STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065387	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOREST STREET COMPASSIONATE CARE CENTER	**3345 FOREST ST DENVER, CO 80207**

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** - Many	**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 properly maintain an infection control program designed to prevent the spread of COVID-19 in three of three neighborhoods. Specifically, the facility: -Failed to ensure appropriate resident hand hygiene was completed before the meal; -Failed to ensure shared medical equipment was cleaned and disinfected before and after use to prevent the spread of infection; -Failed to ensure nursing staff members used appropriate personal protective equipment (PPE) in isolation rooms designated for suspected COVID-19 positive residents as new admissions; and -Failed to ensure environmental staff performed hand hygiene while cleaning resident rooms. Findings include: I. Improper hand hygiene A. Professional standard The Centers for Disease and Prevention (CDC) Hand Hygiene in Healthcare Settings, last up updated 1/31/2020, retrieved from https://www.cdc.gov/handhygiene/providers/index.html, included the following recommendations: Multiple opportunities for hand hygiene may occur during a single care episode. Following are the clinical indications for hand hygiene: Use an alcohol-based hand sanitizer immediately before touching a patient, before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids or contaminated surfaces, and immediately after glove removal. Wash with soap and water when hands are visibly soiled, after caring for a person with known or suspected infectious diarrhea, and after known or suspected exposure to spores. When using alcohol-based hand sanitizer, put the product on hands and rub hands together. Cover all surfaces until hands feel dry. This should take around 20 seconds. When cleaning hands with soap and water, wet hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Avoid using hot water, to prevent drying of skin. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times. B. Facility policy and procedure The Hand Hygiene policy, last revised August 2015, was provided by the director of nursing (DON) on 5/17/2020 at approximately 8:30 a.m. The policy read in pertinent part: This facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All personnel shall follow the hand washing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Personnel should assist residents with performing hand hygiene at an increased frequency during any known outbreak to prevent further spread of infections. C. Observations The secure unit dining room was observed on 6/17/2020 at 7:55 a.m. Seven residents were sitting in the dining room/common area six feet apart. The dietary aide arrived on the unit with the meal cart at 7:57 a.m. Nurse aides (NAs) #1 and #2 washed their hands preparing to serve the residents their meals. NAs #1 and #2 served the residents their meals of toast, bacon and eggs. They did not offer the residents hand hygiene when they were served their meals to prevent transmission of infections. The residents were observed to use their fingers to eat their toast and bacon. Certified nurse aide (CNA) #2 was observed on 6/17/2020 at 8:20 a.m. passing room trays on the 100 hall. She entered room [ROOM NUMBER], placed the breakfast tray on the overbed table, and exited the room. She removed two breakfast trays from the serving cart and entered room [ROOM NUMBER]. She set the trays up for both residents and exited the room. She returned to the cart and removed one breakfast tray and entered room [ROOM NUMBER]. She set up the breakfast tray for the resident and exited the room. She then removed two trays from the cart and entered room [ROOM NUMBER]. She set the trays up for each resident and exited the room. She returned to the cart and removed one tray. She entered room [ROOM NUMBER]. She set the tray up for the resident and exited the room. CNA #2 failed to offer hand hygiene to the residents before eating breakfast. CNA #1 was observed on 6/17/2020 at 8:35 a.m. in the common area where two residents were waiting for breakfast. CNA #1 removed a breakfast tray from the cart and served it to the resident sitting at the first table. She removed a second breakfast tray from the cart and served it to the resident at the second table. Both residents began eating their breakfast with their hands. CNA #1 failed to offer either resident hand hygiene before eating breakfast. D. Staff interviews CNA #2 was interviewed on 6/17/2020 at 8:38 a.m. She said residents should be offered hand hygiene before every meal but she had forgotten to do it when she was passing room trays. She said it was important to wash their hands before meals to prevent the residents from getting sick. CNA #1 was interviewed on 6/17/2020 at 8:41 a.m. She said all residents should be offered hand hygiene before meals to help prevent the residents from any illnesses. She said she washed the residents hands and face when she helped them get ready for the day. However, that was hours earlier and some of the residents had already left their rooms and propelled throughout the hallways and common areas. NAs #1 and #2 were interviewed on 6/17/2020 at 8:15 a.m. They said they received Covid-19 training. They said the training included hand hygiene and how to don and doff PPE appropriately. NA #2 said the process was to offer residents hand hygiene in the morning upon arising, after the resident used the toilet and before and after meals. NAs #1 and #2 said they should have offered hand hygiene to the residents when they were served their meals but they forgot to do so. Licensed practical nurse (LPN) #1 was interviewed on 6/17/2020 at 8:17 a.m. She said she received training on Covid-19. She said the training included hand hygiene and how to don and doff PPE correctly. She said residents should be offered hand hygiene frequently during the day to prevent the transmission of infection. She said all staff were educated on hand hygiene. She said NAs #1 and #2 should have offered hand hygiene to the residents when they were served their meals to prevent the spread of infection. The director of nursing (DON) was interviewed on 6/18/2020 at 4:47 p.m. She said all residents should be offered hand hygiene at each meal for infection control. She said many hand hygiene in services had been done with the staff because of the coronavirus. She said going forward she would ensure a system was in place to offer residents hand hygiene before meals. E. Record review The Infection Control-Hand Hygiene training attendance record was provided by the DON on 6/17/2020 at 8:30 a.m. According to the attendance record, staff received hand hygiene training on 6/5/2020 which included: Residents to wash their hands before and after meals to prevent the spread of infection. II. Failure to disinfect resident care equipment before and after use A. Professional reference The Colorado Department of Public Health and Environment (CDPHE) for Covid-19 Preparation and Rapid Response Long Term Care Checklist, updated 5/13/2020, retrieved from https://www.cohca.org/wp-content/uploads/sites/170/2020/04/COVID-19_LTCF-checklist-1-1-1-2.pdf, included: Ensure all non-dedicated, non-disposable resident care equipment is cleaned and disinfected according to manufacturer's instructions after each use (e.g; thermometers, pulse ox, blood pressure cuffs, resident lifts). B. Observations On 6/17/2020 at 7:28 a.m., NAs #1 and #2 were observed in a resident's room on the secure unit taking the resident's vital signs. NA #1 removed the blood pressure (BP) cuff from around the resident's right arm. She immediately proceeded to the resident's roommate and applied the BP cuff around his left arm to take his BP. She did not clean and disinfect the BP cuff before she applied it to the resident's arm. After she had taken the resident's BP, she exited the room and proceeded to another resident who was sitting in the common area. She again applied the same BP cuff around the resident's arm without cleaning and disinfecting

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 BP cuff to prevent the transmission of infection. C. Staff interviews NA #1 was interviewed on 6/17/2020 at 8:16 a.m. She said she was provided education on cleaning and disinfecting shared medical equipment between residents. She said they were instructed to use the bleach clorox wipes to clean and disinfect the equipment before and after each resident's use to prevent the transmission of infection. She said she should have cleaned and disinfected the BP cuff between the residents' use, but she forgot to do so. The DON, who was also the infection control preventionist, was interviewed on 6/18/2020 at 10:15 a.m. She said all staff were provided education on Covid-19. She said the training included the signs and symptoms of Covid-19, hand washing, how to don and doff PPE correctly and social distancing. She said the training was ongoing as they received new updates on Covid-19. She said about two weeks ago, staff were provided education on hand hygiene. She said staff should offer residents hand hygiene before and after meals to prevent the spread of infection. She said staff were provided education on how to clean and disinfect shared medical equipment before and after use between residents. She said NA #1 should have cleaned and disinfected the BP cuff between residents to prevent the spread of infection. She said she would re-educate staff on hand hygiene for residents and cleaning and disinfecting shared medical equipment before and use. III. Failure to ensure nursing staff members used appropriate PPE in isolation rooms designated for suspected COVID-19 positive residents as new admissions A. Facility policy and procedure The Admissions Policy and Procedure was received from the NHA on 6/17/2020 at 8:30 a.m. It read in pertinent part: All recommended PPE should be worn, by dedicated staff, during care of residents under observation; this includes (the) use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. B. Observations The isolation unit was observed on 6/17/2020 at 6:30 a.m. Certified nurse aide (CNA) #3 came over to the entrance of the isolation unit through the zipped off section of the isolation unit. She was wearing a gown, gloves, and a surgical mask. The isolation unit was observed on 6/17/2020 at 9:15 a.m. CNA #3 and registered nurse (RN) #1 were both wearing surgical masks. C. Record review A progress note from 6/16/2020 at 7:22 p.m. documented the resident being admitted to the facility's isolation unit. D. Staff Interviews CNA #3 was interviewed on 6/17/2020 at 6:40 a.m. She said the resident arrived last night. She said they had plenty of all the PPE but had not been given N95 masks for the isolation unit yet. She said the facility had not finished setting up the PPE room yet because the resident was admitted the night before. She said she received PPE training in March and received updates as the facility received them. She said she had a face shield she used when giving the resident a shower. She said she was told she did not need to wear goggles while providing direct care because she wore glasses. RN #1 was interviewed on 6/17/2020 at 3:38 p.m. She said PPE training was given to all employees in March before the outbreak started. She said goggles, N95 masks, gowns, gloves, and face shields were to be worn while providing resident care. She said each staff member was assigned a face shield that they were to sanitize after each use and at the end of their shift before storage. The regional infection preventionist (RIP) was interviewed on 6/28/2020 at 3:48 p.m. She said staff on the isolation unit were to wear full-face shields, full-coverage goggles, gowns, gloves, and N95 masks. She said they had thousands of N95 masks and could not say why they were not stocked on the unit before the resident's arrival. She could not say why the staff was not wearing N95 masks the day before. The DON was interviewed on 6/18/2020 at 4:47 p.m. She said the facility started COVID 19 training back in March and updated staff as they got new information. She said she did the PPE training for all the staff. She said the training covered appropriate PPE to wear when working on the isolation unit and donning and doffing PPE. She said she also had the staff demonstrate how to don and doff PPE correctly. She said all staff working on the isolation unit were to wear a gown, gloves, N95 mask, face shield, and goggles. She said the unit manager in charge of stocking the isolation area did communicate to her that they needed N95 masks. She said she was responsible for double-checking the supplies of the isolation unit. E. Facility Follow-Up The isolation area was observed on 6/18/2020 at 3:21 p.m. There were N95 masks, face shields, goggles, gowns, and gloves in the PPE carts in the PPE room. The facility also added PPE donning and doffing guidance above the PPE carts and to the doors of each of the isolation rooms. IV. Failure to ensure environmental staff perform hand hygiene while cleaning the resident's rooms. A. Facility Policy and Procedure/Professional reference The Handwashing/Hand Hygiene Policy was received from the NHA on 6/18/2020 at 8:30 a.m. It read in pertinent parts: All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. B. Observations Housekeeper (HK) #1 was observed cleaning three rooms on the secured unit on 6/17/2020 at 9:25 a.m. He started cleaning room [ROOM NUMBER]. room [ROOM NUMBER] had a restroom and could occupy two residents; one resident resided in the room at the time. HK #1 donned gloves and began cleaning by spraying down the surfaces of the room and sink area. He let the spray sit while cleaning the floor. He began wiping the surfaces of the room starting with the doorknob, then the sink area, restroom, and finished with the living areas. He used a different cleaning cloth for the sink area, restroom, and living areas. He did not perform hand hygiene or change gloves between the living areas of the room. He removed his gloves and went down the hall to use the hand sanitizer dispenser on the wall. At 9:40 a.m. he began cleaning room [ROOM NUMBER]. room [ROOM NUMBER] had no restroom, only a sink, and was occupied by two residents. He donned gloves and began cleaning by spraying down the surfaces of the room and sink area. He let the spray sit while cleaning the floor. He began wiping the surfaces of the room starting with the doorknob, then the sink area, and finished with the living areas. He used a different cleaning cloth for the sink area and living areas. He did not perform hand hygiene or change gloves between the living areas of the room. He removed his gloves and went down the hall to use the hand sanitizer dispenser on the wall. At 10:00 a.m. he began cleaning room [ROOM NUMBER]. room [ROOM NUMBER] had a restroom and was occupied by two residents. He donned gloves and began cleaning by spraying down the surfaces of the room and sink area. He let the spray sit while cleaning the floor. He began wiping the surfaces of the room starting with the doorknob, then the sink area, restroom, and finished with the living areas. He used a different cleaning cloth for the sink area, restroom, and living areas. He did not perform hand hygiene or change gloves between the living areas of the room. He removed his gloves and went down the hall to use the hand sanitizer dispenser on the wall. C. Record review The Record of In-Service for Thorough Housekeeping/Deep cleaning/Hand hygiene, dated 6/15/2020, was received from the NHA on 6/18/2020 at 4:00 p.m. The documented objective of the in-service was that all environmental services staff be educated on the importance of keeping the facility clean and tidy, the thorough and mandatory cleaning of high touch surfaces, hand hygiene or hand washing between every room and after every bed, and donning and doffing gloves between each room performing hand hygiene between glove use. The in-service revealed HK #1 participated in the training for washing hands between each room and after all beds. D. Staff interviews HK #1 was interviewed on 6/17/2020 at 10:21 a.m. He said he received hand hygiene and PPE training when the outbreak started in March. He said he began cleaning in the living areas then worked his way to the restrooms or sink area while cleaning resident rooms. He said he had not received training on when to perform hand hygiene and change gloves while cleaning a resident room. The regional environmental services director (RESD) was interviewed on 6/18/2020 at 4:11 p.m. He said housekeeping staff went through the COVID-19 training with all the staff. He said housekeeping staff should perform hand hygiene before entering a room, between each area of the room and after completing the room before moving onto another room. He said it was important to perform hand hygiene after cleaning the restroom and sink area to prevent cross-contamination of the room. The NHA was interviewed on 6/18/2020 at 4:47 p.m. He said he conducted the hand hygiene and cleaning training with housekeeping and environmental services staff. He said the training covered cleaning and disinfecting the rooms and when to perform hand hygiene.