STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065355	A. BUILDING _____ B. WING _____	08/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHARMAR VILLAGE CARE CENTER	**1209 W ABRIENDO AVE PUEBLO, CO 81004**

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 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure 15 (#3, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17 and #1) out of 17 sample residents provided services that met professional standards of quality. Specifically, the facility failed to: -Ensure medications were given timely for 15 residents and the provider was notified when medications were given late, outside the acceptable time frame; and, -Identify, monitor and care plan [MEDICAL CONDITION] for Resident #1. I. Medications A. Facility policy and procedure The Medication Administration policy, revised March 2019, was provided by the director of nursing (DON) on 8/12/2020 at 1:20 p.m. It revealed in pertinent part, Administration will be timely to achieve the optimum benefit. Unless the physician orders [REDACTED]. B. Observations and interview On 8/12/2020 at 10:45 a.m. LPN #3 was observed passing out medications to Resident #1. Review of Resident #1's medication revealed she had an order for [REDACTED]. She said since the medication was ordered at 9:00 a.m., it was considered late. She said she needed to make a late entry and notify the provider. LPN #3 was interviewed on 8/12/2020 at 11:05 a.m. She said she only had nine residents left to administer medications to. She said she knew she was running late, she said she had arrived late and was orientating a new nurse. C. Record review On 8/12/2020 from 11:26 a.m. to 11:52 a.m. the following 14 residents had not received A.M, medications: [REDACTED]. -At 11:28 a.m. Resident #17 had not received her morning medications. -At 11:31 a.m. Resident #16 had not received her morning medications. -At 11:33 a.m. Resident #7 had not received her morning medications. -At 11:35 a.m. Resident #8 had not received his morning medications. -At 11:36 a.m. Resident #9 had not received her morning medications. -At 11:38 a.m. Resident #10 had not received her morning medications. -At 11:40 a.m. Resident #11 had not received her morning medications. -At 11:42 a.m. Resident #12 had not received her morning medications. -At 11:45 a.m. Resident #13 had not received her morning medications. -At 11:46 a.m. Resident #14 had not received her morning medications. -At 11:49 a.m. Resident #15 had not received her morning medications. -At 11:50 a.m. Resident #3 had not received her morning medications. -At 11:52 a.m. Resident #6 was observed having her blood glucose (BG) taken in her room. She received her insulin and her lunch, but had not received her morning medication. The facility failed to administer medications within the prescribed time. Review of the residents records (identified above) on 8/13/2020 revealed no notification to the providers of the late morning medications from 8/12/2020. D. Interview The DON was interviewed on 8/13/2020 at 10:55 a.m. She said the nurse should have notified the provider before leaving for the day. She said she could not find any notifications to the providers of the late medications. She said her and the ADON would notify the providers. She said the medications needed to be given on time for the proper efficacy. She said most medications have the window of 6:00 a.m. to 11:00 a.m. She said medications that are ordered for a specific time needed to be given within the hour before and after. She said more education would be provided to the nurse on medication administration times. II. Failures specific to Resident #1 A. Resident #1 status Resident #1, age 98, was admitted on [DATE]. According to the August 2020 computerized physician order [REDACTED]. The 6/11/2020 MDS assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of eight out of 15. No behaviors or refusal of care noted. She needed limited assistance with transfers, walking, dressing, toilet use, and personal hygiene. B. Observation Resident #1 was sitting on a sofa in the common area on 8/12/2020 at 8:10 a.m. Her left arm was wrapped in an ACE bandage from her shoulder to her wrist. Her left hand was swollen and in her lap. C. Record review The resident did not have a care plan to address the [MEDICAL CONDITION] in her left arm. The monthly nursing summaries for February 2020, March 2020, and July 2020 did not identify [MEDICAL CONDITION] of her left arm. The DON was interviewed on 8/13/2020 at 2:10 p.m. She said the [MEDICAL CONDITION] should have been identified and monitored in the monthly summaries. She said she could not locate the monthly nursing summaries for April 2020, May 2020, and June 2020. The 7/16/2020 Physician's visit note, provided by the DON on 8/13/2020 at 2:04 p.m., included, She continues to be followed by [MEDICAL CONDITION] Clinic and she utilizes [MEDICAL CONDITION] stocking to left upper extremity on routine basis. The patient without exacerbation of [MEDICAL CONDITION] and no signs or symptoms of infection noted. The physician's visit note had a handwritten notation, Does not go to the [MEDICAL CONDITION] clinic, was followed by therapy and wound care doctor and wound nurse. The facility failed to monitor the resident's left arm for [MEDICAL CONDITION], failed to care plan [MEDICAL CONDITION], and failed to clarify physician's orders [REDACTED]. Interviews Certified nurse aide (CNA) #3 was interviewed on 8/12/2020 at 10:07 a.m. She said Resident #1's arm was due to a [PROCEDURE]. She said if there were any changes to the arm when care was being provided she would tell the nurse. She said there were no measurements, the changes were determined by visual inspections. She said there was not any special care her arm required. A family member of Resident #1 was interviewed by telephone on 8/12/2020 at 3:54 p.m. They said she had a [PROCEDURE] in the 70's. They said her arm fluctuates with swelling and shrinking for as long as they could remember. They said when her arm would swell often the family would elevate the arm on a pillow while she was sitting on the sofa. They said she had a sleeve once, but when she wore it her skin would tear when it was removed because of the swelling.They said the facility now used an ACE bandage. Licensed practical nurse (LPN) #4 was interviewed on 8/13/2020 at 8:30 a.m. He said her arm would swell with fluid. He said she used to wear a harness, but when removing the harness, she would get skin tears. He said she currently had an order for [REDACTED]. He said her arm was never measured. He said there was never an order for [REDACTED]. He said he did not know why just her left arm would swell. The DON was interviewed on 8/13/2020 at 10:00 a.m. She said she was not aware the facility had not monitored or assessed the [MEDICAL CONDITION] in her left arm. She said she was not sure why the left arm swelled. She said the facility had changed the dressings and tried several different approaches to treat the [MEDICAL CONDITION]. She said the therapy department had been involved at one point. She said there should have been a personalized care plan addressing the [MEDICAL CONDITION] and individualized interventions specific to [MEDICAL CONDITION], treatment for [REDACTED]. She said the facility would encourage her to elevate her arm. She saicd the facility did not have a method in place to identify and report changes in her left arm to the provider. The medical doctor (MD) was interviewed on 8/13/2020 at 1:50 p.m. by telephone. He said the [MEDICAL CONDITION] in Resident #1's left arm was normal to swell and shrink. He said it was a classic sign for [MEDICAL CONDITION]. He said he thought the resident was being followed by the [MEDICAL CONDITION] clinic. He said it would be reasonable to measure the left arm with a paper ruler to monitor for changes. He said he knew the resident was using an ACE bandage because the compression dressing was causing skin damage. The facility failed to ensure all staff working with the resident knew the [MEDICAL CONDITION] for this resident was from a [PROCEDURE] and how to care for the resident's left arm.
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to ensure adequate supervision and assistive devices to prevent accidents for one (#3) of three residents reviewed for accidents out of 17 sample residents.

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

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Specifically, the facility failed to ensure interventions were implemented after being care planned for Resident #3 after a fall. Findings include: I. Resident #3 A. Resident status Resident #3, age 92, was admitted on [DATE]. According to the August 2020 CPO, [DIAGNOSES REDACTED]. According to the 7/16/2020 minimum data set (MDS) assessment, the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of seven out of 15. The resident had no behavioral symptoms. She required extensive assistance for bed mobility, transfers, grooming and toilet use. The MDS revealed the resident had one fall since admission. B. Observation and interview On 8/12/2020 at 4:00 p.m., the resident was observed lying in bed sleeping. The resident ' s wheelchair was next to the resident ' s bed and her call light was in her dresser drawer approximately five feet away from the resident. There was no fall mat next to the resident ' s bed. RN #2 was standing next to the medication cart outside of Resident #3 ' s s room preparing her afternoon medications. The resident was not in RN #2 ' s eyesight. Registered nurse (RN) #2 was interviewed on 8/12/2020 at 4:05 p.m. RN #2 said he was familiar with the Resident #3's care plan. RN #2 observed the resident while she was sleeping. RN #2 said the resident ' s call light should be next to the resident and not in the dresser drawer. He said the fall mat should be next to the resident ' s bed while she was in bed. RN #2 pulled the fall mat from under the bed and placed it next to the resident ' s bed and placed call light next to Resident #3. He said all fall interventions were not in place at time of observation. He said a negative outcome would be the resident continuing to fall and hitting her head. C. Record review Nursing log note dated 8/4/2020 at 8:48 a.m., documented in part, upon entering the room the medical nurse and therapy were in the room. Resident #3 was sitting on the floor with her back against the bed. Upon examination the resident complained of a left upper leg pain. Personal care provider (PCP), director of nursing (DON), Family notified. Neurological exam started per facility protocol. Vital signs (V/S) within normal limits. Will continue to monitor. Post fall review dated 8/4/2020 identified the resident as being at a high risk for falls. The care plan, initiated 4/30/19 and revised 5/29/2020, identified the resident had an active history of falls. Interventions include assisting with transfers/ambulation as needed. Check oxygen saturation as needed (PRN). Complete fall risk upon admission, post fall, and at least quarterly. Instruct and re-enforce safety awareness measures. Keep call light within reach and keep frequently used items in each reach. Assess the wheelchair for positioning, safety, and comfort staff to encourage and help the resident to the toilet after meals when possible. The care plan, initiated 4/30/19 and revised 5/29/2020, identified the resident required assistance with self-care deficits related to dressing, grooming, bathing, personal hygiene, bed mobility, and has impaired physical mobility, and weakness. Interventions include staff providing a level of assistance as required to groom, dress, and encourage participation. Therapy services to evaluate and screen and treat as needed. Staff to report changes to nurse and medical doctor. Encourage resident to verbalize or use call-light when possible for assistance. Floor mat by bedside when in bed, bedside table next to the residents bed and call light within reach. -Even though these interventions were documented in the care plan for this resident, floor mat and placement of call light, it was not implemented as observed above. D. Interview The director of nursing (DON) was interviewed on 8/13/2020 at 1:00 p.m. She said the resident did get up on her own and would self-propel herself to the restroom. The DON said staff should offer to help the resident lie down. Staff should use the fall mat and keep her call light cord within reach. The DON said failing to provide care planned interventions could contribute to further falls for this high-risk resident.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident observations, record review, and interviews, the facility failed to ensure one (#3) of three residents reviewed for hydration and nutrition out of 17 sample residents, were provided with nutritional care and services to maintain proper nutrition. Specifically, the facility failed to recognize, evaluate and address Resident #3's significant weight loss timely. Findings include: I. Resident status A. Resident #3 Resident #3, age 92, was admitted on [DATE]. According to the August 2020 CPO, [DIAGNOSES REDACTED]. According to the 7/16/2020 minimum data set (MDS) assessment, the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of seven out of 15. The resident had mild depression with the resident scoring nine of 27 on the patient health questionnaire (PHQ-9). The resident had no behavioral symptoms. She required extensive assistance for bed mobility, transfers, grooming and toilet use. She was occasionally incontinent of the bowel and bladder. The resident required cueing and encouragement for eating. The resident was not on a prescribed weight loss plan. B. Observations On 8/12/2020 at 9:36 a.m. Resident #3 was sitting in her wheelchair next to her bed. She was slouched over sleeping. She had sausage links, scrambled eggs and juice. She did not eat any of her breakfast. -At 11:43 a.m. Resident #3 was lying in bed sleeping. CNA #2 placed the resident ' s meal tray on the bedside table, which was approximately four feet away from the resident ' s bed. Not next to the resident. Resident up in wheelchair eating. -At 12:26 p.m., Resident #3 was sitting in her wheelchair watching television. Resident #3 ate approximately 40% of her meal. CNA #2 picked up the resident's tray but did not ask her if she wanted anything else to eat. C. Record review 1. Care plan The care plan, initiated 4/30/19 and revised 5/29/2020, identified the resident was at nutritional risk related to (r/t) disease process/condition, depression, dementia, dysphagia, chronic pain, constipation, acute [MEDICATION NAME], recent fracture (FX) , loss of appetite, and lactose intolerant per wound care nurse. Interventions include administering nutritional support as ordered. Assess and report to the physician signs/symptoms of malnutrition, significant weight loss, and chewing/swallowing problems. Encourage fluids, no straws. Offer substitutes if 50% or less was consumed. Provide regular diet texture/ thin consistency as ordered. Provide supplement Ensure 237ml PO (chocolate only) BID between meals as ordered. Honor food preferences. The resident was lactose intolerant and avoids dairy products. Meal intake from 7/14/2020-8/12/2020 identified the resident had an intake of 0-25% 37 times, 26-50% 20 times, 51-75% 24 times, and 76-100% 5 times during this time period. 2. Weight loss failure Review of the resident's weight revealed on 5/30/2020 she weighed 117 pounds and on 7/3/2020 she weighed 109.5 pounds, a 7.5-pound weight loss or 6.41% (percent) weight loss in a five week period of time. Review of the resident's clinical record on 8/12/2020 failed to reveal the facility recognized, evaluated or addressed the resident's significant weight loss. D. Staff interviews Certified nurse aide (CNA) #2 was interviewed on 8/12/2020 at 12:39 p.m. She said Resident #3 was independent with eating. She said, I chart all of the residents ' meal intake and report to the nurse if a resident was eating less than 25 percent (%). Licensed practical nurse (LPN) #4 was interviewed on 8/13/2020 at 8:21 a.m. He stated weights were obtained by the certified nurse aides (CNAs) and recorded in the resident's clinical record by the nurse. He stated the nurse should assess the weight for a significant change and if a significant change was identified, a re-weight should be obtained. He said if a significant weight change was identified, the nurse should complete a change of condition report and notify the restorative CNA or dietary manager. The dietary director (DD) was interviewed on 8/13/2020 at 8:37 a.m. She said we have a stand up meeting every Friday and discuss any weight loss issues. She said this would be the time the nurses would identify any resident who had weight loss, meal intake or any other issues with all residents ' She said, The facility had a lot of weight loss since the outbreak of COVID-19. She said Resident #3 had not been identified for weight loss or any other issues. She said she did not know where the facility monitored residents ' meal intakes. She said the negative outcome for not identifying weight loss for Resident #3 would be continued weight loss. Restorative CNA #1 was interviewed on 8/13/2020 at 9:00 a.m. She said the resident had weight loss but it was due to her dentures not fitting correctly. She said weight will trigger me when the weight loss was three to five pounds for any resident. She said Resident #3 did not trigger for weight loss. The registered dietitian (RD) was interviewed on 8/13/2020 at 11:30 a.m. She said she was in the facility once a month. She said whenever a significant weight change was identified, they would review it in their weekly phone nutritional at risk meeting on Fridays ' . She said when a resident was identified as having a significant weight change, she would want to evaluate the resident as soon as possible but at least within seven days. She said the resident had a history of [REDACTED]. She said the residents care plan identified that staff would report when Resident #3 had an intake of less than 25% meal intake. She said it would be her expectation staff should have reported the low intake numbers to the dietary manager and staff should have offered cueing and reminders and offered alternative meals to meet the resident ' s food preferences. She said she had made recommendations late last night and had sent them to the director of nursing. She said the recommendation for Resident #3 was to have the dietary manager reassess the residents food preferences, weekly weights, and to increase the residents supplement from two times daily to three times daily. She said a negative outcome would be continued weight loss for Resident #3 due to staff not cueing or encouraging the resident ' s to eat and offering alternative food preferences to Resident #3. The director of nursing (DON) was interviewed on 8/13/2020 at 1:00 p.m. She said we review weight loss and review the certification and survey provider enhanced reports (CASPER) to identify any weight loss in the facility. She said, I do not recall discussing Resident #3 for any weight issues. She said, I look to the RD to bring up weight loss into every meeting. She said the RD works from home and will be in the facility once a

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F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) month. She said the struggle was getting the information and recommendations from the dietician in a timely manner. She said, I am not satisfied this had not been brought up by the RD as it was part of her job to identify and address weight loss. She said weight loss should be identified when a resident had lost three to five pounds or greater. She said it was her expectation that staff should have been encouraging the resident to eat and to offer any alternatives when her meal intake was low. She said a negative outcome would be malnutrition and potential for greater weight loss.
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 establish and maintain an infection control program designed to provide a safe, sanitary environment and to help prevent the development and transmission of communicable diseases and infections such as COVID-19. Specifically, the facility; -Failed to ensure hand hygiene was performed when entering and exiting a residents room; -Failed to offer face coverings for residents when entering rooms; -Failed to ensure face coverings were encouraged with residents when not in their personal rooms; -Failed to ensure social distancing in common areas; and, -Failed to ensure PPE was worn when entering an isolation room. Findings include: I. The Centers for Disease Control (CDC) recommended guidelines The CDC, Preparing for COVID-19 in Nursing Homes, updated June 25, 2020, retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html (8/18/2020). It read in pertinent part, Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown. Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP (healthcare personnel) should wear 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 when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. Testing at the end of this period can be considered to increase certainty that the resident is not infected. Implementing Social Distancing Measures. Implement aggressive social distancing measures (remaining at least 6 feet apart from others). Cancel communal dining and group activities, such as internal and external activities. Remind residents to practice social distancing, wear a cloth face covering (if tolerated), and perform hand hygiene. Remind HCP to practice social distancing and wear a facemask (for source control) when in break rooms or common areas. The Center for Disease Control (CDC), Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings (8/18/2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#minimize, (Update July 15, 2020) Implement Universal Source Control Measures. Patients may remove their cloth face covering when in their rooms but should put it back on when around others (e.g., when visitors enter their room) or leaving their room. II. Hand hygiene and resident facial coverings when staff enter resident rooms A. Observations and interviews On 8/12/2020 at 10:50 a.m. the van driver was observed entering room [ROOM NUMBER]. She asked the resident where she would like the adult briefs to be stored. She left the room at 10:52 a.m. She said she only had to ask the residents to wear a mask when they left their room. She said she had not received training to ask a resident to cover their face when she entered their room. On 8/13/2020 at 8:52 a.m. housekeeping (HSKP) #1 was observed entering room [ROOM NUMBER]. She knocked on the door, entered, did not wash/sanitize her hands, and did not ask the resident to cover her mouth with a mask or tissue. She left the room at 8:53 a.m. She did not wash/sanitize her hands when she left the room. She said her training to enter a resident's room was to knock and announce herself and tell them what she was going to do. She said she had not received training to ask a resident to cover their face when she entered a room. She said she had received training to wash her hands when entering and exiting a room. She said she did not wash/sanitize her hands before or leaving room [ROOM NUMBER]. On 8/13/2020 at 8:44 a.m. CNA #5 was observed entering room [ROOM NUMBER] with two covered cups of liquid. She did not wash/sanitize her hands upon entrance to the room. She did not ask the resident to cover their face with a mask otr tissue. She left the room at 8:45 a.m. with one covered cup in her hand.She did not wash/sanitize her hands when exiting the room. She entered room [ROOM NUMBER] at 8:45 a.m. with one covered cup in her hand. She did not wash/sanitize her hands when entering the room. She did not ask the resident to cover their face with a mask or tissue. She exited the room empty handed. She did not wash/sanitize her hands when she exited the room. She entered room [ROOM NUMBER] at 8:46 a.m. She did not wash/sanitize her hands when she entered the room. She did not ask the residents to cover their faces with masks or tissues. She exited the room at 9:03 a.m. She said she did not have to wash/sanitize her hands when she entered or exited rooms [ROOM NUMBERS] because she did not touch anything. She said she did not have to ask the residents to cover their faces. She said she had never heard anything about that. B. Interview The DON was interviewed on 8/13/2020 at 10:42 a.m. She said anytime a staff member broke the barrier of a room the expectation was for them to wash/sanitize their hands. She said she performed audits with staff and handwashing and was not aware the staff were not completing it all the time. She said she expected the staff to offer a face covering when entering the room. She said she would re-educate staff on offering face coverings and handwashing. III. Failed to ensure residents had face covering while out of their rooms A. References The Center for Disease Control (CDC), Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings (4/28/2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#minimize, (Update April 13, 2020) Patients may remove their cloth face covering when in their rooms but should put them back on when leaving their room or when others (e.g., HCP, visitors) enter the room. Screening for symptoms and appropriate triage, evaluation, and isolation of individuals who report symptoms should still occur. B. Observations On 8/12/2020 at 8:08 a.m., observation of the facility revealed five residents ' sitting in their wheelchairs on Sweet Meadows hall. All five residents did not have on any face masks. -At 10:00 a.m. a male resident was in his wheelchair sitting outside of room [ROOM NUMBER]. He did not have a mask on. CNA #4 did not encourage residents to put on a mask. -At 10:50 the resident exited her room with no mask. Physical therapy assisted the resident and did not encourage the resident to put on a mask. On 8/13/2020 at 8:18 a.m., four residents were sitting in their wheelchairs around a table on Sweet Meadows. All residents ' did not have on any face masks and no staff were observed in the area. During the observations above no staff encouraged residents to wear masks when not in their personal rooms. D. Staff interviews Certified nurse aide (CNA) #4 was interviewed on 8/12/2020 at 8:35 a.m. She said one resident prefers to wear her mask but all other residents do not wear masks when they are out of their rooms. She said we know which residents ' would wear their mask and those who do not. Licensed practical nurse (LPN) #1 was interviewed on 8/12/2020 at 10:06 a.m. She said, All the residents should have had their masks on while out of their rooms. CNA #2 was interviewed on 8/12/2020 at 9:49 a.m. She said, Some residents ' would wear their masks and some residents wouldn't. The director of nursing (DON) was interviewed on 8/13/2020 at 1:00 p.m. She said all of the residents ' should have a mask on while out of their room. She said staff get too comfortable with the residents they know who don't wear their masks. She said staff should encourage all residents when out of their rooms to wear a mask and they should encourage them to wear them. IV. Ensure social distancing was followed during meals. A. common area on Sweet Meadow Hall observations On 8/12/2020 at 8:08 a.m. four residents in wheelchairs were seated around a table in the common area. The resident's seated at the tables were sleeping in their wheelchairs. The distance between the residents seated in the common area was approximately one to three feet away from each other. -At 10:06 a.m., LPN #1 was observed administering medications to two residents ' . There was two other residents all next to each other as she administered the medications. LPN #1 said the residents were not following social distancing as they were too close to each other. She said a negative outcome would be the spread of infection. B. Staff interview The DON was interviewed on 8/3/2020 at 1:00 p.m. The DON was told of the observations above. She said all residents should be [MEDICATION NAME] safe social distancing. She said staff should ensure all residents; are six feet apart when they are in common areas. She said a negative outcome would be cross contamination and spread of infections. V. To ensure personal protective equipment (PPE) was worn for the isolation room. A. Observations On 8/12/2020 at 8:24 a.m., room [ROOM NUMBER] had an isolation cart sitting outside of the room. There was a sign on the door stating before entering the room to contact the nurse station before entering the room. Registered nurse #2 was observed going into room [ROOM NUMBER]. She entered the isolation room and did not put on any PPE prior to entering the resident's room. -At 9:00 a.m., RN #2 exited the resident's room without any PPE on. RN #2 had an empty glass in her hand and proceeded to go to the kitchen to fill the glass with water for the resident. B. Staff interview RN #1 was interviewed on 8/12/2020 at 8:40 a.m. RN #1 said, We do not have any residents ' on isolation precautions. In facility. CNA #2 was interviewed on 8/12/2020 at 8:49 a.m. She said, I have one resident who was in isolation. She said the resident in room [ROOM NUMBER] was on isolation precautions as she was a new admit to the facility. She said all staff are required to wear

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHARMAR VILLAGE CARE CENTER	**1209 W ABRIENDO AVE PUEBLO, CO 81004**

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	(continued... from page 3) full PPE, which entailed putting on gloves, and a gown before entering the room [ROOM NUMBER]. RN #2 was interviewed on 8/12/2020 at 8:59 a.m. She said, I was told by RN #1 that I did not have to wear any PPE when entering room [ROOM NUMBER]. RN #1 was interviewed again at 9:15 a.m. He said there was a mix up on passing the information to RN #2. He said, I was not aware of the resident being on 14 day isolation for new admit. The DON was interviewed on 8/13/2020 at 1:00 p.m. The DON was told about the observation from the previous day. She said RN #1 did tell her of the mix up. She said RN #1 new better than that, as all new admits are placed on isolation precautions for the first 14 days and full PPE was to be worn upon entering an isolation room. She said PPE would entail face mask, gown, and gloves. She said all staff had been in serviced on isolation precautions after she was told of the mix up. She said a negative outcome would be the spread of infections.