STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065266	A. BUILDING _____ B. WING _____	05/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GARDEN TERRACE ALZHEIMER'S CENTER OF EXCELLENCE	1600 S POTOMAC ST AURORA, CO 80012

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.** Based on observations, interviews and record review, 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 Coronavirus disease (COVID-19). Specifically, the facility failed to: - Ensure all staff entering the designated COVID unit donned full personal protective equipment (PPE); - Ensure appropriate hand hygiene was completed; - Ensure N95 masks fit appropriately on the face, and; - Ensure trash, soiled linen containers, and supply carts were not taken from the COVID unit to other areas of the facility. Findings include: I. Professional standards A. The Centers for Disease Control and Prevention (CDC) Using personal protective equipment (PPE), last updated 4/3/2020, retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html. It included the following recommendations for how to put on (don) PPE gear: 1. Identify and gather the proper PPE to don. 2. Perform hand hygiene using hand sanitizer. 3. Put on an isolation gown. Tie all of the ties on the gown. Assistance may be needed by other healthcare personnel. 4. Put on National Institute for OccupationalSafety and Health (NIOSH)-approved N95 filtering facepiece respirator or higher (use a facemask if a respirator is not available). Do not wear a respirator/face mask under your chin or store in a scrubs pocket between patients. Respirator straps should be placed on the crown of head (top strap) and base of neck (bottom strap). Facemask ties should be secured on the crown of head (top tie) and base of neck (bottom tie). If the mask has loops, hook them appropriately around your ears. 5. Put on a face shield or goggles. 6. Perform hand hygiene before putting on gloves. Gloves should cover the cuff (wrist) of the gown. 7. Healthcare personnel may now enter the patient room. B. 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. It included the following recommendations: Multiple opportunities for hand hygiene may occur during a single care episode. Following are the clinical indications for hand hygiene: Use an alcohol-based hand sanitizer immediately before touching a patient, before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids or contaminated surfaces, and immediately after glove removal. Wash with soap and water when hands are visibly soiled, after caring for a person with known or suspected infectious diarrhea, and after known or suspected exposure to spores. When using alcohol-based hand sanitizer, put the product on hands and rub hands together. Cover all surfaces until hands feel dry. This should take around 20 seconds. II. Facility policies and procedures A. The Transmission-based Precautions and Isolation Procedures and the Personal Protective Equipment (PPE) policy and procedure, revised 4/20/2020, was provided by the director of nursing (DON) on 5/5/2020 at 12:00 p.m. It read in pertinent part, Transmission-based precautions and the use of PPE are implemented based on the means of transmission of an infection (contact, droplet, or airborne) in addition to standard precautions in order to prevent or control infection. - Staff are to donn appropriate PPE upon entry into the environment of a resident on transmission-based precautions. - Contact precautions are intended to prevent transmission of infections that are spread by direct or indirect contact with the resident or environment, and require the use of appropriate PPE, including a gown and gloves upon entering the resident ' s environment. - If possible, the facility may consider closing units where symptomatic and asymptomatic residents reside and cohorting staff on either affected or non-affected units to prevent transmission between units. - For a resident with known or suspected COVID-19, associates should wear gloves, isolation gown, eye protection, and an N95 or higher-level respirator if available, this includes care of all residents on the unit. B. The Coronavirus (COVID-19) policy, revised 4/20/2020, provided by the DON on 5/5/2020 at 12:00 p.m. It read in pertinent part, The purpose is to provide a framework to minimize the risk of potential exposure to the Coronavirus (COVID-19) in the long-term facility. Transmission also might occur through contact with contaminated surfaces followed by self-delivery to the eyes, nose, or mouth. III. Observations On 5/5/2020 at 11:00 a.m., the DON was seen outside the doors to the designated COVID unit. There was no PPE available for staff who were not designated to work on that unit. She was wearing an N95 mask with a surgical mask over it. She did not perform hand hygiene, donn a gown, gloves, or eye protection. When she entered the unit, a staff member pushed wheeled trash and laundry containers off the unit. He was not wearing a gown, gloves or eye protection, and did not clean the containers. The DON walked throughout the unit. She pointed out the COVID-19 positive residents that were wandering in the hallway. Those residents ' surgical masks were not covering their noses or the mask was lowered on their faces. - At 11:15 a.m., the floor tech (FT) was seen cleaning a room at the end of the hall on the COVID-19 unit. He said he was to clean three rooms on the COVID-19 wing, then go to a different wing to clean two rooms there. He acknowledged the cart containing the cleaning supplies would be taken to the other hall. - At 11:35 a.m., the FT removed the soiled cloth gown he wore cleaning rooms and placed it on top of a clean cabinet in the hall that contained new gowns. He did not place the soiled gown into the proper container. He removed his gloves and did not perform hand hygiene then exited the unit. He did not remove the N95 or the surgical mask he wore while on the unit. - At 11:42 a.m., the FT re-entered the unit wearing the same N95 and surgical masks. He did not perform hand hygiene or don a gown, gloves, or eye protection before he entered the unit. He walked around the unit and passed several COVID-19 positive residents in the hallway as he searched for a gown. - At 11:45 a.m, licensed practical nurse (LPN) #1 on the North unit, was seen wearing an N95 mask that was loose on her face and moved as she talked. She said staff were wearing the N95 masks because of the resident they had in isolation who was followed by hospice and had an elevated temperature. His family did not want him tested for COVID-19, so they did not know if he was positive. She said the North unit was to be the step-down unit for the COVID-19 residents that have recovered from the illness. -At 1:15 p.m., LPN #2 was seen on the COVID-19 unit walking around with no gown or gloves on. There were several COVID-19 positive residents walking in the hall near him. He was not observed to perform hand hygiene. -At 1:30 p.m., the central supply director (CSD) entered the COVID-19 unit wearing an N95 mask that was loose on her face and did not cover her nose completely. She did not don a gown, gloves, or eye protection before she entered the unit. At 1:35 p.m., she exited the unit with a supply cart that contained unopened packages of briefs and wipes. She did not clean the cart before she took it off the unit and wore the same N95 mask to other areas of the facility and into non-COVID positive resident rooms. She used alcohol based hand rub (ABHR) for 10 seconds, then waved her hands in the air to dry. She took the cart to the service hallway where she and an unidentified staff member placed extra bags of briefs and wipes onto the cart, then took it to the Center unit, and distributed the items into non-COVID positive resident rooms. -At 1:40 p.m., the unidentified staff member on the Center unit, used ABHR for five seconds and with her hands wet, picked up a package of briefs and a package of wipes from the supply cart and delivered them to a resident ' s room. III. Interviews The DON was interviewed on 5/5/2020 at 11:00 a.m. She said staff were to perform hand hygiene and don full PPE (N95 mask, gown, gloves, eye protection), kept in her office, prior to entering the COVID-19 unit. She said the designated staff for the COVID unit did not leave the unit until their shift was over and they wore full PPE all shift. LPN #3 was interviewed on 5/5/2020 at 11:20 a.m. She said the wheeled trash and laundry containers remained in the hallway near the nurses station during the day, and at the end of their shift,

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 -** Some	(continued... from page 1) staff gathered all the trash and used gowns hanging in resident rooms and placed them in the proper containers. They were taken to the double doors that enter onto the unit. Staff then took them out of the unit over to the service hallway to the laundry or outside to the trash receptacle. She said the carts were not cleaned before being taken off the COVID-19 unit. She said the carts should be cleaned with bleach before they were taken off the unit Certified nurse aides (CNA #1 and #2) were interviewed on 5/5/2020 at 11:30 a.m. They said when they arrived for their shift they were to perform hand hygiene and don the appropriate PPE, (N95 mask, a gown, gloves, and face shield), that the DON kept in her office, before they entered the COVID-19 unit. They said they also used a cloth gown assigned to them and kept in the resident room on a designated peg, for use during their shift. When they ended their shift they threw away the disposable gown and put the used cloth gowns in the laundry container. They said they were to perform hand hygiene frequently throughout the shift by washing with soap and water for 20 seconds or using ABHR and rubbing their hands together until it was dry. The nursing home administrator (NHA) and the DON were interviewed on 5/5/2020 at 12:30 p.m. They said the housekeeping cart that the floor tech was using on the COVID-19 unit was stored off the unit, down the supply hall, in the housekeeping department, and they acknowledged it was not cleaned when it was taken off the unit. The NHA and the DON were interviewed on 5/5/2020 at 2:10 p.m. They said the supply cart, the housekeeping cart, and the trash and soiled linen carts, on the COVID-19 unit, should not be taken off that unit into other areas of the facility. They acknowledged they were not cleaned when taken off the unit. They said they would get different carts and designate them for the COVID unit.