STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065376	A. BUILDING _____ B. WING _____	04/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKDALE GREENWOOD VILLAGE	6450 S BOSTON ST GREENWOOD VILLAGE, CO 80111

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, record review, and interviews, the facility failed to properly maintain an infection control program designed to prevent the spread of COVID-19 in one of one neighborhoods. Specifically, the facility: -Failed to ensure staff were given and wore appropriate personal protective equipment (PPE) before entering a presumptive positive COVID-19 room; -Failed to perform hand hygiene before entering and exiting a presumptive covid-19 room, after touching potentially contaminated surfaces, and before donning and after doffing PPE; -Failed to encourage resident hand hygiene before meals; -Failed to ensure facility staff wore surgical mask while working with residents; -Failed to ensure residents were assisted and encouraged to wear face covering; and, -Failed to ensure the door to an isolation room with droplet precautions remained closed. I. Improper use of PPE A. Professional standard According to the Centers for Disease Control and Prevention (CDC) Using PPE, last updated 4/3/2020, retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html, included the following recommendations for how to put on (don) PPE gear: 1. Identify and gather the proper PPE to don. 2. Perform hand hygiene using hand sanitizer. 3. Put on an isolation gown. Tie all of the ties on the gown. Assistance may be needed by other healthcare personnel. 4. Put on NIOSH-approved N95 filtering facepiece respirator or higher (use a facemask if a respirator is not available). Do not wear a respirator/face mask under your chin or store in a scrubs pocket between patients. Respirator straps should be placed on the crown of head (top strap) and base of neck (bottom strap). Facemask ties should be secured on the crown of head (top tie) and base of neck (bottom tie). If the mask has loops, hook them appropriately around your ears. 5. Put on a face shield or goggles. 6. Perform hand hygiene before putting on gloves. Gloves should cover the cuff (wrist) of the gown. 7. Healthcare personnel may now enter the patient room. The CDC Key Strategies to Prepare for Coronavirus COVID-19 in Long Term care facilities, dated April 2020, the facility failed to ensure appropriate use of PPE. It read in pertinent part; If COVID-19 was identified in the facility, have health care providers (HCP) wear all recommended PPE for care of all residents (regardless of symptoms) on the affected unit (or facility-wide depending on the situation). This includes: an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and gown. HCP should be trained on PPE use including putting it on and taking it off. This approach is recommended because of the high risk of unrecognized infection among residents. Recent experience suggests that a substantial proportion of residents could have COVID-19 without reporting symptoms or before symptoms develop. B. Facility policy and procedure The infection prevention and surveillance policy and procedure, last revised in January provided by the NHA on 4/29/20 at 9:40 a.m., read in part: Nurse leader designee Plans and coordinates education programs based on prevention Shall assist with implementation of infection control and prevention and policies and support associate compliance and resident safety The COVID-19 mask guidance policy, dated April 2020 provided by the NHA on 4/29/2020 at 9:40 a.m., read in part: (Facility) requires all associates to wear masks and it is strongly encouraged that all residents and patients wear masks. The mask/respirator guide, dated 4/1/2020, was provided by the NHA. According to the guide, surgical masks must be utilized in combination with a face shield when caring for a COVID resident. The guide indicated the N-95 mask with a seal check had the highest level of filtration and was to be used when treating a COVID resident. C. Observations On 4/29/2020 at 10:15 a.m., an isolation cart was placed in front of room [ROOM NUMBER] on the third floor. The cart contained personal protective equipment (PPE) including a box of surgical masks. The cart did not contain staff issued N-95 masks. Two signs hung on the outside of the closed isolation room door. The signs read the resident was on droplet and contact precautions. According to registered nurse (RN) #2, the resident had some symptoms of COVID-19, including fever and vomiting. RN #2 said he continues to monitor her symptoms. -At this time, the staff needed to treat this resident as a presumptive case for COVID-19 until test results were obtained. On 4/29/2020 at 10:17 a.m., a resident sat in her wheelchair in the middle of the South hall. A cloth mask hung around her neck. The cloth mask was not properly secured around her face. Multiple staff members interacting with her did not encourage or assist her to secure her mask over her nose and mouth as she sat in the hall. -At 12:10 p.m. a resident sat out of her next to the housekeeping cart. She interacted with three staff members. They did not encourage her to wear a mask when she was outside of her room in the hallway. On 4/29/2020 at 12:20 p.m., RN #2 stood in front of the isolation room. RN #2 performed hand hygiene and donned PPE. RN #2 did not wear a N-95 mask or a full face shield over his surgical mask in place of a N-95. The RN entered the room and closed the door. -At 12:25 p.m. RN #2 exited the isolation room. Between 12:25 p.m. and 12:40 p.m., the door was left open to the hallway. Multiple staff members passed the open door. All the residents' room doors were open to the hallway on the South hall. The isolation room was directly across from the kitchen as staff exited the kitchen with plated room trays from resident delivery. D. Staff interviews The nursing home administrator NHA was interviewed on 4/29/2020 at 9:45 a.m. He said he recently received a shipment of N-95 masks two weeks ago. He said a resident on the third floor was exhibiting some symptoms of COVID-19. He said her test results were not back yet to confirm so staff was taking precautionary measures to prevent the spread of the [MEDICAL CONDITION]. CNA #4 was interviewed on 4/29/2020 at 11:13 a.m. She said staff was not provided with N-95 masks. She said staff was instructed to only wear surgical masks during resident cares, including when residents were in isolation for potential COVID-19. RN #2 was interviewed on 4/29/2020 at 11:40 a.m. He said he was not issued a N-95 or face shield to provide care to the isolated resident on contact and droplet precautions with potential COVID-19. The unit manager (RN #1) was interviewed on 4/29/2020. She said she was unsure why staff were not issued N-95 masks to provide care to a resident with potential COVID-19. RN #2 was interviewed a second time at 12:40 p.m. He said he was not sure if the isolation room door should be closed for a resident with potential COVID-19. He met with the UM and she informed him that the isolation room door should remain shut. RN #2 closed the door. At 12:45 p.m. the NHA was interviewed. He said he would issue N-95 masks to staff working with the resident in isolation to decrease the risk of staff contamination and spread of the [MEDICAL CONDITION]. The NHA and the clinical nurse consultant (CNC), who identified herself as the director of nursing and the NHA were interviewed on 4/30/2020 at 2:00 p.m. According to the NHA and the CNC, staff were inserviced on appropriate precautions after observations were shared. NHA stated that staff would be required to wear appropriate masks, direct care staff would not use cloth masks. Use of available and appropriate PPE would be available to staff. Staff would be issued N-95 masks when working with residents exhibiting symptoms of covid-19. The NHA stated staff should have worn all appropriate PPE, and don and doff in correct order to prevent the spread of potential transmission based infections, viruses. Doors of isolation rooms with residents on precautions with potential symptoms of covid-19, should remain closed. The NHA indicated residents would continue to be reminded and encouraged to wear a mask when outside of their room. II. Improper hand hygiene A. Professional standard According to 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

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) 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. Observations On 4/29/20 at 10:35 a.m., the laundry aide (LA) was observed removing bagged soiled linens out of the soiled lined closet with her gloved hands and placing the bags into her laundry cart. LA doffed her gloves, without hand hygiene, crossed the hall to the clean utility room, and touched the door handle of the door. She retrieved a bag from the clean utility room, donned new gloves without hand hygiene and fastened the bag to a barrel in the soiled utility room. She doffed the gloves without hand hygiene and pushed the laundry cart to the laundry room, touching high touch surfaces such as the elevator buttons, the hallway divider door and the laundry room door. At 10:40 a.m., LA entered the laundry room, donned a personal protective equipment (PPE) gown and a new pair of gloves without performing hand hygiene. Touched the handle of the washing machine to open. She removed the soiled linens out of each bag and placed the linen into the washing machine. She wiped down the laundry cart after all the soiled linens were emptied. LA doffed her gloves and then removed her gown, touching the front of the gown with her bare hands. LA disposed of the gown and then performed hand hygiene. On 4/29/20 at 12:10 p.m., an unidentified certified nurse aide (CNA) was observed serving a room tray to room [ROOM NUMBER] as the resident sat in her wheelchair outside of her room next to a housekeeping cart. The CNA placed the meal onto the resident ' s bedside table. The resident rolled herself into the room and in front of her bedside table. The CNA exited the room. The resident was not offered or encouraged hand hygiene before her meal. At 12:15 p.m., CNA #5 was observed serving a room tray to room [ROOM NUMBER]. The CNA did not offer hand hygiene to the resident prior to serving the meal and exiting the room. D. Staff interviews The director of maintenance (DM) was interviewed 4/29/20 at 10:55 a.m. She said she also oversaw the housekeeping and laundry staff. The DM said she witnessed several of the observed failures. She said hand hygiene should be performed after touching potential contaminated items, when donning and doffing PPE and when entering the laundry room. She said the LA should have removed her gloves after doffing her gown. The DM said LA should have defected the touched surfaces of the washing machine. The DM reviewed the observations with the LA and said she would also provide reminders to the other laundry staff members. CNA #5 was interviewed on 4/29/20 at 12:30 p.m. She said hand hygiene should have been offered to each resident before meals. CNC was interviewed with NHA on 4/30/20 at 2:00 p.m. The NHA said he was aware of the identified concerns with the LA. He said the DM provided increased education to the LA and the other laundry staff. The CNC and the NHA said staff have been in-serviced on proper staff and resident hand hygiene. The NHA said residents should always be offered hand hygiene before meals. He stated that staff should always perform hand hygiene, before, after and in between donning and doffing gloves to prevent the potential spread of viruses and infections. I. Professional reference According to 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. A. Observations On 4/29/2020 at 10:40 a.m., certified nurse aide (CNA) #3 was observed to push a resident from the shower room to her room in her wheelchair. The resident did not wear a mask or face covering. On 2/29/2020 at 11:00 a.m., CNA #1 was observed standing in the hallway on the unit. She wore a cloth mask. She did not have a surgical mask on. CNA #1 was further observed in a resident's room assisting the resident with his meal. She did not have a surgical mask. She wore a cloth mask. On 4/29/2020 at 12:35 a.m., CNA#2 went into a presumptive COVID-19 resident's room who was on transmission based precaution. She did not don PPE before entering the room. She was observed to reposition the resident with her bare hands. She exited the room and did not perform hand hygiene. B. Staff interviews CNA #3 was interviewed on 4/29//20 at 10:50 a.m. She said she provided shower to the resident. She said when residents were out of their rooms, they should wear a mask or face covering. She said the resident had a mask but she forgot to remind the resident to wear her mask while she was out of her room. CNA #1 was interviewed on 4/29/20 at 11:05 a.m. She said she was wearing a cloth mask. She said her brother made the mask for her and it was approved by the administration for her to wear it in the facility. CNA #2 was interviewed on 4/29/20 at 12:40 p.m. She said she was provided training on covid-19. She said she was trained on hand washing and PPE. She said She usually doesn't work on that unit. She said she was not aware the resident was on isolation precaution and she did not see the isolation cart in front of the door. Registered nurse (RN) #1 who was also the unit manager was interviewed on 4/29/20 at 1:00 p.m., she said all staff were trained on hand hygiene and PPE. She said CNA#2 should have performed hand hygiene and don appropriate PPE before entering the resident's room to prevent the spread of infection. She said she would reeducate CNA #2. The nursing home administrator (NHA) and the clinical nurse consultant were interviewed via phone on 4/30/20 at 2:00 p.m. The NHA said when residents were out of their rooms, staff should ensure residents wore a mask or face covering. He said staff should wear a surgical mask while in the facility. He said if staff wore a cloth mask, they should have a surgical mask under it. He said all staff were trained on hand hygiene and PPE. He said staff should perform hand hygiene before entering and exiting the resident's room to prevent the spread of infection He said staff should don the appropriate PPE before entering an isolation room. He said CNA #2 should not have entered the isolation room without performing hand hygiene and donning appropriate PPE. He said CNA #1 should have worn her surgical mask under her cloth mask. He said education would be provided to both CNAs.