STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065212	A. BUILDING _____ B. WING _____	08/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CENTENNIAL HEALTH CARE CENTER	1637 29TH AVENUE PL GREELEY, CO 80634

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** - Some	**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 maintain an effective infection prevention and 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 ensure hand hygiene was completed between glove changes while staff cleaned resident's rooms; -Failed to ensure staff doffed contaminated gloves before exiting resident rooms; and, -Failed to ensure residents covered their noses and mouths when staff were in their rooms. Findings include: I. Professional reference According to the Centers for Disease and Prevention (CDC) Hand Hygiene in Healthcare Settings, last updated 1/31/2020, retrieved on 8/10/2020 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. II. Facility policy and procedure The Infection Control policy and procedure, last updated 7/15/2020, was provided by the nursing home administrator (NHA) on 8/4/2020 via email. It read in pertinent part, Remove and discard gloves when leaving the resident room or care area, and immediately perform hand hygiene by washing hands with soap and water or using an alcohol-based hand sanitizer that contains 60 to 90 percent alcohol for at least 20 seconds. Resident use of face masks, when possible, when COVID-19 symptoms are present or not, residents should cover their nose and mouth whenever staff is in their room. Residents can use tissue to do this or they can use cloth non-medical masks when those are available. III. Observations A. Failure to perform hand hygiene while cleaning resident rooms. On 8/4/2020 at 10:40 a.m., housekeeper (HK) #1 was observed standing in front of room [ROOM NUMBER] located on unit three hall, with her cleaning cart, preparing to clean the resident's room. She had a pair of gloves on. She picked up a disinfectant from her cleaning cart and proceeded into the resident's room which was shared by two residents. She sprayed the disinfectant in the sink and in the toilet. After she was done spraying the disinfectant, she removed the trash from the room and proceeded to her cleaning cart. She removed her gloves and did not perform hand hygiene. She donned a clean pair of gloves. She took a wet rag from the cleaning cart from a bucket of solution and proceeded into the resident's room. She started cleaning the right side which was one resident's side of the room. She wiped down the bedside table, the dresser and the call light button. She proceeded to her cleaning cart and removed her gloves without performing hand hygiene. She donned a clean pair of gloves. She took another wet rag from the bucket of solution on her cleaning cart. She proceeded in the resident's room and started to clean the left side which was the other resident's side of the room. She wiped down the bedside table, the dresser, call light button, drawer handles and light switches. She proceeded to her cleaning cart and removed her gloves without performing hand hygiene. She donned a clean pair of gloves. She took another wet rag from the bucket of solution on her cleaning cart and proceeded to the resident's bathroom. She wiped down the sink and the toilet. She exited the bathroom and proceeded to her cleaning cart. She removed her gloves and did not perform hand hygiene. She donned clean pair gloves. She took the mop from her cleaning cart and proceeded to the resident's room. She mopped the floor. She removed her gloves and washed her hands. At 10:54 a.m., she proceeded to room [ROOM NUMBER] with her cleaning cart. She donned a pair of gloves. She picked the disinfectant from her cleaning cart and proceeded in the resident's room which was shared by two residents. She sprayed the disinfectant in the sink and in the toilet. She proceeded to her cleaning cart and placed the disinfectant on the cart. She proceeded in the room and removed the trash from the room. She placed the trash in the trash bag on her cleaning cart. She removed her gloves and did not perform hand hygiene. She donned clean gloves. She removed a wet rag from a bucket of solution on her cleaning cart and proceeded to the resident's room. She started cleaning the right side which was one resident's side of the room. She wiped down the bedside table, the dresser, drawers and call light button. After she had finished cleaning one side of the resident's room, she wiped down the door handles and light switches. She proceeded to her cleaning cart. She removed her gloves and did not perform hand hygiene. She donned a clean pair of gloves. She took a wet rag from the bucket of solution on her cleaning cart and proceeded to the other side (left side) of the room which was the other resident's side. She wiped down the bed side table, the dresser and the call light button. She proceeded to the bathroom and wiped down the sink and the toilet. She exited the bathroom and proceeded to her cleaning cart. She removed her gloves without performing hand hygiene and donned a clean pair of gloves. She took the mop from her cleaning cart and proceeded in the room. She mopped the floor. She proceeded to her cleaning cart. She removed her gloves and washed her hands. B. Failed to ensure staff removed contaminated gloves before exiting the resident care area. On 8/5/2020 at 9:58 a.m., certified nurse aide (CNA) #1 was observed in room [ROOM NUMBER]. She was measuring the resident's vital signs. After she was done measuring the resident's vital signs, she exited the room with her contaminated gloves on and proceeded down the hall to another resident's room, potentially spreading infection. She removed her contaminated gloves into another resident's room and she washed her hands. C. Failed to ensure residents covered their noses and mouths when staff were in their rooms. On 8/5/2020 at 10:05 a.m., CNA #1 entered Resident #1's room. The resident was sitting up in her wheelchair. There was no covering over the resident's nose and mouth. CNA #1 told the resident she was in her room to measure her vital signs. She did not offer the resident a face covering while she was in her room. -At 10:20 a.m., CNA#1 entered Resident #2's room. The resident was lying in her bed. She had a face mask on. The mask did not cover the resident's nose. The mask was below the resident's nose. CNA #1 bent over to the resident and told her she was in her room to measure her vital signs. She did not encourage or offer the resident to cover her nose while she was in her room. -At 10:25 a.m., CNA #1 proceeded to Resident #3 in the same room. The resident was lying in bed. There was no covering over the resident's nose and mouth. She bent over the resident and told her she was in her room to measure her vital signs. She did not offer the resident a face covering while she was in her room to prevent possible development and transmission of COVID-19. IV. Staff interviews HK #1 was interviewed on 8/4/2020 at 11:10 a.m. She said she received training on COVID-19 that was provided by her supervisor. She said the training included the steps on cleaning resident's rooms, dwell times for chemicals and handwashing. She said she was trained to wash her hands with soap and water after she was done cleaning the room. She said she was not aware that she should perform hand hygiene every time she removed her gloves. She said moving forward, she would perform hand hygiene every time she removed her gloves. CNA #1 was interviewed on 8/5/2020 at 10:17 a.m. She said she received training on COVID-19 that was provided by the director of nursing (DON). She said the training included signs and symptoms of COVID-19, handwashing, social distancing, face covering for residents when out of their rooms, disinfecting shared medical equipment before and after use and appropriately donned and doffed personal protective equipment (PPE) correctly. She said she was aware that contaminated gloves should be removed before exiting the resident's room after

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 -** Some	(continued... from page 1) providing care. She said when she measured the resident's vital signs, she forgot to remove her gloves before exiting the resident's room. She said she did not receive training about offering the resident to cover their noses and mouths while staff was in their rooms. She said moving forward she would ensure to offer residents to cover their noses and mouths when in their rooms. The housekeeping supervisor (HKS) was interviewed on 8/5/2020 at 10:00 a.m. She said she was responsible for the housekeeping and laundry department. She said she provided education to her staff on COVID-19 and the training was ongoing as new updates became available. She said the training included the signs and symptoms of COVID-19, handwashing and the process of cleaning the resident's room. She said HK#1 was trained to perform hand hygiene every time she removed her gloves while cleaning the resident's room to prevent the development and the transmission of COVID-19. She said HK #1 should have performed hand hygiene every time she removed her gloves and before putting on clean gloves and would provide additional training to HK #1. The DON, who was also the infection control preventionist, was interviewed on 8/5/2020 at 11:07 a.m. She said she had been in her position since June 2020. She said there were no current cases of COVID-19 at the facility. She said she provided training to all staff on COVID-19. She said the training included handwashing and PPE since June 2020. She said the staff received training on COVID-19 prior to her being in her position. She said the training included signs and symptoms of COVID-19, how COVID-19 was transmitted, facemask, social distancing, hand washing and PPE. She said all staff were trained to wash their hands with soap and water or to use the alcohol-based hand sanitizer every time gloves were removed to prevent the development and transmission of infection. She said HK #1 should have performed hand hygiene every time she removed her gloves before donning on clean gloves. She said CNA #1 received training on the appropriate way to doff PPE. She said she should have removed her contaminated gloves before exiting the resident's room to prevent the spread of possible infection. She said she had not trained staff to offer residents to cover their noses and mouth when staff was in their rooms providing care. She said she would immediately educate all staff to offer residents face covering when they are in their rooms providing care. V. Facility follow-up On 8/5/2020 at 12:05 p.m., the DON provided an in-service training form dated 8/5/2020, that she provided to CNA #1. It documented: gloves should be removed before exiting the patient room, hand hygiene performed before leaving the room. When providing patient care, encourage patients to wear face covering to prevent possible transmission. On 8/6/2020 at 1:53 p.m., the NHA provided an in-service training form dated 8/4/2020 via email. It documented: infection control, hand washing, donning and doffing It revealed the training was provided to laundry and housekeeping staff.