STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065320	A. BUILDING _____ B. WING _____	05/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LITTLETON CARE AND REHABILITATION CENTER	5822 SOUTH LOWELL WAY LITTLETON, CO 80123

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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 COVID-19. Specifically, the facility failed to: -Ensure resident supplies and durable medical equipment (DME) was stored appropriately; -Ensure necessary PPE was worn by staff while cleaning an isolation room; -Ensure Resident #13 was placed in quarantine after he was hospitalized and returned to the facility; -Encourage, assist, and provide Resident #1, (a resident who was coughing and sneezing), with a protective mask to cover his nose and mouth when in the dining room; -Encourage, assist to properly wear, and/or provide residents with, protective masks when in common areas, or tissue to cover their nose and mouth while within less than six feet; and, -Perform hand hygiene with the alcohol based hand rub (ABHR) for at least 20 seconds. Findings include: I. Professional reference According to the Centers for Medicare and Medicaid Services (CMS) COVID-19 Long-Term Care Facility Guidance April 2, 2020, if possible, isolate all admitted residents (including readmissions) in their room for 14 days if their COVID-19 status is unknown. According to the Centers for Disease and Prevention (CDC), Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings, 4/13/2020, retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html read in part, Current data suggested person-to-person transmission most commonly happened during close exposure to a person infected with [MEDICAL CONDITION] that causes COVID-19, primarily via respiratory droplets produced when the infected person speaks, coughs, or sneezes. Droplets could land in the mouths, noses, or eyes of people who were nearby or possibly be inhaled into the lungs of those within close proximity. Transmission also might occur through contact with contaminated surfaces followed by self-delivery to the eyes, nose, or mouth. -Unrecognized asymptomatic and pre-symptomatic infections likely contributed to transmission in these and other healthcare settings. Source control, which involved having the infected person wear a cloth face covering or facemask over their mouth and nose to contain their respiratory secretions, might help reduce the risk of transmission of [DIAGNOSES REDACTED] CoV-2 from both symptomatic and asymptomatic people. According to the Centers for Disease and Prevention (CDC) Transmission-Based Precautions, 1/16/2016, retrieved from: https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html read in part, In settings where Airborne Precautions cannot be implemented due to limited engineering resources, masking the patient and placing the patient in a private room with the door closed would reduce the likelihood of airborne transmission. According to the Centers for Disease and Prevention (CDC) Hand Hygiene in Healthcare Settings, last up updated 1/31/2020, retrieved from: https://www.cdc.gov/handhygiene/providers/index.html, the recommendations were: Hand hygiene helped prevent the spread of viruses. When ABHR was used, put the product on hands and rub hands together, cover all surfaces until hands feel dry; this should take around 20 seconds. II. Observations and interviews Tour of the facility on 5/7/2020 at 8:22 a.m. revealed it had two hallways North and South with resident rooms, down the north hallway there were six doorways with isolation carts observed outside the door. There were residents observed in the dining room, several residents were observed without facial coverings or masks. Several boxes of supplies on the floor stacked along the wall was observed at the front of the north hallway, (briefs, personal cleaning cloths and oxygen tubing). There was an oxygen concentrator in the hall outside of room [ROOM NUMBER]. -At 8:33 a.m. housekeeper (HSK) #1 was down the north hallway cleaning rooms, she pushed her cart next to room [ROOM NUMBER] (a room with an isolation cart at the doorway), used alcohol based hand sanitizer (ABHS) and donned gloves. She knocked on the door and entered, she did not donn an isolation gown prior to entering. She proceeded to clean the resident's room. -At 8:39 a.m. the maintenance services director (MSD) came down the hallway and approached the room in which HSK #1 was in, he told the housekeeper she needed to donn an isolation gown, which she did after she was instructed. -At 8:40 a.m. the assistant director of nursing (ADON) was observed cleaning the oxygen concentrator and removed it from the hallway. III. Staff interviews Licensed practical nurse (LPN) #2 was interviewed was interviewed on 5/7/2020 at 8:40 a.m. She said all the residents she was caring for were on isolation because they were new admissions with the exception of one resident who was on contact isolation. HSK #1 and the nursing home administrator (NHA) was interviewed on 5/7/2020 at 10:10 a.m. HSK #1 said that she had not received any training related donning PPE or what precautions to use in an isolation room, nor was she trained on transmission based precautions (droplet, contact, or airborne). The NHA said HSK #1 was new and it was her fourth day working at the facility. He said the MSD had been showing HSK #1 how to clean resident rooms and observed her to ensure she was following isolation precautions. He had no response if any training had been provided to ensure HSK #1 had been following infection control policies and procedures. Certified nurse aide (CNA) #2 was interviewed on 5/7/2020 at 10:17 a.m. She said residents were allowed out of their rooms with a facial coverings (mask). She said some of the residents refused to wear masks. She said she was not sure who was supposed to encourage residents to wear a mask when they came out of their rooms. The MSD was interviewed on 5/7/2020 at 10:41 a.m. He said he had been training housekeeper #1 and been shadowing her since Monday 5/4/2020 to ensure she was following infection control practices. He said he verbally educated HSK #1 on procedural isolation precautions related to Covid-19, but had nothing in writing. He provided a copy of HSK procedures which he said was always available on the housekeeping cart. He said officially his staff would check off competency of proper isolation techniques including using PPE by nursing staff which had not been done until that morning. -At 10:37 a.m., the director of nursing (DON) provided a copy of immediate skills checklist (donning and doffing PPE) training based on the level of precautions required (standard, droplet, contact or airborne infection isolation) which was completed with HSK #1. IV. Failure to ensure Resident #13 (a readmission) was placed on isolation/quarantine for the required 14 days. 1. Family interview Resident #13's family was interviewed on 5/8/2020 at 11:00 a.m. He said on 4/18/2020 he visited his father and the staff assisted the resident outside on to the patio. He said his father was not responding to him and he was unable to get Resident #13 to speak or respond to him verbally. He said his father did not have on a mask or any facial covering. He said his father did not look well so he took Resident #13 to the hospital and he tested positive for Covid-19 two days later. 2. Record review Resident #13 was admitted to the facility on [DATE]. He was discharged to the hospital on [DATE] and readmitted to the facility on [DATE]. Review of progress notes 4/15/2020-4/18/2020 revealed Resident #13 had a decline and was not eating or drinking. Resident #13's son was notified and he was supposed to discharge to the son's home on hospice care. The nurse's note dated 4/18/2020 at 1:15 p.m., revealed Resident #13 was brought out to the patio to visit with his son around 12:15 p.m. Resident #13 was not smiling or talking to his son and Resident #13's son wanted him transported to the hospital. V. Administrative interview The director of clinical services (DCS), NHA, DON, and ADON were interviewed on 5/8/2020 at 3:10 p.m. They said Resident #13 was tested for Covid-19 in the hospital prior to his readmission 4/3/2020 and later found to be negative. They said this was one of the reasons the resident was not isolated. The DON confirmed Resident #13 was not placed in quarantine for the recommended 14 days per CMS (see above). They said the resident had a change in condition in which he was monitored. They said he had been declining since the end of March 2020 and this was his normal behavior (not eating, wanting to be left alone and wanting to sleep a lot). They said he would push his food away and he did not want to talk on

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) the phone with his family. They said they were treating Resident #13 urinary tract infection [MEDICAL CONDITION] and he just did not respond positively. The NHA said they did not consider testing the resident for Covid-19 because he had just been tested in the hospital prior to admission and he tested negative. The DON said oxygen tanks were usually cleaned by housekeeping and should not have been left in the hallway but stored in the clean utility area for new admissions. She said they completed infection control training upon hire to include standard precautions after they had completed basic training in their dedicated area. She said the staff member's manager would send them to either her or the ADON for specific training (to include transmission based precautions). She said they had not completed specific infection control training with HSK #1 because she would be shadowed for a week or so and then the MSD would inform them she was ready for the training. She said they immediately trained HSK #1 on transmission based precautions that morning. They acknowledged residents should be offered facial coverings/mask while out of their rooms, and new admissions or readmissions should have been in quarantine for the recommended 14 days to prevent the spread of Covid-19. VI. Observations A. Lack of prompting use of appropriate PPE A continuous observation which began on 5/7/2020 at 8:29 a.m. revealed LPN #1 did not offer Resident #1 a mask to cover her nose and mouth when she coughed and sneezed in the dining room. LPN #1 said to her I see you're still coughing and sneezing. Resident #1 said Yes (as she continued to cough and sneeze). LPN #1 did not provide, encourage, or assist Resident #1 to cover her mouth and nose with a mask. Resident #2 with her mask worn under her chin, which exposed her mouth and nose, self-propelled in her wheelchair within three feet of LPN #1 and Resident #1. Resident #1 continued to cough and sneeze as Resident #2 passed by her. LPN #1 did not encourage Resident #2 to cover her nose and mouth with her mask as she passed Resident #1. LPN #1 did not offer Resident #1 the ability to sanitize her hands after Resident #1 repeatedly coughed and sneezed into her hands. Although Resident #1 had a tissue in her hand, it was balled up and did not cover her mouth, it remained that way as she repeatedly coughed and sneezed into her hands. LPN #1 did not offer her another tissue or a mask to cover her nose and mouth as she coughed and sneezed. LPN #1 assisted Resident #1 to stand with her walker she did not offer the resident to sanitize her hands. LPN #1 did not perform hand hygiene after she touched Resident #1's walker. Resident #1 coughed and sneezed while she walked to her room. LPN #1 did not offer Resident #1 a mask to cover her nose and mouth when she coughed and sneezed along the hallway. Resident #1 and Resident #2 were roommates and they were not in isolation. As Resident #2 entered their room, she passed LPN #1 who stood by Resident #1; Resident #1 continued to cough as Resident #2 passed by her. Resident #2 said as she passed LPN #1 I have chills. LPN #1 left their room without sanitizing her hands nor assisting Resident #1 to sanitize her hands. LPN #1 did not disinfect Resident #1's walker. An observation on 5/7/2020 at 8:58 a.m. revealed Resident #2 self-propelled along the hallway in her wheelchair with her mask under her chin and passed by unidentified staff. Staff did encourage Resident #2 to cover her nose and mouth with her mask. An observation on 5/7/2020 at 9:25 a.m. revealed Resident #6 self-propelled passed the dietary aide (DA) and then self-propelled past Resident #7 (less than three feet), while in the dining room; neither resident wore a mask. The DA did not provide, encourage, or assist either resident to cover their mouth and nose with a mask. An observation on 5/7/2020 at 9:32 a.m. revealed Resident #7 self-propelled passed CNA #1 in the hallway; Resident #7 did not wear a mask. CNA #1 did not provide, encourage, or assist her to cover her mouth and nose with a mask. An observation on 5/7/2020 at 9:40 a.m. revealed Resident #7 was in the dining room and did not wear a mask. The occupational therapist (OT) approached Resident #7, this was less than three feet from her, and she did not provide, encourage, or assist her to cover her mouth and nose with a mask. An observation on 5/7/2020 at 10:05 a.m. revealed Resident #8 stood at the nurse's station with his mask under his chin, less than three feet from LPN #1; he spoke to LPN #1 and she did not encourage, or assist him to cover his mouth and nose with his mask. There were other unidentified staff at the nurse's station as well. After their interaction, he continued to keep his mask under his chin and sat down, within view of the nurse's station. LPN #1 nor the other unidentified staff did not encourage, or assist him to cover his mouth and nose with his mask. An observation on 5/7/2020 at 10:21 a.m. revealed the OT was providing care to Resident #10 in her room. She exited the room with the vital sign cart and then performed hand hygiene with ABHR for less than 20 seconds. An observation on 5/7/2020 at 10:28 a.m. revealed Resident #8 stood in the hallway with his mask under his chin, unidentified staff passed him and did not encourage, or assist him to cover his mouth and nose with his mask. An observation on 5/7/2020 at 10:30 a.m. revealed the OT was in the dining room, interacted with Resident #7 at a distance of less than three feet, and Resident #7 did not have a mask on. The OT did not provide, encourage, or assist her to cover her mouth and nose with a mask. An observation on 5/7/2020 at 10:43 a.m. revealed Resident #7 was in the dining room and did not wear a mask. Three unidentified staff were in the dining room, Resident #7 was within their view, none of the staff tried to provide, encourage, or assist her to cover her mouth and nose with a mask. B. Open doors to isolation rooms An observation on 5/7/2020 at 8:45 a.m. revealed Resident #3 had an isolation cart outside of her room which contained gloves and gowns; the door to her room was open to the main hallway. Resident #4 had an isolation cart outside of his room which contained gloves and gowns; the door to his room was open to the main hallway. An observation on 5/7/2020 at 8:48 a.m. revealed the physical therapist (PT) entered the open door of Resident #3's room to provide treatment. The PT did not shut her door. She sat down less than three feet across from Resident #3 and began to type on her computer. She did not provide, encourage, or assist Resident #3 to cover her mouth and nose with a mask. An observation on 5/7/2020 at 8:50 a.m. revealed ADON stood at Resident #3's open doorway, did not shut it, then walked away. An observation on 5/7/2020 at 9:08 a.m. revealed Resident #4 had an isolation cart outside of his room which contained gloves and gowns; the door to his room was open to the main hallway. An observation on 5/7/2020 at 9:21 a.m. revealed the door to Resident #3 and Resident #4's rooms remained open. C. Failure to sanitize multiuse activity game and puzzle pieces An observation on 5/7/2020 at 9:15 a.m. revealed the activity assistant (AA) took a scrabble game into Resident #5's room, sat less than three feet across from her, and proceeded to play scrabble with her. She did not provide, encourage, or assist Resident #5 to cover her mouth and nose with a mask. An observation on 5/7/2020 at 9:38 a.m. revealed AA exited Resident #5's room with the scrabble game and did not sanitize the game board and its pieces. She stored the game in a cabinet which contained other games and puzzles; she did not perform hand hygiene afterwards. An observation on 5/7/2020 at 10:42 a.m. revealed Resident #2 was putting a puzzle together with AA in the dining area. Resident #2 started to cough. AA continued to put the puzzle together with Resident #2 and did not ask about her cough nor stop putting the puzzle together with her to have a nurse evaluate her cough. D. Resident interview Resident #2 was interviewed on 5/7/2020 at 10:40 a.m. She said she had chills since this morning and had a cough. She said she told the nurse about it. E. Staff interviews LPN #1 was interviewed on 5/7/2020 at 10:06 a.m. She said residents were to wear masks when out of their rooms to help protect themselves and other residents and to prevent the spread of viruses. If residents were in the dining room and not eating they should have their masks on for the same reason. She said the facility had not told us about having residents cover their nose and mouth with a mask when we are providing care for them; or when less than three feet from them. She said doors to isolation rooms should be closed to prevent the potential spread of virus while in quarantine. She said Resident #1 had an itchy cough and she complained of being tired and sneezing a lot, and always wanting to lay down. She said she hadn't taken care of her before today, and did not know why she was coughing and sneezing, I don't know what her baseline is. (Resident #2) said she felt cold today, she said she had chills. She was in isolation because her husband passed due to COVID-19. I have seen other residents play with the Scrabble game before. CNA #1 was interviewed on 5/7/2020 at 10:30 a.m. She said residents were to wear masks when out of their rooms to help protect themselves and other residents and to prevent the spread of viruses. She said the facility had not told them about having residents cover their nose and mouth with a mask when they were providing care for them; or when less than three feet from them. She said doors to isolation rooms should be closed when on quarantine and staff were to sanitize their hands for 20 seconds. The DON was interviewed on 5/7/20 at 11:03 a.m. She said all residents were placed on 14 day isolation if presumed positive for COVID-19. All residents were screened every eight hours for COVID-19. Resident #2 was in isolation in March because she was presumed positive for COVID-19 and because her symptoms included a lingering barking cough, the facility kept her in isolation longer than 14 days. Her cough had since resolved and she was removed from isolation and was not in isolation now. Resident #1 always had a cough, but had not been sneezing. Resident #1 was in isolation before her former roommate passed due to COVID-19. The DON was interviewed a second time on 5/7/20 at 11:43 a.m. She said residents were to wear masks while out of their rooms; staff were to encourage them to use one to protect and prevent them from COVID-19. She said she would re-educate staff to continue to encourage residents to wear masks when out of their rooms due to their cognitive deficits. She said staff were to use ABHR for at least 20 seconds and she would re-educate them on that as well. She said LPN #1 had not reported to her that Resident #2 had chills, and Resident #1 was coughing and sneezing. She and the ADON would complete full assessments on Resident #1 and Resident #2, and notify their

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