STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065191	A. BUILDING _____ B. WING _____	07/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AUTUMN HEIGHTS HEALTH CARE CENTER	3131 S FEDERAL BLVD DENVER, CO 80236

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 the novel Coronavirus (COVID-19) in three of three neighborhoods. Specifically, the facility: -Failed to consistently provide, document and review active screening for staff and other visitors before they entered the building; -Failed to develop and follow an active screening policy and procedure for COVID-19; -Failed to ensure staff properly and consistently used personal protective equipment (PPE) when entering the facility and entering presumptive COVID-19 positive residents' rooms; -Failed to ensure staff performed hand hygiene after they touched and adjusted their facemasks; -Failed to encourage and ensure residents wore facemasks appropriately when out of their rooms; and, -Failed to encourage residents who smoked outside without supervision to perform hand hygiene when they returned into the building. Findings include: I. Facility status The nursing home administrator (NHA) was interviewed on 7/14/2020 at approximately 8:15 a.m., 12:45 p.m. and 4:30 p.m. She said no current staff or residents were positive for Covid-19. Two residents were presumptively positive, recently hospitalized and readmitted , and on isolation precautions. Ninety-two residents resided in the facility. There were no presumptively positive staff cases, all staff were tested weekly, and staff testing was being conducted that day. She said the facility was in conventional mode for PPE. II. Failed to consistently provide, document and review active screening for staff and other visitors A. Professional standards 1. According to the Centers for Disease Control and Prevention (CDC) updated 6/25/2020, retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, included the following recommendations: Actively screen everyone for fever and symptoms of COVID-19 before they enter the healthcare facility. Screen all healthcare personnel at the beginning of their shift. Actively take their temperature and document the absence of symptoms consistent with COVID-19. 2. Centers for Medicare and Medicaid Services (CMS) (4/2/2020) COVID-19 Long-Term Care Facility Guidance. Retrieved from: https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf. It read in pertinent part, Long-term care facilities should immediately implement symptom screening for all. Facilities should limit access points and ensure that all accessible entrances have a screening station. B. Observations On 7/14/2020, the facility's screening process for all healthcare personnel and other visitors who entered the facility was observed. The screening area was located at the main entrance receptionist's office, and was secured with a keypad code. Staff knew the code and were able to enter it in order to enter the facility to be screened. Other visitors pushed the doorbell and were selectively allowed entrance into the screening area. The following was observed: -At 8:03 a.m., the business office assistant (BOA) was at the reception desk and held an infrared forehead thermometer. She took the temperatures of four people who entered the facility. She took them quickly, one immediately after the other, and announced the results aloud for the recipient to hear. Each person completed their own screening form, documented their temperature on the paper, and then inserted the form facedown into a three-ring binder. The screener did not look at the documents and allowed the people to enter the facility. She said when the binder became full; the screening forms were placed in a box in the business office. -At 8:36 a.m., the business office manager (BOM) entered the facility and the BOA performed her screening. The BOA took the BOM's temperature and informed her what the results were, and the BOM completed the form herself and placed face down in the binder. The BOA did not review it, and the BOM was allowed to work in the building. -At 9:00 a.m., a staff member entered the facility. The BOA took her temperature and announced it verbally. The staff member completed her own screening form and placed face down in the binder. The BOA did not review the form and the staff member was allowed to work in the building. -At 9:05 a.m., two staff members entered the facility. The BOA took their temperatures and announced them aloud. The staff members completed their screening forms independently and placed them face down in the binder. The BOA did not review either of the forms and they were allowed to work in the building. -At 9:07 a.m., a female staff member entered the facility. The BOA took her temperature and announced it verbally. The staff member completed the screening form independently and placed it face down in the binder. The BOA did not review the form and the staff member was allowed to work in the building. -At 9:08 a.m., a male staff member entered the facility. The BOA took his temperature and announced it verbally. The staff member completed the screening form independently and placed it face down in the binder. The BOA did not review the form and the staff member was allowed to work in the building. -At 9:16 a.m., a male staff member entered the facility and explained he was there for new employee orientation. The receptionist took his temperature and announced it verbally, then began talking to a resident who had questions about his personal needs fund. The new staff member completed the screening form independently and placed it face down in the binder. The receptionist did not review the form and the staff member was allowed to work in the building. -At 12:03 p.m., food/nutrition assistant (FNA) #2 approached the receptionist's area but had not entered through the main entrance. The receptionist took her temperature and announced it verbally. The receptionist offered her a new facemask and the FNA accepted it and placed it on over her nose and mouth. -At 12:13 p.m., a staff member entered the facility. The receptionist checked her temperature, announced it aloud, then walked away from the reception area and left the associate to complete the form independently. The staff member placed the form face down in the binder and proceeded into the building. The receptionist did not review the screening form. C. Record review On 7/14/2020 at 2:13 p.m., the nursing home administrator (NHA) was asked to provide the facility's policy and procedure for screening staff and visitors upon entrance for COVID-19. She said the facility had a policy for screening residents but did not have a policy specific to screening staff and visitors. The in-service/education documentation provided to the front desk staff was reviewed. It included one training date of 3/31/2020, which was provided by the staff development coordinator (SDC). It was attended by the BOA, the receptionist, and accounts payable associate (APA). It included the following guidance: You must take the temperatures and check the form for every person entering the building. You need to inquire who they are and why they were there as well. Please ensure all checks are signed off and accurate. Notify NHA with any questions or concerns on the screens. There were no additional follow up in-services or education provided to the screeners since the initial training on 3/31/2020. The screening form, Respiratory Disease Screening, last updated 6/26/2020, was reviewed and included the instructions, Must be completed with any person entering building. If a person had a new onset of fever, coughing, or shortness of breath/difficulty breathing, the form instructed them they must speak to management prior to entering the community. If they had two of the following symptoms, they must speak to management prior to entering: Sore throat, congestion, runny nose, nausea/vomiting/diarrhea, new loss of sense of taste and/or smell, chills/shaking with chills, headache, fatigue, or muscle/body aches. The bottom of the form asked if the individual had washed their hands or used alcohol-based hand rub (ABHR) on entry, and if they did not, please ask them to do so. The forms did not include a space to document who provided the screening, time the screening was completed or any follow up that was conducted if the individual had symptoms. Sixty completed screening forms were reviewed and included the following: Three forms, dated 7/12/2020, were void of documentation of a temperature. A form, dated 7/12/2020, was void of documentation of a temperature or whether the individual performed hand hygiene upon entry. A form, dated 7/12/2020, documented the individual did not perform hand hygiene upon entrance to the facility. A form, dated 7/13/2020, was void of documentation if the staff member had headache,

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) fatigue, or muscle/body aches. A form, dated 7/13/2020, was void of documentation if the individual had a new loss of sense of taste or smell, and documented they did not perform hand hygiene upon entrance to the facility. Two forms were undated and void of documentation if the individuals performed hand hygiene upon entry. Four forms, dated 7/13/2020, were void of documentation if the individuals performed hand hygiene upon entry. A form, dated 7/13/2020, was void of documentation if the staff member had fatigue. D. Staff interviews The BOA was interviewed on 7/14/2020 at 12:44 p.m. She said was the designated screener in the mornings before the receptionist arrived for the day at 9:00 a.m., and had been conducting the screenings since they started locking the main entrance doors at the beginning of the COVID-19 pandemic. She said the main front entrance was where all staff were supposed to enter in order to be screened. She said prior to providing the screenings, the staff development coordinator (SDC) showed her how to use the thermometer to take temperatures, but did not recall the screening form being reviewed with her. The BOA said when an individual approached the building, if they were a visitor, they would ring the doorbell and the screener would answer it. Staff members knew the code and would enter it to go into the facility. She said the screener would take the individuals' temperatures and then they were supposed to perform hand hygiene and complete the screening form themselves. She explained she was supposed to check it to make sure they were doing it correctly. She said if they had any symptoms, even if it was only one symptom, she was supposed to inform the NHA who would follow up with them. She said sometimes individuals just quickly filled out the form and did not complete it correctly. The receptionist was interviewed on 7/14/2020 at 12:50 p.m., and said she was the facility's designated screener five days a week from 9:00 a.m. to 5:00 p.m. She said she was taught how to use the thermometer, to instruct individuals to sanitize their hands when they first entered, and to fill out their own form. She said she would look over their form after the individual completed it and then place it in the binder. She said if the person had any symptoms, she took the form to the NHA who would review their symptoms further. The receptionist said the signs and symptoms they were screening for included a fever, sore throat, headache and fatigue. She said, I think that's all there is to look for. Whatever is on that form. She said the form changed frequently. She explained after the individuals completed it, she would make sure they filled it out correctly and then place it in the binder. The SDC and assistant director of nurses (ADON) were interviewed on 7/14/2020 at 1:06 p.m. The SDC said she supported the staff members who were designated to screen individuals who entered the facility, and provided re-education to the process if needed. She clarified that her training responsibilities were broader and included the whole building, rather than individual training for screeners. However, she said she had reviewed the screening forms with them, told them what needed to be filled out, and if a person had any symptoms, the individual was supposed to talk to the NHA before they were allowed to enter the facility. The ADON said the facility had one entrance for staff to enter through, which was at the main entrance of the building. She clarified the facility had several entrances, but the main entrance was the one they utilized. She said, That is how we keep everyone on track. The SDC said the screeners were supposed to review the completed form at the time an individual's entrance to the facility, and make sure everything was filled in. Beyond that review, she did not know of any other staff members who reviewed the forms. The ADON said she did not personally review them and thought maybe the NHA did. The SDC and ADON said they were not aware of any competencies or checklists completed for the staff who provided screening. The NHA was interviewed on 7/14/2020 at 2:13 p.m. She said if an individual had a symptom of COVID-19 that was identified during the screening process, the follow up and further review of the symptoms should be written on the screening form, but that was not happening. She said the screeners received training in March 2020 that described their duties at the front desk. She said the screening process had evolved since the beginning of the pandemic and they did more informal training for the screeners as things changed. She said the expectation was each form should be filled out completely and the screeners should review for that. She said they did not complete competencies or a skills checklist that documented those expectations, and the training was done one-on-one with each screener. The NHA said the last time the screening forms were reviewed by the facility staff was on 5/5/2020, and there was not a process in place for them to be periodically reviewed. She said an action plan, dated 7/14/2020 (that day) had been completed to address this and moving forward, they would be reviewed daily in the morning meetings and then again monthly in the QAPI (quality assurance/performance improvement) meetings. She said in the future, they would review the forms to make sure they were accurate. She said, It was just check, check, check down the form and we weren't reviewing it. III. Failed to consistently provide and document active screening for staff and other visitors A. Observations On 7/14/2020 at 12:00 p.m., food/nutrition aide (FNA) #2 entered the facility through the door adjacent to the dietary department. She walked through the facility to the screening station located inside the main entrance. There was no employee screening located in the hallway where she entered. B. Interviews Food/nutrition aide (FNA) #2 was interviewed on 7/14/2020 at 12:20 p.m. She said she entered through the door by the dietary department out of habit. She said she had entered through this door many times to begin her shift and had not been told to only enter through the front door. The food/nutrition manager (FNM) was interviewed on 7/14/2020 at 1:15 p.m. He said he educated FNA #2 on the proper entrance to use when staff report to work and dietary staff education would be ongoing. IV. Failed to ensure staff properly and consistently used PPE A. Observations On 7/14/2020 at 8:20 a.m., maintenance assistant (MA) #1 was observed as he entered the building through the door adjacent to the environmental services office. His cloth mask slipped below his nose multiple times after which he would readjust the mask to cover his nose. MA #1 was observed a second time on 7/14/2020 at 9:30 a.m. and he was wearing a surgical style mask. He said he had been asked to change his mask because the cloth mask did not fit properly. On 7/14/2020 at 9:08 a.m., registered nurse supervisor (RNS) #1 was observed in the common area adjacent to the supervised smoking area. She was in conversation with two other staff members and was not wearing a face mask. On 7/14/2020 at 12:00 p.m., food/nutrition aide (FNA) #2 entered the facility through the door adjacent to the dietary department. Her surgical mask was looped behind her ears and pulled below her chin as she spoke on her cell phone. She continued her call in the hallway with her mask below her chin as multiple staff members walked out the exit door or to the downstairs area. B. Staff interview The nursing home administrator (NHA) was interviewed on 7/14/2020 at approximately 1:30 p.m. She said staff members shared with her the observations of RN #2 and FNA #2 not wearing face masks while in the facility. She said education had been provided to these two staff members and education for all staff was ongoing. V. Failed to ensure staff wore proper PPE when entering isolation rooms A. Facility policy and procedure The COVID-19 PPE Use, Isolation and Best Practices policy, dated 6/2/2020, was provided by the NHA on the afternoon of 7/14/2020. The policy documented, in pertinent part, the following: -People who enter the room of a patient with known or suspected COVID-19 should adhere to standard precautions and use a respirator (or facemask if a respirator is not available), gown, gloves, and eye protection. (Droplet Precautions). -Admissions from the hospital: .Unknown Covid status (includes persons who have had a negative Covid test): Admit and observe for 14 days, using full PPE. B. Professional standards According to the Centers for Disease Control (CDC), Considerations for New Admissions or Readmissions to the Facility, https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html, updated 4/30/2020 (accessed 7/14/2020), in pertinent part: Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19. -All recommended COVID-19 PPE should be worn during care of residents under observation, which includes 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. -Testing residents upon admission could identify those who are infected but otherwise without symptoms and might help direct placement of asymptomatic [DIAGNOSES REDACTED]-CoV-2-infected residents into the COVID-19 care unit. However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. Testing should not be required prior to transfer of a resident from an acute-care facility to a nursing home. C. Observations Beverage pass prior to lunch service by certified nurse aide (CNA) #2 was observed on 7/14/2020 at 12:00 p.m. for two Covid-19 presumptive resident rooms (#400 and #406). CNA #2 was wearing a surgical mask, performed hand hygiene, donned a gown and gloves, and knocked on the open door and entered room [ROOM NUMBER]. She did not don an N95 mask or eye protection. She asked the resident what he would like to drink, poured the drinks, and set the resident's drinks on his bedside table. She then doffed the gown and gloves, performed hand hygiene and wheeled the beverage cart down the hall. -At 12:06 p.m., CNA #2 donned a gown and gloves, poured drinks and entered room [ROOM NUMBER] to deliver drinks to the resident. She was wearing the same surgical mask, and did not wear an N95 mask or eye protection. D. Staff interviews CNA #2 was interviewed on 7/14/2020 at 12:12 p.m. She said the residents in rooms #400 and #406 were on isolation precautions due to recent hospitalization s, and staff had been instructed to wear gowns, gloves and masks but not N95 masks or eye protection when entering their rooms. She said the residents had tested negative, staff were tested

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) on ce weekly, and she was not providing direct resident care. Even so, she said there was no need for N95 masks and eye protection. She said her most recent training was received at the beginning of the Covid-19 pandemic. The NHA was interviewed on 7/14/2020 at 12:45 p.m. She said the resident in room [ROOM NUMBER] was readmitted from the hospital on [DATE], the resident in room [ROOM NUMBER] was readmitted from the hospital on [DATE], and both residents would be in isolation for 14 days after their readmitted s. She said when entering their rooms, staff should wear gowns, masks, face shields, gloves and N95 masks. During an interview on 7/14/2020 at 4:30 p.m., the NHA and ADON/infection control nurse said they would ensure staff wore appropriate PPE in presumptive positive resident rooms. They said staff training on proper PPE use was being conducted that day. VI. Staff failed to perform hand hygiene after touching facemasks A. Observations On 7/14/2020 at 8:27a.m., MA #1 was observed as he exited the building through the door adjacent to the environmental services office. He carried a piece of furniture to the trash dumpster area. He closed the two large lids to the trash dumpster and entered the building. He touched his cloth face mask multiple times to adjust it over his nose. He did not perform hand hygiene after touching the trash dumpster and entering the building or after touching his cloth mask. On 7/14/2020 at 9:32 a.m., the ADON touched her facemask that was falling below her nose with her right hand and adjusted it on her face. She did not wash or sanitize her hands after touching the facemask, and continued down the hallway and began talking to another staff member. B. Interview During an interview on 7/14/2020 at 4:30 p.m., the NHA said staff should perform hand hygiene after touching thei rmasks, because touching and adjusting one's mask was the same as touching one's face. VII. Failed to encourage residents to wear facemasks when out of their rooms A. Professional standard According to the Centers for Disease Control and Prevention (CDC) Preparing for COVID-19: Long-term Care Facilities, Nursing Homes Using PPE, Recommendations, Background, Minimize Chance of Exposures, last updated 4/15/2020, retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, included the following recommendations that residents may remove their cloth face covering when in their rooms but should put them back on when leaving their room. B. Facility policy and procedures The NHA was interviewed on 7/14/2020 at approximately 4:25 p.m. She said the facility did not have a policy related to resident's wearing facemasks. C. Resident observations The following was observed on 7/14/2020: -At 8:21 a.m., a male resident was observed seated in his wheelchair in the hallway near the medication cart on the 300 hall. The resident was not masked, dressed in a hospital gown and partially disrobed, as the gown was coming off his right shoulder. Several staff passed this resident with no encouragement to the resident to don his mask. At 8:26 a.m., a staff member was observed assisting the resident by re-donning his hospital gown, but failed to encourage the resident to don a facemask when out of his room. -Between 8:00 a.m. and 8:26 a.m., five different residents were observed in the resident hallways without a mask donned. Three of these residents were currently being assisted by various staff and no encouragement from staff was observed to have the residents don their masks. -At 8:28 a.m., two residents were observed in the 300 hall dining room and were unmasked. No staff was observed encouraging them to don their masks. -At 8:33 a.m., a female resident in room [ROOM NUMBER] was observed coming out of her room to get her breakfast tray from the staff passing the meals. This resident was not masked and staff did not encourage the use of mask or face covering when the resident was out of her room. -At 8:34 a.m., an unidentified female staff was observed passing a female resident in the 300 hall. The resident had her mask secured below her nose and the staff (after almost running the resident over) did not encourage the resident to pull up her mask. -At 9:08 a.m., a male resident was observed propelling himself down the 200 hall with his mask secured below his nose. He was observed passing three different staff who did not encourage him to pull up his mask. -At 9:09 a.m., a female resident was observed propelling herself down the 200 hall with no mask at all. Staff was not seen to be encouraging this resident to don a mask or face covering. -At 9:28 a.m., a male resident was observed propelling himself down the 200 hall with no mask and no staff encouragement. His mask was in his left hand, being contaminated by the left wheelchair wheel, as the resident was propelling himself with the same hand in which he was propelling his wheelchair. -At 9:38 a.m., two male residents were observed in the front lobby area with their masks secured below their noses. A male staff passed by with no encouragement and the front office staff did not observe or encourage the residents to don their masks appropriately. -At 9:48 a.m., a male resident was observed walking down the 400 hall with no mask and no staff encouragement to don a mask. -At 10:09 a.m., a male resident was observed rapidly pushing his rolling walker down the 400 hall. He was not masked and no staff encouraged the resident to don a mask. -At 10:20 a.m., a male resident was unmasked while propelling himself down the 200 hall. No staff, including the human resources director, encouraged the resident to don a mask. -At 10:39 a.m., a male resident was observed propelling his wheelchair down the 300 hall with his mask secured below his nose. At this time, another male resident was observed ambulating down the 300 hall with his mask secured below his nose. A third resident was seated in the hallway in his wheelchair. Two staff passed all three residents with no encouragement to don or pull up their masks. -At 10:49 a.m., a male resident was observed letting himself outside to the independent smoking area. He had propelled down the entire length of the hallway with no mask and no staff encouraging the resident to don a mask. -At 10:57 a.m., a male resident was observed ambulating down the 400 hall with his mask below his nose. No staff was observed to encourage proper PPE use for the resident. -At 11:20 a.m., a female resident was observed speaking to an unidentified CNA in the hallway. The resident's mask was secured below her nose and the CNA did not encourage the resident to pull up her mask. -At 11:23 a.m., in the dining room before lunch was served, a female resident was seated in a wheelchair at a dining room table, wearing her mask below her chin, not covering her nose or mouth. Three staff members were observed walking by, without reminding the resident to properly don her mask. -A second female resident was seated at a dining room table, wearing her mask under her nose. Three staff members were observed walking by, without reminding the resident to properly don her mask. -A staff person was observed wheeling a male resident into the dining room in his wheelchair. The resident wore his mask under his nose. The staff person did not remind or assist him to properly don his mask. -A staff person was observed wheeling a female resident into the dining room and positioning the resident at a table. The resident was not wearing a mask; the mask was observed hanging off the back handle of her wheelchair. Staff did not ask or assist her to don it. -A resident was observed walking into the dining room with her walker, wearing her mask below her nose. Although she walked by two staff members, they did not remind or assist her to don it properly. -At 11:26 a.m., a female resident was observed leaving room [ROOM NUMBER]. The resident passed three different staff with her mask donned below her nose and no staff encouraged her to pull her mask up. -At 11:34 a.m., a male resident in an electric wheelchair was observed heading down the 300 hall and out the door for the independent smoking residents with his mask below his nose. -At 11:40 a.m., a male resident was observed walking down the hall and entering room [ROOM NUMBER] without a mask. This resident passed by one staff, who did not encourage the resident to don a mask when out of his room. -At 12:08 p.m., a female resident was observed ambulating down the 400 hall. Her mask was secured below her nose at this time. -At 12:11 p.m., a female resident was seated in her wheelchair outside of the dining room. She had finished her lunch and her mask was located below her chin. No staff encouraged the resident to pull her mask up. -At 12:13 p.m., a female resident was observed in the dining room, but had finished eating as evidenced by her clothing protector lying across her plate. Her mask was hanging from one ear and no staff encouraged the resident to don her mask again. -At 12:14 p.m., a male resident was observed wheeling himself out of the dining room with his mask below his chin. He passed a maintenance staff who did not encourage him to pull his mask back up. -At 2:55 p.m., a female resident was ambulating down the 400 hall and an unidentified staff passed her with no encouragement to mask. -At 3:20 p.m., a male resident came out of room [ROOM NUMBER] without a mask and asked the staff manning the one-on-one resident rolling table, located in the 200 hallway, a question. The staff did not encourage the resident to don a mask or face covering when out of his room. The staff's mask was secured below her nose. -At 3:25 p.m., a female resident in a wheelchair was observed propelling herself down the 200 hall with her mask secured below her nose. Again, the staff seated at the rolling table in the hallway did not encourage the resident to pull up her mask. -At 3:35 p.m., a male resident was observed in the hall outside the social services director's (SSD's) office, speaking with the SSD without a mask on. The SSD did not encourage the resident to don a mask or face covering when out of his room. D. Staff interviews The NHA and ADON were interviewed on 7/14/2020 at 4:30 p.m. The ADON said all residents should be masked, per infection control standards, anytime they were out of their rooms in the common areas. The NHA and ADON said staff should be reminding and encouraging residents to wear their masks, as well as assist the resident in repositioning their mask if being worn inappropriately and the resident was unable to reposition the mask themselves. VIII. Failed to encourage residents who smoked outside to perform hand hygiene A. Professional standard The COVID-19 Preparation and Rapid Response Checklist for Long-Term Care Facilities (LTCFs), revised 5/13/2020, included that if residents must leave their room, they should perform hand hygiene, limit their movement within the facility, wear a cloth face covering and perform social distancing (stay at least six feet from others). B. Facility policy and procedures The facility policy titled Handwashing/Hand Hygiene, revised August 2019, was provided by the NHA the afternoon of 7/14/2020. It read hand

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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	(continued... from page 3) hygiene products and supplies should be readily accessible and convenient to encourage compliance with hand hygiene policies. It documented residents, family members and/or visitors would be encouraged to practice hand hygiene through the use of fact sheets, pamphlets and/or other written materials provided at the time of admission and/or posted throughout the facility. C. Resident observations The following was observed on 7/14/2020: -At 8:44 a.m., two residents were observed returning into the facility from the outside independent resident's smoking area. One resident was reminded to put his mask back on, but the other resident was observed propelling himself quickly down the hall in his wheelchair, unmasked. A third resident came inside with his mask secured below his chin and no staff was observed encouraging him to pull up his mask after returning inside. -At 10:45 a.m., three residents were observed outside in the independent resident's smoking area. All three residents were unmasked and two of the three residents were not [MEDICATION NAME] appropriate social distancing, as they were seated on a bench just a few feet from each other. No hand sanitizer was seen outside in the smoking area or in the entry area between the outdoors and the hallways proper. Residents were observed ente