 when the glass window was opened during an unscheduled window visit. Findings include: I. New admissions A. Professional standard According to the Center for Disease Control and Prevention (CDC), Preparing for COVID-19 in Nursing Homes, revised 6/25/2020 and retrieved 8/18/2020 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html. .(place) the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP (health care personnel should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission . B. Facility policy The Admission Standards for COVID-19 Pandemic policy, revised 4/13/2020, directed staff to obtain COVID-19 test results before admission for residents who are confirmed negative. Upon admission to the facility, staff were to educate the resident why droplet and contact isolation was necessary and in effect for a minimum of 14 days to prevent transmission to others. If unable to tolerate a mask make sure the resident has and can place a tissue over their mouth when caregivers are present in the room. C. Observation and interview A tour of the memory care unit was completed with the nursing home administrator (NHA) on 8/10/2020 at 4:45 p.m. Multiple residents were seated at tables in the common area, waiting for the evening meal to be served. Isolation carts were placed next to the entrance to two resident rooms. The NHA said Resident #4 and Resident #7 were on isolation as new admissions to the facility. Resident #4 and Resident #7 were not found in their respective rooms but instead were seated with other residents at the tables in the common area. None of the residents seated in the area wore protective face coverings. Licensed practical nurse (LPN) #1, who was passing medications in the memory care unit, said the new residents would not stay in their rooms and none of the residents cooperated with wearing a protective face covering. He said the staff tried to keep all of the residents separated but, because of their cognitive impairment, none of the residents cooperated very well. On 8/11/2020 at 11:18 a.m., housekeeper (HK) #1 was observed entering Resident #4's room. HK #1 wore a mask, eye protection and gloves but did not put on a gown. She said the nurse told her the resident was on isolation but he tested negative so it was okay to not don a gown. Resident #4 was seated in the common area near two other residents. None of the residents were wearing a protective face covering. Staff did not redirect the resident to his room and did not encourage any resident to wear their protective face covering. On 8/11/2020 at 12:38 p.m., Resident #7 was seated at a table near other residents in the memory care unit common area. Resident #4 wore a mask under his chin as he pushed his wheelchair across the common area within several feet of other residents who were seated at tables in the common area. Staff did not redirect Resident #4 or #7 to their room or encourage any of the residents to wear their protective face covering. On 8/11/2020 at 3:55 p.m., Resident #4 was observed as he lay on the bed in his room. Certified nurse aide (CNA) #1 went to check on him but did not don PPE prior to entering the room. Resident #7 was seated in the common area and did not have a protective face covering. Staff did not redirect Resident #7 to her room and did not encourage her to wear a protective face covering. CNA #1 said she was aware both residents were under isolation precautions because they were new to the facility. She described isolation precautions as having the residents stay in their room and the staff donned a gown, mask, eye protection and gown before entering the isolated resident's room. She said the residents did not have any symptoms and were not cooperative. D. Record review 1. Resident #4 Resident #4, age 79, was admitted on [DATE]. According to the admission facesheet, [DIAGNOSES REDACTED]. The 8/6/2020 minimum data set (MDS) revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of five out of 15. The comprehensive care plan, provided on 8/12/2020, identified the resident as a recent admission and was on isolation for 14 days. Interventions included, in pertinent part, isolate and initiate droplet precautions keeping (the room) door closed; and, restrict visitation, communal dining and group activities. The care plan also identified the resident was resistive to isolation orders and chose not to stay in a designated room during the isolation period. Interventions included, in pertinent part, discuss with resident implications of not complying with the therapeutic regime(sic); encourage to wear a mask when outside the room and wash hands frequently; if refuses care, leave and return in five to ten minutes; and, try to redirect undesired behavior. A laboratory report revealed the resident's test on 7/29/2020 was negative for COVID-19 (two days before admission). 2. Resident #7 Resident #7, age 81, was admitted on [DATE]. According to the admission facesheet, [DIAGNOSES REDACTED]. The 8/11/2020 MDS revealed the resident had severe cognitive impairment with a BIMS score of zero out of 15. The comprehensive care plan, provided on 8/12/2020, identified the resident as a recent admission and was on isolation for 14 days. Interventions included, in pertinent part, isolate and initiate droplet precautions keeping (the room) door closed; and, restrict visitation, communal dining and group activities. The care plan also identified the resident was resistive to care and isolation orders, choosing not to follow isolation guidelines and refusing to stay in her room. Interventions included, in pertinent part, discuss implications with resident; encourage resident to wear a mask when outside of room and to wash hands frequently; try to redirect undesirable behavior; and, if resident refused care, leave and return in five to 10 minutes. A laboratory report revealed the resident's test on 7/28/2020 was negative for COVID-19 (seven days before admission). E. Interviews LPN #1 was interviewed on 8/11/2020 at 4:00 p.m. He said staff try to get residents on the memory care unit to wear their masks and stay separated but sometimes the residents forget. He said newly admitted residents were supposed to be under isolation precautions for 14 days but, because of their cognitive impairment, they do not cooperate. He said staff should monitor the residents and encourage them to keep their distance from others while out of their rooms, depending on the physician's orders [REDACTED].#1 was interviewed on 8/11/2020 at 4:04 p.m. She said staff cannot do much about residents coming out of their rooms on the memory care unit. She said staff tried to keep them separated but the residents did not cooperate. ACT #1 said she was not sure what was left to do. The corporate director of clinical services (CDCS), the NHA and the director of nursing (DON) were interviewed on 8/11/2020 at 4:09 p.m. The NHA said there a lot of conversations were had with the county health department and with the epidemiology department at the Colorado Department of Public Health and Environment (CDPHE) about the facility's isolation plan. She said the facility received the go-ahead to have new admissions to the facility after being cleared of its previous outbreak of COVID-19. The NHA said staff from CDPHE epidemiology did a virtual tour of the facility, including the COVID-19 isolation unit and the facility's isolation plan was submitted to local and state agencies and was approved. The CDCS said the county health department was aware of the facility's plan to place new admissions directly on the rehabilitation and memory care units and the feeling was, do the best you can when it came to having residents with cognitive impairment

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 -** Few	(continued... from page 1) cooperate with staying in their rooms. The DON and NHA said residents were tested for COVID-19 prior to admission and were placed on 14 day isolation to observe for signs/symptoms of COVID-19 or other transmittable disease. The NHA and CDCS said residents on the memory care unit were not always cooperative with staying in their rooms despite staff encouragement. The DON said trying to get residents to wear a mask in that setting sometimes increased their agitation. The DON, NHA and CDCS acknowledged testing before admission was not required for admission as all newly admitted residents needed to be quarantined for 14 days. The CDCS agreed tests samples taken several days before admission would not necessarily reflect the resident's COVID-19 status at the time of admission. The NHA and DON said six of the nine residents on the memory care unit were recovered from COVID-19 however, the other three residents were not known to have been infected. Based on being newly admitted to the facility and their unknown COVID-19 status, the CDCS agreed Resident #4 and Resident #7 should have been isolated from the other residents on the memory care unit. The CDCS said the newly admitted should be encouraged to stay in their rooms and away from other residents. The NHA said any resident with a positive COVID-19 test or being presumptive positive would be transferred to the COVID-19 isolation unit. She said any resident with cognitive impairment would be placed on the isolation unit and receive one-to-one or other close supervision to keep them from wandering. The CDCS said the facility would suspend admissions to the memory care unit until a plan could be made to make new admissions directly to the COVID-19 isolation unit; discuss testing the three negative and newly admitted residents on the memory care unit; and, increase monitoring of residents and cleaning of surfaces in the memory care unit. The NHA and CDCS said staff should wear full PPE when entering the room of a person to provide care or clean. The CDCS said this should include eye protection, an N95 respirator, gown and gloves. II. Visits and social distancing A. Professional standard According to the CDC's Preparing for COVID-19 in Nursing Homes, revised 6/25/2020 and retrieved 8/17/2020 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, health care professionals (HCP) should Facilitate and encourage alternate methods for visitation and communication with the resident. A link to alternative methods for visitation included technology, cards and letters, recorded video messages and visits through a glass window . According to the CDC's Preparing for COVID-19 in Nursing Homes, revised 6/25/2020 and Retrieved 8/18/2020 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, each facility should, implement aggressive social distancing measures (remaining at least six feet apart from others) encourage resident and visitor use of face coverings, and, schedule visitation in advance to enable continued social distancing. B. Observation On 8/12/2020 at 11:05 a.m., Resident #10, who was not wearing a mask, was seated next to the exterior window in her room. The glass window was opened four to five inches as the resident was having a conversation through the window screen with someone outside her window. The visitor was seated in a folding chair several feet from the window. The visitor, who initially wore a mask, leaned into the window screen so the resident could hear which was less than six feet away. LPN #5 was summoned to the room. She knocked and entered as the door to the hallway was left open. LPN #5 told the resident she could not have the window opened during the visit. LPN #5 washed her hands and exited the room. The resident reopened the window several inches and spoke with the visitor, who had removed the mask and was within six feet from the resident. ACT #2, CNA #5 and HK #2 each passed by Resident #10's room but did not stop. LPN #5 did not return to monitor the resident's compliance and none of the staff listed above intervened, even though the voices of both the resident and visitor were clearly audible from the hallway as the window remained open. At 11:08 a.m., the NHA was summoned to the room and told the resident she would have to be placed on isolation as she had unprotected contact with someone who's COVID-19 status was unknown. The NHA told the resident it was important to follow this procedure to ensure [MEDICAL CONDITION] was not potentially spread to others in the facility. C. Interviews LPN #5 was interviewed on 8/12/2020 at 11:05 a.m. She said activities staff were responsible for scheduling resident/family visits that nursing staff were supposed to monitor. The LPN said she was not aware a visit had been scheduled. The NHA was interviewed on 8/12/2020 at 11:22 a.m. The NHA said the facility was not aware of the unscheduled window visit between the resident and her family from out of state. She said having the window opened during the visit increased the risk of transmitting COVID-19 to the resident and others in the building. She said the resident was placed on isolation precautions but was worried about having her door shut. The NHA said staff would work with the resident to leave her door open while continuing to limit the risk of potentially spreading an infection to others. The NHA said staff should have been aware the visit was taking place when they passed by the room. She also said staff should have followed up afterwards to ensure the resident did not open the window again.