STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06A173	A. BUILDING _____ B. WING _____	07/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SEDGWICK COUNTY MEMORIAL NURSING HOME	901 CEDAR ST JULESBURG, CO 80737

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** - 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 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: -Active screening was being done for all employees to check for signs and symptoms of COVID-19 prior to allowing them to work; -Staff performed hand hygiene when appropriate; -Staff used appropriate face covering while in the facility; -Employees used alcohol based hand rub (ABHR) appropriately; and, -Social distancing was being practiced. Findings include: I. Failure to actively screen employees upon arrival for work A. Professional reference According to the Centers for Disease Control and Prevention (CDC), Preparing for COVID 19 in Nursing Homes updated 6/22/2020, accessed on 8/4/2020 retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, revealed in part, Screen all HCP at the beginning of their shift for fever and symptoms of COVID-19. Actively take their temperature and document absence of symptoms consistent with COVID-19. B. Facility policy The COVID-19 Guideline Policy, revised 6/1/2020, was provided by the nursing home administrator (NHA) on 7/28/2020 at 1:30 p.m., it read in pertinent part: Staff will be screened at the beginning of each shift for fever and respiratory symptoms. If symptoms arise during the shift staff will be evaluated accordingly. C. Observation On 7/28/2020 at 12:40 p.m. two staff members were observed walking into the facility at the employee entrance. They both said they were dietary aides (DA) for the afternoon shift. They were observed screening themselves. DA#2 took her own temperature and wrote the number on the screening sheet and filled out (checked off) the questions related to signs and symptoms of COVID-19. DA#3 followed the same process. They were not screened by another staff member and proceeded to the kitchen. D. Interviews The NHA was interviewed on 7/28/2020 at 11:15 a.m. She said the staff were allowed to screen themselves immediately after they entered the facility. She said she did not have enough staff to dedicate one person for screening all of the employees at each shift. She said employees were all trained on how to properly take and monitor vital signs. She said they recorded their temperature on a sheet daily and the document was reviewed by her or the director of nursing (DON) daily. She said if an employee didn't feel comfortable screening themselves, the person would ring a bell for assistance and a nurse would come to screen that person. The dietary manager (DM) was interviewed on 7/28/2020 at 11:45 a.m. She said the dietary staff was screening themselves for COVID-19 signs and symptoms at the employee entrance before each shift. Licensed practical nurse (LPN) #1 was interviewed on 7/28/2020 at 12:00 p.m. She said when she arrived at work she entered the facility through the employee entrance, took her body temperature and filled out the screening form. She said all of the nursing staff was screening themselves before each shift. II. Failure to perform hand hygiene during the screening process A. Professional reference According to the Centers for Disease Control and Prevention (CDC) Hand Hygiene, last updated 5/17/2020, accessed on 8/4/2020 retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/hand-hygiene.html, included the following recommendations: Protect yourself and your patients from potentially deadly germs by cleaning your hands. Be sure you clean your hands the right way at the right times. Hand hygiene is an important part of the U.S. response to the international emergence of COVID-19. [MEDICATION NAME] hand hygiene, which includes the use of alcohol-based hand rub (ABHR) or handwashing, is a simple yet effective way to prevent the spread of pathogens and infections in healthcare settings. CDC recommendations reflect this important role. The exact contribution of hand hygiene to the reduction of direct and indirect spread of coronaviruses between people is currently unknown. However, hand washing mechanically removes pathogens, and laboratory data demonstrate that ABHR formulations in the range of alcohol concentrations recommended by CDC, inactivate [DIAGNOSES REDACTED]-CoV-2. ABHR effectively reduces the number of pathogens that may be present on the hands of healthcare providers after brief interactions with patients or the care environment. B. Observation On 7/28/2020 at 12:40 p.m. two staff members were observed walking into the facility at the employee entrance. They both said they were dietary aides for the afternoon shift. DA #2 put her handbag into a locker, completed a screening form and went to the kitchen. She did not disinfect or washed her hands. DA#3 took off her street shoes (flip-flaps) touching the soles with her hands and put tennis shoes on. Without washing or disinfecting her hands she stepped into the kitchen and left her handbag. She came to the screening table, checked and recorded her body temperature, and completed her screening form. She went back to the kitchen without disinfecting or washing her hands. C. Interview The NHA was interviewed on 7/28/2020 at 1:30 p.m. She said it was unacceptable for the staff to not disinfect their hands before and after the screening process. She said the disinfectant is always available at the screening station for all the staff and visitors. She said her expectation was all the staff and visitors disinfect their hands before they enter residents' care areas including the kitchen. III. Failure to ensure appropriate face covering for staff in the facility A. Professional reference According to the Centers for Disease Control and Prevention (CDC) website, Preparing for COVID-19: Long-term Care Facilities, Nursing Homes updated 6/25/2020, accessed on 8/4/2020) and retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, included the following recommendations: Cloth face coverings are not considered personal protective equipment (PPE) because their capability to protect healthcare personnel (HCP) is unknown. HCP should wear a facemask at all times while they are in the facility. When available, facemasks are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. Cloth face coverings should NOT be worn by HCP instead of a respirator or facemask if PPE is required. B. Observations On 7/28/2020 at 11:50 a.m., a dietary aide (DA#1) was observed in the hallway walking with the DM. She was wearing a cloth facemask. She said it was her first day working in the facility and she did not receive a surgical mask. On 7/28/2020 at 11:55 a.m., a housekeeper (HSK#1) was observed cleaning residents' rooms. She was wearing a cloth facemask. She said she did not know she had to wear a hospital grade facemask in the facility. On 7/28/2020 at 12:40 p.m. DA#2 and DA#3 were observed at the employee entrance pulling cloth facemasks from their handbags and putting them on, covering their mouth and nose. They both were later observed in the kitchen area and in the residents' dining room, wearing the cloth masks. Some residents were still in the dining room. C. Interview The NHA was interviewed on 7/28/2020 at 1:40 p.m. She said she was not aware that some staff were wearing cloth masks in the facility and in residents' care areas. She said a hospital grade/surgical masks were available for all staff at all times at the nurses' desk. She said she will provide education to all staff about appropriate facemasks in the facility. IV. Hand hygiene during meal service A. Professional reference According to the Centers for Disease and Prevention (CDC) Hand Hygiene in Healthcare Settings, last up updated 1/31/2020, accessed on 7/30/2020 retrieved from https://www.cdc.gov/handhygiene/providers/index.html, 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

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) 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. When cleaning hands with soap and water, wet hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Avoid using hot water, to prevent drying of skin. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times. B. Observations and interview On 7/28/2020 from 11:55 a.m. to 12:58 p.m., noon meal service in the main dining room was observed. At 12:02 p.m., certified nurse aide (CNA#1) sat down with two residents who were waiting to eat their meals. CNA #1 did not perform hand hygiene prior to sitting to help the two residents with their meals. She did not perform any hand hygiene throughout the meal service; even while assisting two residents to eat at the same time. CNA #1 was initially helping a male resident eat his meal, with spoon size bites of food, then the CNA rolled his chair beside the female resident and started arranging her dishes, so she could see what was on her plate. The CNA stood up and helped the female resident put on a clothing protector, pick up her ponytail and move it to the side while tying the clothing protector across her back. The CNA picked up the female resident's spoon encouraging her to take a bite of food. The resident declined her assistance and picked up the spoon that the CNA held with her unwashed hand and began to eat with it. The CNA rolled her chair back to the male resident to assist him with another bite of food and still did not perform hand hygiene. CNA #1 continued going back and forth assisting both residents to eat, using her same unwashed hand to touch both resident's eating utensils and plates. On 7/28/2020 at 12:07 p.m. Dietary aide (DA) #4 served juice and cookie to the population of residents who sat in the dining area during the noon meal service. In the course of serving the cookies and juice, DA #4 patted residents on their shoulders and upper back whilst she requested the residents preference. She repeated the sequence of patting the resident's shoulders and upper back amongst the entirety of the 16 residents who sat in the dining room. By failing to perform hand hygiene, DA #4 had potentially cross-contaminated the residents by whatever contaminant she picked up between resident contacts as described above. She did not perform hand hygiene between the contacts. She later sat and assisted a resident with feeding without performing hand hygiene. On 7/28/2020 at 12:19 p.m. CNA #2 was assisting a male and female resident to eat. She went from helping one resident to the other, touched their plates, eating utensils and drinking cups. She wiped the mouth of the female resident to remove some food. She went back and forth between the two residents feeding and assisting them and did not perform any hand hygiene in the process. CNA #2 was interviewed on 7/28/2020 at 12:59 p.m. CNA #2 said staff were to wash their hands or use hand sanitizer after each contact with a resident. When assisting a resident at meal time, staff were to wash their hands prior to starting to serve the residents and use hand sanitizer immediately after serving a resident their food and before serving the next resident. CNA #2 said when assisting more than one resident with their meal, staff were to wash their hands before starting the task and use each of their hands to feed one resident at a time throughout the meal to prevent cross contamination. -The CNA acknowledged it would be a best practice to use hand sanitizer throughout the meal service between helping each resident eat, but she did not do so during the noon meal service. Licensed practical nurse (LPN) #1 was interviewed on 7/28/2020 at 1:13 p.m. LPN #1 said staff were to perform hand hygiene before serving food and in between any contact with residents. If staff were helping or assisting two residents at the same time, they should use different hands to assist each resident and not use the same contaminated hand to feed both residents. -After describing the above meal service observations to LPN #1 , she acknowledged the staff should have performed hand hygiene after having physical contact with one resident and before moving to help another resident. V. Social distancing The CDC (2020) Preparing for COVID-19 in Nursing Homes, updated 6/25/2020, retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, on 7/30/2020. It revealed in part, Implement aggressive social distancing measures (remaining at least 6 feet apart from others). The dining room was observed on 7/28/2020 at 11:58 a.m. during the noon meal. The tables had two residents seated per table. The tables were six feet apart. At 12:41 p.m., residents were observed as they left the dining room. At the time, four residents who propelled themselves on the wheelchair left the dining room at the same time. The residents were not guided to ensure the traffic from exiting the dining room encouraged social distancing. At 12:53 p.m., a group of three residents in the same condition as above left the dining room. Their traffic from the dining room was not guided to encourage social distancing. LPN #1 was interviewed on 7/28/2020 at 1:13 p.m. She said they were seating residents two per table to encourage social distancing. She acknowledged the residents traffic exiting the dining room should have been guided to keep encouraging social distancing. She said the process (not monitoring residents traffic when exiting the dining room) had been in place for a long time and she was not sure if the facility had considered monitoring the process before. She said she would bring the observation to the attention of the facility's administration. The nursing home administrator (NHA) was interviewed on 7/28/2020 at 1:28 p.m. The NHA said training on infection control practices to address COVID-19 started back in March of 2020. She said though infection control training were in place prior to the emergence of COVID, they were reinforced to comply with Center for Disease Control and Prevention (CDC) guidelines for COVID-19. She said hand hygiene training was done everyday and that staff should perform hand hygiene in-between residents contact. She said not directing the traffic of residents exiting the dining room had not been previously identified. She said she would reinforce the training hand hygiene and also ensure staff knew to maintain social distancing among themselves and with residents alike.