STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065206	A. BUILDING _____ B. WING _____	05/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROWAN COMMUNITY, INC	4601 E ASBURY CIR DENVER, CO 80222

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.** Based on observation and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of Coronavirus disease (COVID-19) and infection. Specifically, the facility failed to: -Ensure personal protective equipment (PPE) was worn in a safe and appropriate manner; -Ensure residents were provided with reminders and assistance to perform hand hygiene before meals; and -Ensure staff consistently washed or sanitized their hands to prevent cross-contamination. Findings include: I. Facility policy and procedures The Covid-19 policy and procedure, updated 3/31/2020, was provided by the director of nursing (DON) on 5/26/2020 at 3:31 p.m. The policy documented in part: - Donning/doffing PPE - Make sure to put on PPE prior to entering rooms on isolation, and remove and discard PPE before leaving the room. -For suspected or known COVID-19 staff are required to wear gloves, gowns, eye protection and N95 respirator. -Even if gloves are used, hand-hygiene always needs to be done in these situation: before and after contact with a resident, after contact with blood, body fluids, or visibly contaminated surfaces, after contact with objects and surfaces in the resident's environment, after removing PPE and before performing a procedure. -Make sure you are assisting residents with hand hygiene after toileting and before meals and please remind residents that are able to perform hand hygiene on their own. II. Professional standard The Centers for Disease Control and Prevention (CDC) Hand Hygiene in Healthcare Settings, last updated 4/15/2020, retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-strategies.html included: facilities should remind residents to perform frequent hand hygiene. III. PPE not donned properly A. Observations On 5/21/2020 at 12:00 p.m. registered nurse (RN #1) was observed at her medication cart preparing to go into a resident room with medications. She was wearing an N95 respirator with one strap holding it in place behind her head. The second strap was hanging down in front of her face below her chin. She had a blue surgical mask on underneath the N95 mask. The resident room was not under isolation precautions. On 5/21/2020 at 12:08 p.m. certified nurse aide (CNA #1) was observed at the East nurses station wearing her N95 mask and spraying a face shield with a spray bottle containing disinfectant. She was wearing a blue surgical mask underneath the N95. She said she was assigned to take care of the resident in isolation for Covid-19, and other residents that were not in isolation. She said she had just come out of the isolation room and was disinfecting her face shield for reuse. She said she wears her shield over her face each time she goes into the isolation room. On 5/21/2020 at 12:11 p.m. RN #1 continued down the east hallway to pass out more medications. She was still wearing her N95 mask in the same manner as previously observed (above). On 5/21/2020 at 12:12 p.m. RN #1 was observed preparing to go into the isolation room to give medications. She was wearing a disposable gown, gloves and her N95 mask. She had on a blue surgical mask underneath the N95 mask. The N95 straps were not placed on her head correctly. She did not apply a face shield or any goggles. She exited the room wearing only her face mask and in the same manner as when she went in. B. Staff interviews RN #1 was interviewed on 5/21/2020 at 1254 p.m. She was wearing the N95 mask in the same manner as observed earlier. She said she was almost finished passing out medications. She said she had received training in donning and doffing PPE but could not remember when that was. She said she did not know if she needed to wear a shield or eye protection when she entered a Covid-19 positive room. She said that there were directions outside the room on how to don the PPE appropriately. She said she must remove all PPE and wash her hands before coming out of the room. She said the preferred method was soap and water but that they could use hand sanitizer also. She said she did not receive specific education or training on how to properly wear the N95 mask. She said the one she had on today did not fit her well and it kept sliding off her face. She said staff was issued an N95 mask to wear for seven days and then they would get a new one after that. She said she wore the surgical mask underneath because it was more comfortable and easier to wear the N95 mask. Activity assistant (AA #2) was interviewed on 5/21/2020 at 12:58 p.m. She said she received a surgical mask to wear for five days. She said if she had to go into a Covid-19 positive room she would wear gown, gloves, face shield and her surgical mask and then dispose of all other PPE except the surgical mask. RN #2 was interviewed on 5/21/2020 at 1:07 p.m. She said when caring for a Covid-19 positive resident she would wear a gown, gloves, face shield and foot covers. She said an N95 mask had to be worn instead of a surgical mask and after caring for the resident she would discard all of her PPE and store her N95 in a paper bag for reuse. CNA #2 was interviewed on 5/21/2020 at 1:16 p.m. He was wearing an N95 mask. He said he wore the mask for five days and would get a new one after that. He said he received initial training on PPE as a group and staff receive updates as things change. He said if he was taking care of a Covid-19 positive resident he would put on a gown, gloves, face shield and booties. He said once the care was completed, he would remove all of the PPE except for the N95 mask. He said it was important to wear the face shield over the N95 to protect the mask. IV. Resident and staff hand hygiene A. Observations On 5/21/2020 beginning at 11:55 p.m. to 12:15 p.m., several staff were observed to pass out lunch trays to 10 residents on the East unit. The staff members did not remind or offer to assist these residents with hand hygiene. On 5/21/2020 at 11:53 a.m. and 12:01 p.m. two residents on the West unit received their lunch meal. These residents required assistance with eating. The residents were not offered hand hygiene by staff. RN #1 was observed coming out of the isolation room (above). She shut the door by the door knob with her bare hand and did not perform hand hygiene. She then pushed her medication cart to the next room to continue passing out medications. She entered a resident's room and proceeded to move a Hoyer lift out of the room into the hall. The CNA approached RN #1 and said she needed the lift back in the room. RN #1 then took the Hoyer back into the room. She did not wash or sanitize her hands after moving the lift. She then pushed her med cart to another room and began to prepare medications for the next resident. B. Staff interviews The central supply clerk (CSC) was interviewed on 5/21/2020 at 11:55 p.m. He said that he helps when he can. He said today he was helping to pass out the trays. He said he would go into the room, set the tray up for the resident and ask them if they need anything else. He said he would wash his hands inside the room before coming out or use hand sanitizer. He said he did not think about asking the residents to wash or sanitize their hands today. RN #1 was interviewed on 5/21/2020 at 2:40 p.m. She said that residents should be offered hand hygiene at meal time when taking the tray in to them. AA #1 was interviewed on 5/21/2020 at 2:45 p.m. He said he was also trained as a certified nurse aide (CNA). He said that he received training regarding Covid-19 policy and procedures. He said that included hand washing. He said that residents should be offered hand hygiene when they get their meals. He said the residents had small sanitizer bottles and wipes in their rooms. He said they could also go in the bathroom and wash with soap and water. He said that some residents were able to do this for themselves if they were reminded. He said other residents need guidance and assistance. He acknowledged that he did not offer residents hand hygiene today when passing out their lunch trays. The nursing home administrator (NHA), DON and infection preventionist (IP) were interviewed on 5/27/2020 at 10:15 a.m. The IP said staff had received training through their computer training program regarding hand hygiene and PPE use. The DON said managers observed 15-20 staff daily through audits for following proper procedure for hand hygiene and PPE. The IP said they have had a couple of staff trainings. He said they had training in March 2020 and then recently around May 18th. The NHA said they had a logging system for tracking staff training to ensure 100 percent completion. The NHA said that residents are educated about washing their hands after meals and wearing

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) masks. He said most of them are doing these things and some are not. The IP said residents had also been educated on coughing and sneezing etiquette. The IP said that staff are trained on the importance of hand hygiene. He said they should be washing hands before and after working with residents, in between residents, or; when touching surfaces. He said they should be washing their hands when they come out of resident rooms or after removing gloves. The NHA said staff should also be using hand sanitizing solution in between hand washing. The DON said that resident hand hygiene should be provided before and after meals. The NHA said that all staff had been trained on offering and assisting residents with hand hygiene with meals. The facility was asked to provide any additional training they had completed with staff regarding PPE and hand hygiene since 3/31/2020. As of 5/29/2020, no further information was received from the facility as requested.