STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065113	A. BUILDING _____ B. WING _____	06/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDALLION POST ACUTE REHABILITATION	**1719 E BIJOU ST COLORADO SPRINGS, CO 80909**

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 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, the facility failed to maintain a sanitary, orderly, and comfortable environment for residents in 10 of 33 resident rooms and on two of three hallways. Specifically, the facility failed to ensure walls and floors were repaired, painted and properly maintained. Findings include: I. Initial observations Observations of the facility's occupied resident living environment, conducted on 6/8/2020 beginning at 8:42 a.m., revealed: room [ROOM NUMBER]; the ceiling outside of the room had four large water stains approximately six inches in diameter. The floors in the room were visibly dirty with tissue and other debris on the floor. -room [ROOM NUMBER]; the floors had crumbs, pop cans and paper next to the resident's chair. There were several red stains in front of the resident's chair which appeared to be thick paste like material. The sink countertop had a large section approximately four inches long by three inches wide of chipped laminate. The wall had a section approximately six feet long by two inches wide where the resident's wheelchair had rubbed away the wall paper. -room [ROOM NUMBER]; the wall next to the resident's bed had a section approximately three feet high by four feet wide of deep scratches from the bed being lifted and lowered. The wall next to the resident's bed had black marks and dried fluid drips along the wall. -room [ROOM NUMBER]; the wall in the restroom had eight quarter sized holes above the commode. The resident's towel rack was missing. -Room #S-2; the wall behind the resident's bed was damaged from the bed being lifted and lowered. The floor was cluttered with trash and visibly dirty. -Room #S-5; the floors were dirty and cluttered with trash including a pair of blue gloves on the floor underneath the resident's bed. -Room #S-8; the wall next to the restroom had two dime sized holes. The resident was missing a towel rack which was on her dresser. -room [ROOM NUMBER]; the wall next to the resident bed had a section which had chipped and damaged sheet rock approximately six inches long by three inches wide. The wall in between the residents' room had four large sections approximately three inches in diameter of patch work which had not been completed. The wall behind the resident's bed had scratches from the bed being lifted and lowered. The commode had rust and missing caulking around the base. room [ROOM NUMBER]; the baseboard cove next to the restroom was peeling away from the wall with sheetrock damaged. The wall behind the resident's bed was damaged from the bed being lifted and lowered. -room [ROOM NUMBER]; the wall behind the resident's bed was damaged from the bed being lifted and lowered. II. Environmental tour and staff interview The environmental tour was conducted with the maintenance supervisor (MS) on 6/8/2020 at 12:23 p.m. The above detailed observations were reviewed. The MS said he had just accepted the position of MS. The MS documented the environmental concerns. The MS said staff filled out requisition forms which are available at every nursing station. The MS said he did not have any repair requisition requests for the above mentioned rooms. The MS said the above-mentioned damage should have been repaired and addressed in a timely manner.
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 prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections including Covid-19. Specifically, the facility: -Failed to clearly identify rooms S9-1 and S9-2 as isolation rooms with proper signage; -Failed to follow proper housekeeping protocols to prevent cross-contamination; -Failed to maintain proper cleaning standards and procedures; -Failed to properly discard isolation gowns after use; and -Failed to properly sanitize goggles after exiting an isolation room. Findings include: I. No signage for isolation room precautions A. Facility policies and procedures The Infection Control policy, revised 4/8/2020, was provided on 5/9/2020 at 4:31 p.m. by the director of nursing (DON). The policy included the facility shall establish routine, ongoing, and systematic collection, analysis, interpretation, and dissemination of surveillance data to identify COVID-19 outbreaks, and to maintain or improve resident health status. The system for surveillance shall be based upon national standards of practice and the facility assessment, including the resident population and the services and care provided. B. Observations and interviews On 6/8/2020 at 8:20 a.m. during the initial facility tour a housekeeping cart was observed between rooms S9-1 and S9-2. Further observation of the hall revealed an isolation cart behind the housekeeping cart. The housekeeping cart hid the isolation cart between rooms S9-1 or S9-2. There was no signage on either S9-1 or S9-2 identifying which room was on isolation precautions. Housekeeper (HSK) #2 was observed donning personal protective equipment (PPE) and said both room S9-1 and S9-2 were in isolation. On 6/8/2020 at 9:01 a.m. registered nurse (RN) #1 said both residents in rooms S9-1 and S9-2 were on 14-day isolation as they were admitted on [DATE] and 6/5/2020. RN #1 was asked to observe the residents' doors. RN #1 said, Oh they should have an isolation sign to identify they are on isolation precautions. She said a negative outcome would be someone could walk into the residents' rooms not knowing they were on isolation precautions. She said she would put signs on both rooms immediately. C. Staff interviews The director of nursing (DON) was interviewed on 6/8/2020 at 11:42 a.m. The DON was told of the observations above. She said when a resident was a new admit they were placed on 14-day isolation precautions. She said it would be her expectation the rooms would have had signage clearly identifying S9-1 and S9-2 were on isolation precautions. She said each room should have an isolation cart for each resident outside their room. She said a negative outcome would be staff or others could walk into the residents' rooms not knowing they were on isolation precautions. II. Failure to follow proper housekeeping protocols to prevent cross-contamination A. Observations On 6/8/2020 at 8:35 a.m., HSK #2 was observed cleaning room #S9-1. HSK #2 put on her personal protective equipment (PPE) and a pair of gloves, and grabbed a rag and cleaner. HSK #2 proceeded to spray three squirts of the sanitizer spray into a cloth rag. She wiped the door knob and outside of the door. HSK #2 then proceeded to wipe the resident's sink and countertop with the same rag and then moved to the window sill. She then wiped the resident's bedside table and the base of the bedside table. HSK #2 did not respray the disinfectant into the rag at any time during this process. HSK #2 exited the resident's room and placed the rag into a plastic bag on her cart. She grabbed another rag and sprayed several squirts of the disinfectant into the rag. She reentered the resident's room and proceeded to enter the resident's restroom. She was in the restroom for approximately two minutes and exited the resident's room. She placed the rag into a plastic bag on her cart. She grabbed the broom and dust pan and reentered the resident's room. She swept under the resident's bed and under the sink. She swept the debris toward the door. She picked up the dirt with the dustpan and dumped it into the trash can on her cart. HSK #2 then grabbed a mop head out of her cart and placed it onto the mop handle and proceeded to put the mop into the bucket. She wrung the mop out and reentered the resident's room. She mopped underneath the resident bed and worked her way toward the window and under the sink. She entered the resident's restroom and mopped the restroom and finished mopping the resident's floor till she reached the outside of the door. HSK #2 then removed the mop head with her gloved hand and placed the mop into the plastic bag. She placed the mop handle onto her

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) cart and placed the wet floor sign on the floor. She did not wash her hands or change her gloves during this process. B. Interviews HSK #1 was interviewed on 6/8/2020 at 8:50 a.m. She said she starts cleaning the room wiping the door knob, door, sink and countertop. She said then she will clean the window sill then the bedside table. She said she sprays the disinfectant into the rag and would clean all surfaces including the restroom. She said she did not know the dwell time of the disinfectant. She said, I was told I can clean the room with one pair of gloves before I sanitize my hands. The housekeeping supervisor (HSKS) was interviewed 6/8/2020 at 11:37 a.m. The HSKS was told of the observation above. He said he did not train the housekeepers but said they should start from the window and work their way out of the room. He said the restroom was supposed to be cleaned last which included the restroom floors. He said the disinfectant which they used was a peroxide multi surface cleaner and disinfectant. He said it was a new disinfectant which the facility had recently started using. He said he didn't know anything about it and he didn't know what the dwell time was on the product. He said he did not have a business card of the representative who provided the disinfectant. He said it was his expectation the housekeepers should start cleaning from clean to dirty and the restroom should be done last. He said it was his expectation to follow the procedure of cleaning the residents' rooms and wash their hands between every task. He said a negative outcome would be cross contamination from room to room. The disinfectant lab tech (DLT) was interviewed on 6/10/2020 at 10:18 a.m. He said the dwell time for the disinfectant was 45 seconds to three minutes depending on how the disinfectant was applied. He said the disinfectant should be applied by spray bottle. He said the housekeeping staff should start cleaning the room from clean to dirty. The DLT was told of the observation above. He said spraying the rag would not allow for adequate dwell time to disinfect the surfaces adequately. He said the toilet bowl cleaner was a 73 disinfectant which had a dwell time of five minutes. He said he would have to make an appointment with the facility to provide in-services on the proper use of the disinfectant as it sounded like they were not using it correctly. He said he was unaware the maintenance supervisor had been replaced. III. Failure to properly discard isolations gowns after use A. Professional standard According to 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 (updated 4/13/2020): Healthcare Personnel (HCP) should have received job-specific training on PPE and demonstrated competency with selection and proper use (e.g., putting on and removing without self-contamination). B. Observations of isolation room On 6/8/2020 at 8:50 a.m., HSK #2 was observed finishing cleaning room S9-1. HSK #2 placed a wet floor sign in front of the resident's door after completing the resident's room. HSK #2 exited the resident's room and removed her PPE outside of the resident's room. She removed her yellow gown and rolled the gown with her gloved hands. She placed the dirty gown and gloves into the trash can on her cart. She did not wash or sanitize her hands. C. Staff interview The DON was interviewed 6/8/2020 at 11:42 a.m. The DON was told of the observation above. The DON said she had trained everybody across the board. She also trained the department heads who completed follow up training with their staff. She said all PPE should be removed in the resident room and placed in the biohazard containers. She said all staff should wash their hands with soap and water after removing their PPE and after every task. She said she was going to in-service the staff immediately. She said a negative outcome would be cross contamination and contamination of the housekeeping cart. IV. Failure to sanitize protective eyewear after leaving an isolation room A. Professional reference According to the Centers for Disease Control, Preparing for COVID-19 in Nursing Homes, updated 5/19/2020, https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html: 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 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. B. Observation On 6/8/2020 at 9:52 a.m. physical therapist (PT) #1 was observed exiting room [ROOM NUMBER]. The room was on isolation precautions for readmission to the hospital from a hospital stay. The room was identified as droplet precautions. PT #1 washed the goggles with soap and water and placed them back into the cart. She did not sanitize the goggles. The resident used oxygen at 3 liters per minute delivered by nasal cannula for a [DIAGNOSES REDACTED]. Interviews PT #1 was interviewed on 6/8/2020 at 11:35 a.m. She said when she was leaving the isolation room, she was not able to locate a sani-wipe disinfectant to disinfect the goggles after she was finished providing care. She said she thought washing the goggles with soap and water would be ok. The director of nursing (DON) was interviewed on 6/8/2020 at 11:41 a.m. She said the goggles should have been sanitized to prevent any possible cross contamination and spread of germs [MEDICAL CONDITION] to other residents and staff.
F 0923 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have enough outside ventilation via a window or mechanical ventilation, or both.** Based on observations and staff interviews, the facility failed to provide adequate outside ventilation by means of windows and/or mechanical ventilation. Specifically, the facility failed to ensure resident bathroom exhaust fans were functioning on one of three resident hallways. Findings include: I. Observations An observation of the resident environment was completed on 6/8/2020 at 12:20 p.m. Exhaust fans were installed in the ceiling of each bathroom. In 100 hall rooms the fans were not functioning. The rooms which were observed were rooms with no outside window ventilation in the restrooms. Bathroom fans on 100 hall with no windows were not audible and did not create air movement with the switch turned on. As a measure of checking the function of each fan, a small square of single ply toilet paper was placed against the vent. The exhaust fans were unable to hold the toilet tissue in place, which indicated the fans did not function properly. All fan vents in all restrooms had a large buildup of dust particles and visible debris, which was observed by the maintenance supervisors. II. Staff interview During an environmental tour conducted on 6/8/2020 at 12:25 p.m., the maintenance supervisor (MS) confirmed the exhaust fans on 100 hall were not functioning. The MS said he would have to check the motors and electrical breakers on all halls to see why they were not functioning correctly. He said he had recently been hired and had a lot of work to catch up on. The MS said the ventilation fans in every resident room should be in good working condition to eliminate odors.