STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065290	A. BUILDING _____ B. WING _____	04/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONACO PARKWAY HEALTH AND REHABILITATION CENTER	895 S MONACO PKWY DENVER, CO 80224

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 properly maintain an infection control program designed to prevent the spread of COVID-19. Specifically, the facility failed to: -Ensure proper infection control procedures were followed for a resident who was positive for COVID-19 to ensure [MEDICAL CONDITION] was not spread to other residents residing at the facility; and -Ensure residents and staff followed guidelines for facial coverings to prevent the spread of infections. Findings include: I. Professional references According to the Centers for Disease Control (CDC) website, Preparing for COVID-19: Long-term Care Facilities, Nursing Homes https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html (Retrieved 4/29/2020) cloth face coverings are not considered personal protective equipment (PPE) because their capability to protect healthcare personnel (HCP) is unknown. HCP who enter the room of a patient with known or suspected COVID-19 should adhere to standard precautions and use of respirator, gown, gloves and eye protection. When available, respirators should be prioritized for situations where respiratory protection is most important and the care of patients with pathogens requiring airborne precautions. HCP should perform hand hygiene before and after all patient contact, contact with potentially infectious material and before putting on and after removing PPE, including gloves. The PPE recommended when caring for a patient with known or suspected COVID-19 includes: Put on an N95 respirator (or higher level of respirator) or facemask (if a respirator is not available) before entry into the patient room or care area. Cloth face coverings are NOT PPE and should not be worn for the care of patients with known or suspected COVID-19). Remove eye protection before leaving the patient room or care area. Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use. II. Failure to ensure proper infection control procedures were followed for a resident who was known COVID-19 positive to ensure [MEDICAL CONDITION] was not spread to other residents A. Resident #1 status Resident #1, age 65, was admitted on [DATE]. According to the April 2020 computerized physician orders [REDACTED]. The 3/13/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. She was independent with all activities of daily living. B. Observations During a continuous observation on 4/27/2020 beginning at 10:00 a.m. of a positive COVID-19 resident room, the following was observed: -The isolation cart positioned outside the resident's room contained gowns, gloves and facial shields. It did not contain sanitizing wipes and N95 or surgical masks. - At 10:27 a.m., the director of nursing (DON) and director of therapy (DOT) approached Resident #1 room wearing N95 masks. The DON and the DOT were observed donning gloves, a gown, and a facial covering. They entered the resident's room. -At 10:45 a.m., emergency medical technicians (EMT) arrived at the facility, with surgical masks and goggles on, to transport Resident #1 to a COVID-19 positive facility. Both EMTs donned gowns and gloves. One EMT remained outside the room, while the other EMT entered the resident room. -At 10:59 a.m., the EMT who entered the COVID-19 positive room, exited the room and walked down the hallway, while wearing the full PPE (personal protective equipment) donned prior to entering the room. -At 11:00 a.m. the DON and DOT exited the room wearing the same N95 mask and holding face shields. The DON and DOT, with the same masks, carried the face shields throughout the facility to the rehabilitation gym to be disinfected. Additional observations conducted throughout the facility revealed: -At 9:55 a.m. a certified nurse aide (CNA) was observed entering a resident room to deliver a meal tray without disinfecting his hands. He then entered another room, across the hallway to deliver another meal tray without sanitizing his hands. C. Staff interviews The NHA was interviewed on 4/27/2020 at 11:18 a.m. She confirmed the director of therapy (DOT) and the director of nursing (DON) took the facial shield that was used in the COVID-19 positive room, down the hallway, through the next nursing station and into the therapy gym. She said it was taken to be disinfected. The DOT was interviewed at 11:27 a.m. She confirmed the facial shield was used in the COVID-19 room. She said it was carried throughout the facility to the therapy gym to be sanitized. Housekeeper #1 was interviewed on 4/27/2020 at 10:03 a.m. He said he was responsible for cleaning the rooms on that hallway. He said he was aware one of the resident's was tested for COVID-19 but was not sure of the results of the test. -He said he had cleaned the resident's room since the resident had been tested . He said, prior to entering the positive COVID-19 room, he would don PPE, including goggles, gown, gloves and a facial mask. He said he used the same mask to enter the COVID-19 room as he used to enter non-COVID-19 positive rooms. He said he used the same surgical mask all day. -He said he was instructed to use the same mask for three to five days, unless it was soiled and then the facility would provide the staff a new mask. CNA #1 was interviewed on 4/27/2020 at 9:48 a.m. He was observed wearing a black cloth facial mask. He confirmed he was wearing a cloth facial mask. He said he did not have a surgical mask underneath the cloth mask. He said he provided care to the resident who was COVID-19 positive. He said he wore the same cloth mask throughout his shift. He said he wore the same cloth mask after caring for the COVID-19 positive resident to take care of residents who were not infected with COVID-19. He said all the PPE for the COVID-19 positive resident room was kept in the isolation cart outside the room. He said the facility did not keep masks inside the resident's room. Registered nurse (RN) #1 was interviewed on 4/27/2020 at 9:33 a.m. She said one resident on her hallway had a test result that morning of positive for COVID-19. She said all PPE for that resident was in the isolation cart outside the room. She said the resident's room did not contain any PPE. -She said the surgical mask she wore when she started her shift was the same surgical mask she used when she entered the room with a COVID-19 positive resident. She said it was not a practice at the facility to discard the surgical mask after leaving the positive COVID-19 room. She said she would use the same mask to care for non-COVID-19 positive residents. The DON and NHA were interviewed on 4/27/2020 at 11:26 a.m. The DON said when she left the COVID-19 positive resident room, she carried the facial screen throughout the facility to the therapy gym to be sanitized. She said when she exited the room, she realized the isolation cart did not have sanitizing wipes. She said she should have checked the cart prior to entering the room or had another staff member get the wipes instead of walking with the facial screen throughout the facility. She said the isolation carts were not supplied with masks. She said all PPE was kept in the isolation carts outside the resident's room. -She confirmed Resident #1 test had come back positive for the COVID-19 virus that morning. She said the resident had been on droplet precaution isolation since 4/24/2020. She said it was the facility policy to issue a surgical mask to each staff member at the start of their shift. She said facility staff should use the same mask for three to five days unless it became soiled. She said the surgical masks were locked up and the nurse managers had access. -She said the education was provided to facility staff to use surgical masks when entering a COVID-19 positive room. She said the facility had a supply of N95 masks, however only a select few staff had been fit tested . She said those fit tested for N95 masks were not currently providing care to the resident who was positive with COVID-19. She confirmed staff were using the same surgical masks when entering a COVID-19 positive room and then caring for non-COVID-19 residents. -She said she was unaware of the CDC (Centers for Disease Control) guidelines that indicated N95 masks should be used to care for a COVID-19 positive resident. She said she was unaware of the CDC guideline that indicated masks should be changed when going from a COVID-19 positive resident to a non-COVID resident. The NHA said they would provide education to staff to ensure all masks are changed when going from a COVID-19 positive resident to a non-COVID resident. III. Facial coverings A. Observations During

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) continuous observations throughout the facility on 4/27/2020 beginning at 9:05 a.m. the following was observed: -Two residents were observed sitting in the hallway with a breakfast tray in front of them. The food on the plates had been eaten and the residents were observed to no longer be eating. Both residents had facial masks tucked under their chins, exposing their nose and mouth. -A resident was observed sitting in a high back wheelchair, outside of the south unit nursing station, in the hallway. The resident did not have a facial mask on or within reach. The same resident was observed at 10:15 a.m. to be sleeping in her wheelchair, in the same position outside of the nursing station with a surgical mask tucked under her chin. -CNA #1 was observed entering multiple resident rooms and providing personal care and delivering meal trays. He was wearing a cloth mask while coming into direct contact with residents. -Licensed practical nurse (LPN) #1 was observed with her surgical mask tucked under her chin while in a resident area. -A housekeeper was observed wearing a cloth mask. -The DON and the NHA were observed with cloth masks while walking throughout the facility, in resident areas. The NHA was observed interacting with a resident and re-directing her back to her room while wearing a cloth mask. -A resident was observed wheeling herself down the hallway. The resident appeared confused. A staff member approached the resident, who told the staff member she wanted to look at the clock on the wall. The staff member did not offer to obtain a mask for the resident. B. Staff interviews CNA #1 was interviewed on 4/27/2020 at 9:48 a.m. He was observed wearing a black cloth facial mask. He confirmed he was wearing a cloth facial mask. He said he did not have a surgical mask underneath the cloth mask. He said he purchased the mask because he wanted to make sure he always had one if the facility did not provide a mask. He said he was not always provided a mask and that made him nervous. He said he provided direct personal care to residents. He said, with the same mask, provided personal care to the resident on his hallway who was positive for COVID-19 to non-COVID-19 residents without changing his cloth mask. The DON and NHA were interviewed on 4/27/2020 at 11:26 a.m. The DON said the proper way to wear the surgical mask was to ensure it was covering the nose and the mouth. She said the surgical mask was not effective if it was tucked under the chin or nose. She said all staff providing direct care to residents should wear a surgical mask. She said cloth masks should only be used for staff who did not have direct contact with residents. She said a cloth mask could be used as long as a surgical mask was worn underneath the cloth mask. -She said all resident's should be encouraged and provided a facial covering when leaving their room and going to common areas. She said staff should provide reminders to ensure residents were wearing facial coverings when outside of their rooms.