STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065168	A. BUILDING _____ B. WING _____	**10/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ASPEN LIVING CENTER	**1795 MONTEREY RD COLORADO SPRINGS, CO 80910**

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, interviews and record review the facility failed to implement an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the possible development and transmission of Coronavirus (COVID-19) and other communicable diseases and infections in two out of five units. Specifically, the facility failed to: -Ensure residents were provided with hand hygiene prior to eating their meal; -Ensure staff to wear appropriate personal protective equipment (PPE)(N95 masks) and encourage residents to wear face coverings during interactions with staff; -Ensure staff received additional training on infection control procedures prior to working in the facility with COVID-19 positive and presumed positive residents; and, -Ensure proper isolation PPE was done inside residents ' rooms. Findings include: A. The Centers for Disease Control (CDC) references According to CDC guidance, How to Protect Yourself and Others, updated 9/11/2020; retrieved 10/25/2020 from: https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html Everyone should wash your hands often, especially after you have been in a public place, or after blowing your nose, coughing, or sneezing. It is especially important to wash: Before eating or preparing food. Before touching your face. After using the restroom. After leaving a public place. After blowing your nose, coughing, or sneezing. After handling your mask. The CDC PPE Sequence print outs, undated, accessed on 10/25/2020 https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf. It read in part, Remove all PPE before exiting the patient room except a respirator, if worn. According to the Centers for Disease Control (CDC) website, Preparing for COVID-19: Long-term Care Facilities, Nursing Homes last updated 5/7/2020, retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html Patients may remove their cloth face covering when in their rooms but should put them back on when leaving their room or when others enter their room. B. Facility policy The Changes to Current Infection Control Practices, effective 10/18/2020, read in part: Gowns will be changed with each resident/room encounter. New gown upon entry to room, removal at the door followed by hand hygiene. Facility will institute house wide N95 use for all care staff. Facility will increase COVID testing to twice weekly in an attempt to track and respond quicker. C. Observations and interviews 1. Residents ' hands hygiene On 10/19/2020 at 5:20 p.m. Cherry Blossom Lane (unit#5) was observed during supper meal service. Two certified nurse aides (CNAs) were observed taking food trays to residents ' rooms. The continuous observations revealed the residents were not offered hand hygiene before food was served. Most residents were observed using their hands to consume the meal. On 10/19/2020 at 5:56 p.m., Resident #1 said she was not offered by staff to wash or sanitize her hands. She said she did not have a hand sanitizer in her room. On 10/19/2020 at 6:00 p.m. CNA#1 said she did not offer hand washing or a hand sanitizer to residents before the meal. She said the hand sanitizer was in the wall dispensers on the hallway for staff to use. She said residents did not have hand sanitizer in their rooms. On 10/20/2020 at 12:05 p.m. Pine Lane (unit#4) and Cherry Blossom Lane (unit#5) were observed during lunch meal service. Nursing staff was observed taking food trays to residents ' rooms. The continuous observations revealed the residents were not offered hand hygiene before food was served. Most residents were observed using their hands to consume the meal. On 10/20/2020 at 12:35 p.m., Resident #2 said she was not offered by staff to wash or sanitize her hands before lunch meal. She said she did not have a hand sanitizer in her room. On 10/20/2020 at 12:37 p.m., Resident #3 said she was not offered by staff to wash or sanitize her hands before lunch meal. She said she went to the bathroom in the morning and washed her hand then, however she was not reminded to wash hands before lunch. 2. PPE and staff training On 10/20/2020 at 11:54 a.m. two CNAs were observed assisting a resident in room [ROOM NUMBER]. They repositioned him in bed, took his vital signs, and during this time, approximately 10 minutes, the resident was not offered to wear a facemask. On 10/20/2020 at 12:06 p.m. registered nurse (RN#2) was observed on unit #4, going in and out of residents ' rooms. She wore a black colored, fabric facemask. She said she was a staffing agency nurse. She said she entered the facility at 10:00 a.m. and was screened for signs and symptoms of COVID-19 and her body temperature was taken. She said it was her first time working in this facility. She said she works as a nurse practitioner in a psychiatric hospital, in a physician office and for a staffing agency. She said she was never tested for COVID-19. She said she did not receive any infection control training and was not informed of the COVID-19 status at the facility. She said she was not aware she should be wearing a N95 mask in the facility. She said no one informed her, approached her or offered N95 mask. On 10/20/2020 at 12:25 p.m. RN#1 said one resident on unit #4 was showing signs and symptoms of COVID-19. He said the resident was tested for COVID-19 and was on droplet precautions isolation in her room while waiting for the test result. On 10/20/2020 at 12:27 p.m. CNA#2 said she was not updated on the COVID-19 status in the facility and did not remember when was the last time she received infection control training. On 10/20/2020 and 10/21/2020, throughout the infection control survey, staff were observed leaving residents ' rooms wearing full PPE and taking gowns and gloves off (doffing) on the hallway and disposing the used PPE in a containers that were placed outside of residents ' rooms, a few feet away from the doors. D. Interviews The director of nursing (DON) was interviewed on 10/20/2020 at 2:08 p.m. She said it was the facility policy that shaff should be tested for COVID-19 twice a week. She said RN#2 should not be working in the facility without the most recent negative test result for COVID-19. She said the agency was responsible for testing their staff prior to sending them to a nursing facility. She said RN#2 will be tested immediately. The infection preventionist (IP) was interviewed on 10/20/2020 at 2:32 p.m. She said RN#2 should not be working in the facility without a N95 mask. She said she provided the mask to RN#2 as soon as it was brought to her attention. She said all residents in the facility should be encouraged and assisted with hand washing using soap and water or a hand sanitizer. She said she will provide a pocket size hand sanitizer to all of the nursing staff and provide an education on residents hand washing, starting with the evening shift today. She said she will provide all staff education on wearing and appropriately disposing of PPE. E. Status of COVID-19 in the facility The nursing home administrator (NHA) and the DON were interviewed on 10/19/2020 at approximately 7:00 p.m. They said the outbreak started on hall six hundred (unit #6) when COVID-19 test results indicated that seven residents were positive on 10/13/2020. They said at that point hall 600 was closed off and isolated from the rest of the facility. The NHA said all of the residents, except those who refused and all staff, were tested twice a week. On 10/20/2020 at 11:10 a.m., the DON provided a written report of new COVID-19 cases in the facility. She said residents were tested on [DATE] (Sunday) and the results were sent this morning (Tuesday) indicating five residents on hall three hundred (unit#3) were positive for COVID-19. She said four other residents on the unit were still waiting for the test results. She said unit#3 was closed off and all residents were isolated from the rest of the facility. On 10/23/2020 at 3:39 p.m. the DON provided COVID-19 positive test result for resident on unit #4 (symptomatic resident was tested on [DATE], please see above RN#1 interview).

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE