STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065229	A. BUILDING _____ B. WING _____	07/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MINNEQUA MEDICENTER	2701 CALIFORNIA ST PUEBLO, CO 81004

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F 0561 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, record review and staff interviews, the facility failed to promote self-determination for two (#2 and #3) of three residents out of eight sample residents reviewed for preferences and choices. Specifically, the facility failed to: -Provide Resident #2 with showers according to preferences; and, -Provide Resident #3 with her bathing preference of showers. Cross-reference for F725 for insufficient staffing. Findings include: I. Resident #2 A. Resident status Resident #2, age 53, was admitted on [DATE] and readmitted on [DATE]. According to the July 2020 computerized physician orders [REDACTED]. The 6/3/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) of 15 out of 15. She required extensive assistance of one staff for bed mobility, dressing and personal hygiene. She required extensive assistance of two staff for transfers. B. Resident interview Resident #2 was interviewed on 7/21/2020 at 3:00 p.m. The resident said she did not always get her bath as requested. Resident #2 said she has requested three baths a week and she only received two a week. C. Record review The comprehensive care plan, last revised on 6/4/2020, identified the resident required extensive assistance with activities of daily living which included bathing. The approaches included the resident preferred to have three showers a week. The medical record was reviewed and showed the resident consistently received two showers a week from June 2020 to July 2020. II. Resident #3 A. Resident status Resident #3, age 68, was admitted on [DATE]. According to the July 2020 computerized physician orders [REDACTED]. The 7/17/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) of 15 out of 15. She required extensive assistance of two staff for bed mobility, transfers, and toilet use. She required extensive assistance of one staff for dressing and personal hygiene. She required the physical assistance of one staff for bathing. B. Resident interview Resident #3 was interviewed on 7/22/2020 at approximately 2:00 p.m. The resident said she was scheduled to receive two showers a week. She said she did not always receive two showers a week. She said that at times she had to have a bed bath because the shower chair used was not always available. She said the staff would tell her the shower chair was not available and that she needed to take a bed bath. She said she preferred showers because it made her feel good. C. Record review The comprehensive care plan, last updated 6/10/2020, identified the resident required extensive assistance with activities of daily living. The care plan documented if the resident refused a shower than a bed bath needed to be offered. The shower sheets were reviewed for June 2020 and July 2020 and showed no refusals. IV. Staff interview The director of nurses (DON) was interviewed on 7/22/2020 at 4:00 p.m. The DON said showers and baths were decided based on the resident's choice of how many and on either days or evenings. The DON was interviewed again on 7/22/2020 at 6:15 p.m. She said the facility had three bariatric shower chairs and the chairs were exactly the same and in good working condition. She said one shower chair had a crack in the arm rest, other than that nothing different between the chairs. She said Resident #3 and another resident always wanted to use the same chair and at times it was not available for Resident #3. -The DON acknowledged if the shower chair was not available for Resident #3 then she took a bed bath which was not her preference.
F 0585 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure three (#2, #6 and #7) of three out of eight sample residents and two out of six halls for resident council were provided prompt efforts by the facility to resolve any grievances. Specifically, the facility failed to: -Ensure the concerns for staffing was resolved for Resident #2 and #6; -Ensure the food concerns were addressed for Resident #2; -Ensure concerns with specific concerns with staff were addressed with for Resident #7; and, -Ensure the group grievances were addressed and resolution provided. Cross-reference F725 for insufficient staffing. Findings include: I. Facility policy The Truly Listening to Our Customers (TLC) Program policy, last revised May 2017, was provided by the nursing home administrator (NHA) via email on 7/30/2020. It read in part; The facility actively resolves concerns submitted orally or in writing to any member of the facility's staff. To help ensure the right of any resident, his or her representative, family member, employee, or appointed advocate to file a concern without discrimination or reprisal or fear of discrimination or reprisal. If a resident, a resident's representative, or another interested person has a concern, a staff member should encourage and assist the resident, or person acting on the resident ' s behalf to file a written concern with the facility using the concern form. If the facility receives a concern orally, staff should document the concern using the concern form. Staff receiving the concern should acknowledge receipt of concern, immediately notify the grievance official and initiate an investigation. If the concern may be resolved immediately, the staff, under the guidance of the grievance official, will resolve the concern and document the resolution on the concern form. Concerns are investigated and resolved within 72 hours from receipt of the concern. The grievance official and the interdisciplinary team (IDT) will designate an investigator. The investigator will have two days following receipt of the concern to complete the investigation, document his or her conclusions using the concern form, and forward the completed form to the grievance official. Within 24 hours, the grievance official reviews the findings with the investigator and the IDT, as required, to determine a resolution. The grievance official informs the individual filing the concern of the resolution as soon as possible but not longer than 72 hours after receipt of the concern (or as soon as possible after that time frame if the concern cannot be resolved in 72 hours). The grievance official follows through with appropriate corrective action to resolve the concern.The administrator will document receipt of all concerns on the concern log. The grievance official will follow-up with the individual filing the concern within seven days after the initial follow-up to ensure that the concern is addressed to their satisfaction. II. Resident #2 A. Resident status Resident #2, age 53, was admitted on [DATE], and readmitted on [DATE]. According to the July 2020 computerized physician orders [REDACTED]. The 6/3/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) of 15 out of 15. She required extensive assistance of one staff for bed mobility, dressing and personal hygiene. B. Resident interview Resident #2 was interviewed on 7/21/2020 at 3:00 p.m. The resident said that she had many complaints which had not been resolved. She said that she had complaints in regards to the food. She said she requested a salad and was told it was not available as they did not have the produce. She said she asked to speak to a manager about it. The dietary supervisor said that it was available and it should have been made for her. The resident further stated that she had not received her showers as requested three showers a week She said she had complained to the administration in regards to not receiving her showers. C. Staff interview CNA #2 was interviewed on 7/21/2020 at

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 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) approximately 9:00 p.m. The CNA said the resident had requested a salad. She said she went to the kitchen to get a salad and she was told they could not make a salad. The resident then became upset when she heard there was no salad. The resident had requested to talk to someone. The CNA said she had a dietary worker to come and speak with the resident. The dietary manager (DM) was interviewed on 7/22/2020 at p.m. The DM said the kitchen always had the lettuce and the makings of a salad. She said she was told by the cook that a salad was not made at the time it was requested. D. Record review Review of the resident's clinical record revealed no mention of the resident's grievance in regards to not receiving her salad request. The concern form dated 6/26/2020 was completed by the assistant director of nursing (ADON). It documented that resident #2 had not been changed at all during the shift. She had not received her shower and was supposed to have had it on this shift. The form further documented in pertinent part under action taken: facility wide education was conducted on 7/2/2020. -The resident was not informed of the outcome of her concern and the staff education that was provided. III. Resident #7 A. Resident status Resident #7, age 60, was admitted on [DATE]. According to the July 2020 computerized physician orders [REDACTED]. The 7/10/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) of 15 out of 15. She required extensive assistance of one staff for bed mobility, transfer, dressing, toilet use and personal hygiene. She was always incontinent of bladder and bowel. B. Resident interview Resident #7 was interviewed on 7/21/2020 at approximately 2:30 p.m. The resident said she had had her light on for three hours. She said she lowered the bed to the floor and climbed out of it. The staff asked her why she was on the floor and she replied that she had crawled out of bed to the door so she could get some help. She said a couple staff members then came to help her. She said that staffing has been a real issue and that call lights getting answered was an issue. She said a certain CNA never answers call lights and was no coverage from 2:00 p.m. to 2:30 p.m. C. Record review Review of Resident #7's progress notes revealed the following: -On 7/12/2020 at 8:30 a.m. a nurse wrote in pertinent part, Resident sitting on buttocks, on floor next to her bed. Resident stated I slid out of bed, so I could get some attention. Resident stated I ' m not hurt, I ' m pissed. -On 7/15/2020 at 2:37 p.m. a nurse wrote, Resident slid out of bed (OOB), no injuries, denies pain. Resident was angry at the resident care specialist (RCS/CNA) 'for taking forever to get me up'. The 5/4/2020 concern form was completed by the DON. It documented in pertinent part that Resident #7 has not been getting her snacks, the food was cold, too spicy and chewy. She was told snacks were not in the budget. Call light wait times were long, up to two hours at times. She had to sit in urine and feces while she waited for staff to assist her. She had not been showered in over two weeks. She has had to stay in bed until 9:00 a.m. She has not been getting her showers because the shower aide gets pulled to work somewhere else. The form further documented under action taken: The staff was working on the shower situation, attempting to resolve having the shower aide pulled. Staff were educated to be prompt with cares, to help the resident out of bed when she is ready, to make her bed and clean up her room. A grievance form was not filled out for the two incidents which occurred in July 2020 with the resident falling due to not getting timely assistance. IV. Resident #6 A. Resident status Resident #6, age 64, was admitted on [DATE]. According to the July 2020 computerized physician orders [REDACTED]. The 5/20/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) of 15 out of 15. She required extensive assistance of one staff for bed mobility, dressing, toilet use, and personal hygiene. She was totally dependent on the use of a mechanical lift and two staff for transfers. She required the physical assistance of one staff for bathing. She was frequently incontinent of bladder and bowel. B. Resident interview Resident # 6 was interviewed on 7/21/2020 at 3:45 p.m. She said that some of the CNAs were rude to her. She said an incident occurred on 7/16/2020 at 3:15 a.m. in which she fell out of bed. She added that an incident report was filled out by the staff. She said that she asked the staff to send her to the hospital, but they would not let her go. The facility told the resident she may not have her same spot when she got back from the hospital. She indicated that she was upset with the management for not allowing her to go. She said she filled out a grievance form concerning this incident and had not heard back from the administrator yet. C. Record review The concern forms for Resident #6 were provided by the NHA on 7/22/2020 at 6:00 p.m. The forms revealed the following: The 3/20/2020 concern form was completed by the account manager, it documented Resident #6 had put her call light on at 6:10 a.m. A CNA (certified nurse aide) answered her call light at 7:25 a.m. She requested to be changed and was told she would have to wait until after breakfast. The resident received breakfast at 8:25 a.m. She was unable to eat breakfast because she was so upset. She received the care she requested at 9:00 a.m. The grievance further documented the following action that was taken: CNA was investigated. CNA was brought back and given education on how to treat residents, residents' rights and quality of care. The 4/22/2020 concern form was completed by the director of nursing (DON) on 4/22/2020. It documented Resident #6 had put her call light on at 7:00 a.m. to be changed, she was soiled with urine. The CNA answered the call light and told the resident that she would help her after meal trays were passed. There was no documentation to reflect that the CNA returned after passing trays. At 9:30 a.m. the resident had a bowel movement (BM) and a male CNA answered her call light. She requested the CNA assigned to care for her because she wanted to talk to her. The CNA assigned to the resident for care came at 11:45 a.m. The grievance further documented the following action that was taken: corrective education was provided to the CNA to answer call lights timely. The 6/19/2020 concern form was completed by the DON. Resident #6 waited four hours last night, she had to call the facility phone number to get someone to help her. She said that the CNA still had an attitude towards her and was complaining about only having two CNAs on the night shift. The grievance further documented the following under action that was taken: corrective education will be provided to the staff member. V. Group grievances A. Resident council minutes The 6/26/2020 resident council minutes for A hallway documented concerns about long call light wait times, being short staffed, the restorative aide being pulled and not receiving ice water. The 6/26/2020 resident council minutes for B hallway documented, residents expressed concerns about being short staffed, long call light wait times, and that showers are not consistent. Review of the resident council meeting minutes for 7/7/2020 at 2:15 p.m. documented that the residents on A hall had requested this meeting as follow up from the meeting held on 6/26/2020. The residents voiced concerns about significant staffing changes and shortages, staff and resident morale, long call light wait times, and COVID-19 updates not getting shared with them and that the meetings would be held monthly moving forward. -There was no concern form documented for the concerns brought up during the 7/7/2020 meeting. B. Resident council concern forms The 6/28/2020 concern form follow up completed by the dietary department documented the original complaint was that the residents were tired of eating the same food over and over again, the quality of the food was poor, the residents are not allowed to have second portions and breakfast was not served until 9:00 a.m. The concern form further documented under action taken: Residents are encouraged to use a suggestion box for meal concerns and the registered dietician would change the disliked items weekly. -The concern form follow up did not address the issues of the food being poor quality and how the issue of being offered seconds on the meal were being addressed. The 6/28/2020 concern form was completed by nursing documented that the A hall residents expressed concerns about long call light wait times, being short staffed, the restorative aide being pulled and not receiving ice water. The concern form further documented a resident council meeting was held on 7/7/2020, the residents were informed that the facility was in the process of hiring new staff and had been in contact with an agency, management is conducting call light audits and passing ice water. The 6/28/2020 concern form documented that the B hall residents expressed concerns about being short staffed, long call light wait times, and that showers are not consistent. The concern form further documented in pertinent part: under action taken: The facility is staffing to PPD (per patient day). C. Staff interviews The dietary manager (DM) was interviewed on 7/22/2020 at 2:18 p.m. The DM said that she had not received any grievance on the quality or taste of the food. She said she heard about the salad not being made for Resident #2. She provided a copy of the grievance she received from the resident council and said that a suggestion box was used if the resident would like to see something different on the menu then it was placed in the box. She said test trays were completed by various staff members. She said they were evaluated for taste. However, there was not any formal way to test the tray. She said the trays were evaluated weekly. She said residents could have seconds if they wished. The DM said the social service assistant, the wound nurse were two who evaluated on a regular basis. The activity director (AD) was interviewed on 7/22/2020 at approximately 3:00 p.m. The AD said after group meetings she would fill out a grievance form for each department. She said the manager for the department was responsible to answer and come up with a solution. She said the hall meetings were held one time a month. She said at the next meeting the fixes that were put in place were reviewed. She said if the resident's concern was not resolved it was then brought back to the group. The grievances needed to have a plan in place within 72 hours. The social service assistant (SSA) was interviewed on 7/22/2020 at approximately 3:30 p.m. The SSA said she had been given a test tray, but it was not frequent. She said she had no formal review provided or she did not document her findings when given the test tray. The wound nurse was interviewed on 7/22/2020 at approximately 4:00 p.m. She said she had received a tray before, but it had

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F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) been at least a month since she had eaten any meal from the kitchen. She said she told the kitchen if she liked the food or not. Otherwise, she had no specific criteria of how to evaluate the meal tray. The nursing home administrator (NHA) was interviewed on 7/22/2020 at 6:40 p.m. The NHA said she was aware there were problems with the concern/grievance procedure. She said she recently took over the grievance procedure in order to keep track. She said she was aware there were resident complaints with showers, call lights and staffing. She said that call light audits were completed, but not on a regular basis. She said they were actively hiring more staff to address the staffing related concerns.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure for one (#4) resident who was unable to carry out activities of daily living (ADLs), received necessary services to maintain good grooming and personal hygiene out of eight sample residents reviewed. Specifically, the facility failed to ensure Resident #4, who was dependent on staff for ADLs, received showers on a regular basis and according to the care plan. Findings include: I. Resident #4 Resident #4, age 90, was admitted on [DATE]. According to the July 2020 computerized physician orders [REDACTED]. The 7/7/2020 minimum data set (MDS) assessment revealed the resident had cognitive impairments and his cognitive skills for daily decision making were severely impaired. He required extensive assistance of one staff for bed mobility, transfers, dressing, toilet use and personal hygiene. He required the physical assistance of one staff for bathing. He was always incontinent of the bladder and bowel. II. Observation On 7/21/2020 at 9:53 a.m. Resident #4 was in his wheelchair coming out of his room and sat in the doorway. The resident's shirt appeared to be soiled with food and his hair was not combed. The resident had a strong smell of body odor. The body odor could be smelled from approximately three feet away. III. Record review The resident's comprehensive care plan, revised on 5/19/2020, indicated that the resident required assistance for his ADL care and one person extensive assistance with showering. It was documented the staff should encourage active participation from the resident with these activities. -The shower schedule indicated that the resident should be offered assistance with a shower two times per week, on Tuesdays and Saturdays in the mornings. According to the residents bathing history chart, Resident #4 did not shower since 6/23/2020. The shower/bathing record for June and July 2020 revealed the resident did not have a shower or bath on 6/27/2020, 7/4/2020, 7/14/2020, 7/18/2020, and 7/21/2020 (during survey). -The shower refusal chart indicated that the resident refused a shower on 7/4/2020 and the rest of days were marked non applicable. The record did not indicate why the resident did not have a shower on any of those days only that it did not happen. IV. Staff interviews Registered nurse (RN) #5 was interviewed on 7/22/2020 at 11:15 a.m. She said there was a shortage of CNA staff which made it difficult to keep up with the showers for the residents. She said that some residents just did not get their showers due to this. The director of nursing (DON) was interviewed on 7/22/2020 at 2:53 p.m., the above concerns were reported to her for Resident #4 who had not had a shower since 6/23/2020. She said that upon admission, each resident had a care conference with the management team and their family regarding many aspects of the care plan, which included showers. She said the staff should be familiar with the residents care plan in regards to showers. She said the plan of care for residents should notate why the resident did not have a shower. She said the lack of showers being done was a concern for her. She said that the plan was to add more staff to each unit and spread out the showers among the staff to ensure that residents did not miss their showers. She said the plan would be implemented when the facility was fully staffed again which the facility was working on. Cross-reference F725 for insufficient staffing.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to ensure for one (#1) of one resident received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan out of eight sample residents. Specifically, the facility failed to: -Ensure Resident #1 received appropriate hygiene to not develop maggots in between his toes; -Ensure there was orders to check in between Resident #1's toes for maggots; -Ensure treatment orders were updated to reflect there were no maggots in between Resident #1's toes; and, -Ensure the care plan was updated with approaches of alternate treatment plan for poor hygiene. Findings include: I. Facility policy The Skin Management System policy, last revised July 2017, was provided by the nursing home administrator (NHA) via email on 7/24/2020. It read in part, Residents receive care to aid in the prevention or worsening of wounds and/or pressure ulcers. Individuals at risk for skin compromise are identified, assessed, and provided treatment to promote healing, prevent infection, and prevent new ulcers from developing. Ongoing monitoring and evaluation are provided for optimal resident outcomes. For pressure reduction: assist the resident to change position periodically in bed as indicated by the nursing assessment or as requested by the resident; utilize a pressure reducing mattress or pressure reducing overlay; provide a pressure reducing device on wheelchair/chair/recliner; consider elevating heels off of the bed with pillow or use of heel protectors. A weekly skin check will be completed in the resident's record using the Head to Toe Skin Check User Defined Assessment (UDA). II. Resident #1 status Resident #1, age 79, was admitted on [DATE]. According to the July 2020 computerized physician orders [REDACTED]. The 7/13/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) of 14 out of 15. He was independent for bed mobility, dressing, toilet use and personal hygiene. He required supervision for transfers and bathing. He was always continent of bladder and bowel. He did not reject care. -The 7/13/2020 MDS documented the resident did not reject care, although record review below revealed he refused to be showered, but would let the staff clean his bilateral extremities (BLE) where the maggots were found. III. Resident interview Resident #1 was interviewed on 7/21/2020 at 9:10 a.m. He said he had been at the facility since 4/6/2020. He said he had to leave his house because it was deemed condemned and uninhabitable. He said he did not like to take showers but he made an agreement with the facility to take a shower once a week on Mondays and that his previous doctor said that was sufficient. He said he did not want a complete shower, but would have his feet soaked in a tub. He said there was one nurse who would allow him to wash his feet in a bucket but some of the staff did not agree and when he tried to tell the other nurses about it they would ignore him. He said he would let them use the bucket to wash his legs and feet because that was not a complete shower that ran over him. IV. Record review The care plan, revised on 7/13/2020 revealed Resident #1 was resistive to care and showers. Interventions included to allow the resident to make his own decisions about his treatment regimen, negotiate a time for ADLs so the resident participates in decision making process, reassure Resident #1 and return five to 10 minutes later and provide consistency with care. Review of Resident #1's ADL lookback report revealed the resident had not showered in the last 30 days. It was documented as not applicable on 6/26/2020 and 7/16/2020 and he refused his shower on 7/3/2020. -No further interventions were added to Resident #1's care plan for his continued refusals. See social services director (SSD) interview below. Review of the July 2020 treatment administration record (TAR) revealed an order which read, Wound care: Apply [MEDICATION NAME] and Xerform to any open areas on BLE, then apply Vaseline to BLE then wrap with Kerlix gauze every Monday, Wednesday and Friday. Review of the weekly skin assessments for June and July 2020 revealed no documentation of maggots. The skin/wound note dated 6/20/2020 at 9:42 a.m., revealed Resident #1's treatment was performed by the wound care nurse (WCN) and wound physician on 6/19/2020. Resident #1 had been putting tissue paper in his shoes to soak up drainage from his wounds to his BLE. The resident had agreed to shower once a week, but refused to have his clothing changed. Staff reviewed non-compliance with grooming; however, there was no further recommendations for his refusal of care. The skin/wound note dated 6/20/2020 at 7:45 p.m., revealed resident care specialist (RCS) observed two maggots to Resident #1's left shoe, his dressings to his BLE were saturated and staff performed wound care to his BLE. Additional skin/wound notes dated 6/29/2020, 7/8/2020, 7/14/2020 and 7/22/2020 revealed Resident #1 continued to refuse to shower or bathe (continued education was provided about bathing for hygiene and wound healing purposes). -However, there were no further recommendations for treatment or alternate to

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) showering for grooming purposes. The skin/wound note dated 7/22/2020 at 3:37 p.m., revealed Resident #1's BLE wounds were assessed by the WCN and wound physician on 7/17/2020. The wound physician observed maggots in between the resident's left great toe and his left second toe and this was attributed to the resident's poor hygiene. The resident was educated about his poor hygiene and refusal to take showers. -Although the resident was educated about his poor hygiene and refusal to take showers, the resident was not provided any alternate treatment to clean his BLE or in between his toes to ensure he did not get maggots between his toes The social services note dated 6/15/2020 at 4:36 p.m., revealed Resident #1 was encouraged to shower/bathe by his family. There was no other documentation provided by the facility regarding bathing or to cleaning in between his toes. V. Resident observation and interview On 7/21/2020 at 1:15 p.m. Resident #1's wound care was observed being provided by the unit manager (UM). The unit manager said the resident requested to have his feet and legs cleaned in a bucket; however, he was encouraged to go to the shower room to have his legs cleansed. Resident #1 was taken to the shower room where he was observed to have his lower extremities cleansed. Resident #1's legs were dried and he was taken to his room where treatment was provided as ordered. -There were no maggots observed to the resident's BLE or toes as mentioned in the skin wound note dated 6/20/2020. The unit manager said he had not observed any maggots to the resident's toes. However, the interviews reflect there were maggots to the resident's toes. VI. Staff interviews The WCN was interviewed on 7/22/2020 at 4:40 p.m. She said Resident #1 had a history of [REDACTED]. She said during the weekly wound assessment 7/17/2020, the wound physician assessed in-between his left great toe and second toe; Resident #1 had maggot's which they attributed to poor hygiene because the resident would refuse to take showers. She said she knew to always check between his toes during his weekly wound care because this was not the first time the resident had maggots. She said she did not instruct any of the floor nurses to check in-between his toes during his wound care treatments or weekly skin checks. She said there was no order to check between his toes to ensure he did not have maggots. She said they had not offered to wash Resident #1's BLE off in the shower until observed 7/21/2020 during survey. The SSD was interviewed on 7/22/2020 at 5:50 p.m. She said they were aware Resident #1 refused to shower and change his clothes. She said she notified the family and the family tried to encourage the resident to bathe. She said Resident #1 agreed to shower on Mondays; however, continued to refuse. She said they offered the resident bed baths, but he did not like bed baths. They bought him new shoes because his wounds were weeping into his shoes. She acknowledged they did not provide any further recommendation or alternate to having a shower or cleaning of his BLE or between his toes to ensure he did not have maggots. The nursing home administrator (NHA), director of nursing (DON) and WCN were interviewed on 7/22/2020 at 6:30 p.m. They said they were aware the resident refused to shower, change his clothes and had maggots on his toes. They said they offered to wash his clothes while he showered; however, the resident would still continue to refuse. They said they tried to continue to try to build trust with the resident as he was noncompliant; however, he still continued to refuse. They acknowledged there was no further recommendation or alternate provided to the resident to ensure he did not have maggots in between his toes. The NHA said she thought the facility had poor documentation and they had tried many different things and attempts to encourage Resident #1 to shower, but they had not documented their efforts. She said moving forward knowing he was willing to have the water run over his legs and it was a good approach, they planned to encourage that positive effort to ensure good hygiene.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident observation, record review and interviews, the facility failed to ensure one (#5) of three residents reviewed for pressure ulcers out of eight total sample residents, received the treatment and services to prevent pressure ulcer development. Specifically, the facility failed to reposition Resident #5, a dependent resident in a timely manner, according to professional standards. Cross-reference F725 for insufficient staffing. Findings include: I. Professional reference According to the National Pressure Injury Advisory Panel (NPIAP) Prevention and treatment of [REDACTED].cvph.org/data/files/NPIAP% 9.pdf (third edition published 2019, retrieved on 8/4/2020), it read in part, Excess moisture on the skin surface (e.g. due to increased perspiration or incontinence) also increases skin vulnerability to damage related to skin maceration, pressure, and shear forces. Maintaining skin integrity is essential in the prevention of pressure injuries. Implement a skin care regimen that includes keeping the skin clean and appropriately hydrated, and cleansing the skin promptly after episodes of incontinence. Repositioning and mobilizing individuals is an important component in the prevention of pressure injuries. Extended periods of lying or sitting on a particular part of the body and failure to redistribute the pressure on the body surface can result in sustained deformation of soft tissues, and ultimately, in tissue damage. Repositioning involves a change in position of the lying or seated individual at regular intervals, with the purpose of relieving or redistributing pressure and enhancing comfort. Mobilization involves assisting or encouraging a person to move or shift into a new position. Individuals who cannot reposition themselves will require assistance in this activity. No support surface provides complete pressure relief. Pressure is always applied to some area of the skin. Turning and repositioning for pressure redistribution must therefore occur regularly. Pressure and shear forces are important considerations in the development of pressure injuries in seated individuals. Limit time spent sitting out of bed for individuals at high risk of pressure injuries. II. Facility policy and procedure The Skin Management System policy, last revised July 2017, was provided by the nursing home administrator (NHA) via email on 7/24/2020. It read in part, Residents receive care to aid in the prevention or worsening of wounds and/or pressure ulcers. Individuals at risk for skin compromise are identified, assessed, and provided treatment to promote healing, prevent infection, and prevent new ulcers from developing. Ongoing monitoring and evaluation are provided for optimal resident outcomes. For pressure reduction: assist the resident to change position periodically in bed as indicated by the nursing assessment or as requested by the resident; utilize a pressure reducing mattress or pressure reducing overlay; provide a pressure reducing device on wheelchair/chair/recliner; consider elevating heels off of the bed with pillow or use of heel protectors. A weekly skin check will be completed in the resident ' s record using the Head to Toe Skin Check User Defined Assessment (UDA). III. Resident status Resident #5, age 68, was admitted on [DATE]. According to the July 2020 computerized physician orders [REDACTED]. The 7/3/2020 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) of 5 out of 15. She required extensive assistance of one staff for bed mobility, dressing, toilet use, and personal hygiene. She required extensive assistance of two staff for transfers. She was totally dependent on one staff for bathing. She was always incontinent of bladder and bowel. The resident weighed 235 pounds. IV. Resident observations On 7/21/2020 at 10:00 a.m., Resident #5 was observed sitting in her wheelchair watching TV. On 7/21/2020 at 9:10 p.m., Resident #5 was observed sitting up in her wheelchair in her room. -At 9:50 p.m. certified nurse aide (CNA) #3 was observed entering Resident #5's room. The CNA said he was going to assist Resident #5's roommate to bed, but needed help to put Resident #5 to bed. V. Record review A. Care Plan Review of the comprehensive care plan, revised on 5/16/2020 revealed that Resident #5 had an activities of daily living (ADL) self-care performance deficit related [MEDICAL CONDITION] with metastasis. She also had limited physical mobility related to the disease process [MEDICAL CONDITION] and contractures to bilateral wrists and fingers increasing her risk for discomfort. Interventions included that she required extensive assistance of two staff members for repositioning and turning in bed, but sometimes required total dependence of two staff members. Additionally the care plan revealed a focus for skin integrity, revised on 5/5/2020, indicating that Resident #5 was at risk for skin breakdown secondary to a history of healed pressure ulcerations and she was totally incontinent of bowel and bladder increasing her risk for skin breakdown. Other risks include nutrition, hydration, medication side effects,cognition and mobility limitations. Interventions included to check and change/turn and reposition upon rising, before and after meals, at bedtime, and as needed to prevent skin breakdown. Interventions also included to remove the mechanical lift sling after transfer to her wheelchair. The care plan for incontinence, revised on 5/5/2020 revealed that she was unable to use her call light and needed to be checked frequently for incontinence issues. B. Assessments The 7/19/2020 Braden Scale Assessment revealed the Resident #5 had a score of 12, indicating that she was at high risk for the development of pressure ulcers. C. Progress notes Review of resident progress notes revealed the following note written on 6/9/2020 at 2:02 p.m. It read, Resident has a turning and positioning program with no documentation that turning and positioning was completed. This nurse has educated the staff to document as well as complete the turning schedule. Turning schedule has been completed this shift as this nurse has helped. VI. Staff interviews CNA #3 was interviewed on 7/21/2020 at 10:00 p.m. He said at times he was unable to get all of his work tasks completed during the shift. He said Resident #5 had been up since before supper and he usually had all the residents in bed by 9:00 p.m., but at times he was behind because he was the only CNA working on the hall. He said Resident #5 required a two-person transfer because she used a mechanical lift. He said he was behind and still needed to get her to bed along with one other resident.

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	065229	A. BUILDING _____ B. WING _____	07/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MINNEQUA MEDICENTER	2701 CALIFORNIA ST PUEBLO, CO 81004

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) CNA #10 was interviewed on 7/22/2020 at approximately 4:00 p.m. The CNA said Resident #5 used her wheelchair for mobility. He said that when she was transferred a mechanical lift was used. He said her daily routine was to get up in the morning, stay up in her wheelchair through lunch, and then she would lay down for a few hours. He said when he was working, he would get her up around 3:30 p.m. or 4:00 p.m. so she was up for dinner. He said Resident #5 would then stay in her wheelchair until it was time for bed. He said she did not get out of the wheelchair until bedtime. He said her time for going to bed varied. Registered nurse (RN) #4, who was serving as the wound care nurse, was interviewed on 7/22/2020 at 4:45 p.m. She said that Resident #5 used a wheelchair with a cushion on it that could be tilted to relieve pressure in the chair. She said the resident was able to move her legs and kick them off the side of the wheelchair and shift her position in the wheelchair. She said that the resident could move her upper body to reposition. RN #4 said that it was hard to say when to remind staff to reposition residents. She said she told staff to reposition residents every hour to two hours. CNA #3 was interviewed again on 7/22/2020 at 7:00 p.m. He said he worked with Resident #5 every night. He said the resident generally took a nap in the afternoon, and then he would get the resident out of bed at about 4:00 p.m. each day. He said the resident required total assistance with all of her ADLs including toileting and showers. He said the resident was required two-person assistance with a mechanical lift. He said it took two people to reposition the resident in bed or to move her to her chair. He said the resident was at risk for developing pressure ulcers due to her immobility. He said the resident had to sit in the chair longer after dinner due to the shortage of staff available to help with her. The NHA, director of nursing (DON) and RN #4 were interviewed on 7/22/2020 at 6:30 p.m. They acknowledged the current hallway Resident #5 resided on was heavy and there were several residents who required two-person assistance with repositioning. The NHA said they had identified several residents to move rooms to even out the resident care workload; however, due to COVID-19 they had not pursued the room changes. They acknowledged Resident #5 sitting up in her wheelchair until 10:00 p.m. was too long. The DON said the staff needed to coordinate and help each other with the residents who required two-person assistance or a mechanical lift for transfers.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide sufficient nursing staff with the appropriate competencies and skills to ensure the residents received the care and services they required as determined by resident assessments and individual plans of care. Specifically, the facility failed to consistently provide adequate nursing staff which considered the acuity and [DIAGNOSES REDACTED]. As a result of inadequate staffing, the facility had delayed call light response, failed to provide assistance with activities of daily living (ADLs). Cross-reference F561 failure to provide showers as requested; F585 failure to follow up on grievances; F677 failure to provide assistance with activities of daily living; F686 failure to provide offloading for dependent residents at risk for pressure injury. Findings include: I. Resident census and conditions According to the 7/21/2020 Resident Census and Conditions of Residents report, the resident census was 96 and the following care needs were identified: -54 residents needed assistance of one or two staff with bathing and 36 residents were dependent. Six residents were independent. -83 residents needed assistance of one or two staff members for toilet use and three resident was dependent. Seven residents were independent. -83 residents needed assistance of one or two staff members for dressing and one were dependent. Six residents were independent. -80 residents needed assistance of one or two staff members and three were dependent for transfers. Four residents was independent -92 residents needed assistance of one or two staff members with eating and one was dependent. II. Staffing requirements for each station According to the desired staffing pattern documentation provided by the director of nursing on 7/22/2020: Resident census per unit: Hall A 20 Hall B 18 Hall C 5 Hall D 16 Hall E 19 Hall F 15 The nursing schedule was as follows: Day shift 6:30 a.m. to 2:30 p.m. Hall F (secured unit) two CNAs and one licensed nurses Halls A one CNA and one licensed nurse Hall, B one CNA and one licensed nurse Hall C one CNA (the licensed nurse was shared with another hall) Hall D one CNA and one licensed nurse Hall E one CNA (the licensed nurse was shared with another hall) One CNA on the AB split from room #A9 to #B3-which was a total of 11 residents. Evening shift 2:30 p.m. to 10:30 p.m. Hall F two CNAs and one licensed nurses Halls A one CNA and one licensed nurse Hall B one CNA and one licensed nurse Hall C one CNA (the licensed nurse was shared with another hall) Hall D one CNA and one licensed nurse Hall E one CNA (the licensed nurse was shared with another hall) One CNA on the AB split from room #A9 to #B3- which was a total of 11 residents. Night shift 10:30 p.m. to 6:30 a.m. Hall F (secured unit) one CNA and one licensed nurse Hall A, B, C, D and E four CNAs and two licensed nurses However, the schedule above did not reflect the staff that actually worked the floor to assist residents. The staff did not match the schedule and had less staff present. See observations below. III. Residents who required two-person assistance, Hoyer lift or sit to stand lift transfers Hall A One resident required a Hoyer lift, three residents required a sit to stand lift, two residents required two-person assistance and two residents occasionally required two-person assistance. Hall B Five residents required a Hoyer lift, two residents required a sit to stand lift, and one resident occasionally required two-person assistance. Hall C Two residents required a Hoyer lift and one resident required a sit to stand lift. Hall D Two residents required a Hoyer lift and one resident required two-person assistance Hall E One resident required a sit to stand lift and one resident required two-person assistance. Hall F There were no residents in the unit who required use of a lift or two-person assistance. IV. Observations On 7/21/2020 at 9:00 p.m., the hall A, B, C, D, E had only four certified nurse aides. The current census for the unit was for all of the halls was 78. One CNA left the unit at 9:00 p.m. On 7/21/2020 at 9:00 p.m., B hall had one CNA and the current census for the unit was 18. On 7/21/2020 at 9:10 p.m., observed four call lights activated on Steel City B hall. Four call lights were observed activated. Resident #4 was observed sitting up in his wheelchair. Resident #5 was observed sitting up in her wheelchair and her roommate was asleep in her clothes on top of her covers. -At 9:21 p.m., observed RN #2 go down the hallway and she answered two of the call lights at that time room [ROOM NUMBER] and room [ROOM NUMBER] were still activated and down Steel City C hall two call lights were activated. CNA #3 came out of room [ROOM NUMBER] and then entered another room. Then staff answered call light in room [ROOM NUMBER]. There were two lights down Steel City C hall that were activated. -At 9:33 p.m., the call light was still observed activated in room [ROOM NUMBER] along with call lights in room number #5 and room [ROOM NUMBER] and the two call lights were still observed activated down Steel City C hall. room [ROOM NUMBER] on B hall had been activated the longest. -At 9:39 p.m., observed several staff come in from the smoking entrance/exit down E hall. An unknown CNA brought a resident down Steel City C hall and answered the call lights. -At 9:47 p.m., staff answered all the call lights down Steel City B hall, it had been 37 minutes the call light was activated in room [ROOM NUMBER], and resident #5 was observed sitting in her wheelchair. -At 9:50 p.m., CNA #3 was observed entering Resident #5's room. He said he was going to assist Resident #5's roommate to bed, but needed help to put Resident #5 to bed. V. Resident council The 6/24/2020 resident council meeting for the A hall documented, the residents residing on that hall had expressed concerns about long call light wait times, being short staffed and the restorative aide being pulled and not receiving ice water. The concern form further documented: a resident council meeting was held on 7/7/2020, the residents were informed that the facility was in the process of hiring new staff and had been in contact with an agency, management was conducting call light audits and passing ice water. The B hall residents expressed concerns about being short staffed, long call light wait times, and that showers are not consistent. The concern form further documented in pertinent part: under action taken: The facility was staffing to PPD (per patient day). VI. Resident Interviews Resident #7 was interviewed on 7/21/2020 at approximately 2:30 p.m. The resident said call lights were not answered timely and that there was not enough staff to take care of everybody. She said she had complained about the low staffing, however, it had not been resolved. Resident #2 was interviewed on 7/21/2020 at 3:00 p.m. The resident said the facility did not have enough staff. She said her hallway had one CNA and the call lights were not answered timely, meals served late and showers were not always given. She said she had complained about the low staffing, however the issue had not been resolved. VII. Staff interviews The staffing coordinator (SC) was interviewed on 7/21/2020 at 11:45 a.m. She said she was in charge of scheduling the nurses and the CNAs. She said when staff called off their shift the facility had a message board for staff for those who wanted to volunteer for shifts. She indicated that the positions available at the facility were: two nurses for day shift and two CNAs for day shift, evening shift needed three nurses and three CNAs, and the overnight shift

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F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) needed one overnight shift nurse. She said if the shifts could not be filled then they would ask the van driver to fill a shift who was also a CNA. She said that they could also ask the restorative CNAs to fill shifts if needed. She added some CNAs would volunteer for double shifts and then the facility would pay overtime. She said that the facility was training two new CNAs on 7/22/2020. She said the facility had been using agency staff due to the staffing shortage. She said that an RN was in the building on every shift. She said the corporate office posted job ads, then a recruiter would contact those applicants for an interviews. CNA #2 was interviewed on 7/21/2020 at 9:15 p.m. The CNA said there was not enough staff on the evening shift. The CNA said the halls were not evenly spread out in regards to the acuity. She said most days the evening shift had three CNAs rather than four. The CNA said it was difficult to get dinner breaks. She said she was the only CNA on the specific hallways she was working. Licensed practical nurse (LPN) #1 was interviewed on 7/21/2020 at 9:30 p.m. The LPN said she had one CNA assigned to work her floor and they were caring for 20 residents. The LPN said one CNA per hallway was not enough. CNA #1 was interviewed on 7/21/2020 at approximately 9:45 p.m. The CNA said she was the only CNA working her hallway. She said she got all the tasks completed, but it was difficult not to rush, and to take the time to do the little things for the residents. She said having one more CNA on the five hallways would be a big help. She said she was caring for 19 residents. CNA #3 was interviewed on 7/21/2020 at 10:00 p.m. He said at times he was unable to get all of his work tasks completed during the shift. He said Resident #5 had been up since before supper and he usually had all the residents in bed by 9:00 p.m., but at times he was behind because he was the only CNA working on B hall. He said Resident #5 required two-person transfer because she used Hoyer lift. He said he was behind and still needed to get her to bed and one other resident. He said Resident # 4 needed one on one, as he wandered and it was difficult to keep an eye on him. The CNA said getting the charting completed timely was difficult. Registered nurse #4 (RN #4) was interviewed on 7/21/2020 at 10:15 p.m. She included the most staffing issues occurred on the third shift. She said the staff call off two to three times a week. She said this frustrated the staff and made it difficult to work short-handed. She added the staff were worn out. LPN #4 was interviewed on 7/21/2020 at 10:25 p.m. She said that staffing was a big problem, especially on the third shift. She said she was working as a nurse on two units and it was difficult to keep up with the work. She added that there were call offs from nurses and CNAs at least two times per week. The nursing home administrator was interviewed on 7/22/2020 at 6:40 p.m. She said staffing the facility had been a challenge for her. She said she did not want to use a staffing agency but felt like she had no choice. She said the facility had not offered any kind of reward or incentive for staff to work extra hours. She included that it was difficult to get new staff hired because the background checks were taking an extra long time due to the COVID outbreak.
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 ensure infection control practices were established and maintained to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of Coronavirus (COVID-19) and other communicable diseases and infections in three of six units. Specifically, the facility failed to: -Follow an active screening process for staff and visitors before being allowed into the facility; -Follow proper disinfection process/practices; -Staff properly use personal protective equipment (PPE); -Masks were worn by residents when out of their room; and, -Follow proper hand hygiene practices for residents at meal time. Findings include: I. Active screening for staff and visitors and proper disinfection practices A. Professional reference The Centers for Disease Control and Prevention (CDC) Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19, retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp/assessment-tool-nursing-homes.pdf (updated 5/8/2020, retrieved on 7/30/2020), read in part, All healthcare personnel (HCP) should self-monitor when they are not at work and be actively screened upon entering the facility. Ideally, this would occur at the entrance to the facility, before they begin their shift. Screening includes temperature check and asking about symptoms like subjective fever, new or worsening cough, difficulty breathing, chills, repeated shaking with chills, muscle pain, headache, sore throat, and new loss of taste or smell. The Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html (updated 6/19/2020, retrieved on 7/30/2020), read in part, Screen everyone (patients, healthcare personnel, visitors) entering the healthcare facility for symptoms consistent with COVID-19 or exposure to others with [DIAGNOSES REDACTED]-CoV-2 infection and ensure they are [MEDICATION NAME] source control. Actively take their temperature and document absence of symptoms consistent with COVID-19. Fever is either measured temperature =100.0F or subjective fever. B. Facility policy The Center Preparedness: Infection Prevention Strategies and Guidance for COVID-19, updated 7/15/2020, was provided by the nursing home administrator (NHA) on 7/22/2020 at 4:00 p.m. It read in part, To protect our team members, patients, residents, and families, we will be conducting daily screenings before any person enters our center. This includes all team members, visitors, family members and vendors. We are following the Centers for Medicare and Medicaid Services (CMS), Centers for Disease Control and Prevention (CDC), state and local guidance on who to screen and who may not enter our center. C. Observation and interviews On 7/21/2020 at 9:00 p.m. three surveyors entered the facility and were greeted by the night supervisor registered nurse (RN) #1. She said we needed to be screened and she asked us to fill out a visitor questionnaire about COVID-19. All three surveyors filled out the questionnaire (see record review below) and RN #1 asked us to place them on the table. She did not review our (the three surveyors) questionnaire to ensure we did not have COVID-19 signs or symptoms nor did she ask us any of the questions listed on the questionnaire. She grabbed the thermometer to check the first surveyor's temperature but she said the thermometer was not working so she reached into and grabbed a thermometer out of her pocket. She did not sanitize the thermometer from her pocket and then she checked the first surveyor's temperature. She instructed the first surveyor to write down the temperature obtained on the facility's screening form. She was ready to take the second surveyor's temperature and realized she did not clean the thermometer. She walked to the medication cart, obtained an alcohol wipe, cleaned the thermometer with the alcohol wipe and then took the second surveyor's temperature. She used the same alcohol wipe to clean the thermometer and she took the third surveyor's temperature. -At 10:05 p.m., certified nurse aide (CNA) #11 was observed entering the facility. CNA #11 was let in the front door by unknown staff. CNA #11 was observed to take her own temperature and then she logged the information on the employee screening log. CNA #11 was interviewed at 10:15 p.m. She said she had worked the night shift for over two years. She said her understanding of the screening process for COVID-19 was to fill out her information on the facility employee screening form. She said the nurse would actively screen her sometimes but she was in a rush and the nurse was not at the entrance so she just wrote down her temperature and went to the secure unit to get report from the CNA and begin her shift. She said if her temperature was greater than 99.2 she would notify the nurse but tonight it was not. RN #1 was interviewed on 7/21/2020 at 10:27 p.m. She said everyone who entered the facility had to be screened for COVID-19. She said they did not have any visitors enter the building on night shift until that night. She said the process was to have visitors fill out the questionnaire and staff would fill out the facility employee screening log. She said she would instruct staff or visitors to perform hand hygiene, ensure they had a mask on and then complete the screening process by asking the screening questions to ensure the staff or visitor did not have any COVID-19 signs or symptoms. She had no response as to why the COVID-19 questions were not asked of the surveyors or why the surveyor's questionnaires were not reviewed. She said she said she thought it was okay to use an alcohol wipe to disinfect the thermometers in between use. She had no response as to why CNA #11 screened herself other than all the nurses were too busy to complete the screening process. She acknowledged one of the nurses should have screened CNA #11 prior to letting her into to the facility. D. Record review The facility screening tool kit, revised 5/4/2020 was provided by the director of nursing (DON) on 7/22/2020 at 3:30 p.m. This was the facilities screening guidance for COVID-19 (see DON interview below). It read, in pertinent part, Visitor/Vender/Surveyor: To help ensure the safety of our residents and healthcare workers, visitation is restricted. A nurse will assist you with questions regarding the information on this form. This form is required for all visitors during [MEDICATION NAME] care situations, for venders, and for surveyors. -1. Have you completed hand hygiene by washing your hands or using alcohol-based hand rub (ABHR) upon entry to the center? -2. Do you have any of the following symptoms? Presence of a fever will prohibit visitation even if other symptoms are not present. (Cough or shortness of breath, or at least two of the following fever, sore throat, repeated shakes with chills, headache or new onset of loss of taste or smell, diarrhea, chills, muscle pain and vomiting. If any of the items are checked, a licensed nurse must evaluate for other plausible causes (i.e., Asthma, allergies [REDACTED]. Based on the evaluation results, the visitor may be prohibited from entry. The form had a signature section for the licensed

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) staff to sign off acknowledgement of the review. The employee and essential healthcare personnel screening log for staff included the same criteria above and documented a section for the nurse completing the screen. E. Staff interview The DON was interviewed on 7/22/2020 at 2:50 p.m. She said the facility used the recommended toolkit for screening staff and visitors. She said this included a visitor questionnaire and staff log with questions related to COVID-19. She said the proper procedure for screening staff and visitors for COVID-19 included an active screener at the entrance to greet staff member and visitors as they came through the door. She said the screener would ask the staff member or visitor if they had any COVID-19 symptoms, take their temperature and ask them to use hand sanitizer. She said visitors could also fill out the questionnaire or the screener asked the questions listed on the questionnaire to ensure they have not answer yes to any of the (COVID-19 signs and symptoms) questions and sign off that they had reviewed it. She said if staff entered the building and no one was sitting at the door, they were responsible to find the nurse so that they could be screened for COVID-19. She said the staff should not be taking their own temperature. She said there was always a nurse available to screen staff at night, the door had remained locked and someone from inside had to open the door to let staff in the building prior to starting their shift. She said the nurse should verify a staff member did not have any active symptoms of COVID-19 prior to working in the facility. She said the staff were trained to use CaviWipes (an EPA disinfectant wipe) to clean the thermometer. She said RN #1 should have used the CaviWipes to clean the thermometer in between use. II. Staff personal protective equipment (PPE) A. Professional references 1. The Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings, retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html (updated 5/19/2020, retrieved on 7/29/2020), read in part, If worn properly, a facemask helps block respiratory secretions produced by the wearer from contaminating other persons and surfaces. Patients should be wearing their own cloth face covering, which should be worn while they are in the facility (if tolerated). Patients may remove their cloth face covering when in their rooms but should put them back on when leaving their room or when others enter the room. Health care personnel (HCP) should wear a facemask at all times while they are in the healthcare facility. They should also be instructed that if they must touch or adjust their facemask or cloth face covering they should perform hand hygiene immediately before and after. 2. The Centers for Disease Control and Prevention (CDC) Strategies for Optimizing the Supply of Facemasks, retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html (updated 6/28/2020, retrieved on 7/28/2020), read in part, Crisis capacity: strategies that are not commensurate with U.S. standards of care. These measures, or a combination of these measures, may need to be considered during periods of known facemask shortages. Strategies: Use facemasks beyond the manufacturer-designated shelf life during patient care activities B. Facility policy The Center Preparedness: Infection Prevention Strategies and Guidance for COVID-19, updated 7/15/2020, was provided by the nursing home administrator (NHA) on 7/22/2020 at 4:00 p.m. It read in part, Please remember to practice all infection control precautions and follow infection control procedures discussed by your infection preventionist. Personal protective equipment is available as needed. C. Observations and interviews of staff not wearing masks On 7/21/2020 at approximately 11:00 a.m., certified nurse aide (CNA) #10 was observed to be walking down B hallway. The CNA failed to have his mask over his nose. -The CNA did pull his mask up, after he was questioned with the way he was wearing the mask and he did not complete hand hygiene after touching his mask. On 7/21/2020 at approximately 2:00 p.m., a staff member in the housekeeping department did not have his mask on properly. The mask was below his nose. -He did pull his mask up, after he was questioned with the way he was wearing the mask. He did not complete hand hygiene after touching his mask. On 7/22/2020 at 7/21/2020 at 10:47 p.m., the registered nurse (RN) #5 was observed at the medication cart, with her mask below her chin. RN #5 was immediately interviewed after the observation and said she was hot and that she needed to keep the mask off of her face for a little bit. D. Management interview The director of nursing (DON) was interviewed on 7/22/2020 at approximately 4:30 p.m. The DON said the mask should be worn to cover the nose and the mouth. She said that the staff had all had training on how to properly wear the masks. She said if the staff touch their mask then they should do proper hand hygiene. E. Observations of storage of masks The front entrance was observed on 7/21/2020 at 9:30 a.m. The wall near the front door had three strings with clips which held paper bags with names on them. The bags were used to store the individual staff member masks. On 7/22/2020 at 8:30 p.m., the paper bags with the individual names were gone. The sign hanging in place instructed the staff that a new mask was to be obtained for each day. -The facility staff was reusing facemasks during the survey. F. Management interview The DON was interviewed on 7/22/2020 at 4:00 p.m. The DON said the face masks were worn for three days unless soiled or dirty. -The DON did not know how much PPE was being used by staff in the facility. G. Follow-up The NHA reported on 7/27/2020 via email at 10:55 a.m. that their inventory of masks included 6,050 surgical masks and 287 N95 masks. The facility was not in crisis mode with face masks H. Facility COVID-19 status The NHA was interviewed on 7/21/2020 at approximately 10:00 a.m. The NHA said the building did not have any residents who were COVID-19 positive. The facility used Hall C for residents who required isolation for the 14 days of quarantine. The facility has not had any COVID-19 positive residents for the past five months. III. Masks worn by residents and hand hygiene offered at meal time A. Professional references The Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings, retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html (updated 5/19/2020, retrieved on 7/23/2020), read in part, If worn properly, a facemask helps block respiratory secretions produced by the wearer from contaminating other persons and surfaces. Patients should be wearing their own cloth face covering, which should be worn while they are in the facility (if tolerated). Patients may remove their cloth face covering when in their rooms but should put them back on when leaving their room or when others enter the room. Health care personnel (HCP) should wear a facemask at all times while they are in the healthcare facility. They should also be instructed that if they must touch or adjust their facemask or cloth face covering they should perform hand hygiene immediately before and after. The Centers for Disease Control and Prevention (CDC) Hand Hygiene in Healthcare Settings, retrieved from https://www.cdc.gov/handhygiene/index.html (updated 4/29/19, retrieved on 7/23/2020), read in part, As a patient in a healthcare setting, you are at risk of getting an infection while you are being treated for [REDACTED]. Your hands can spread germs too, so protect yourself by cleaning your hands often. When should you clean your hands: -Before preparing or eating food; -Before touching your eyes, nose, or mouth -Before and after changing wound dressings or bandages; -After using the restroom; -After blowing your nose, coughing, or sneezing; and, -After touching hospital surfaces such as bed rails, bedside tables, doorknobs, remote controls, or the phone. B. Masks worn by residents 1. Resident status Resident #4, age 90, was admitted on [DATE]. According to the July 2020 computerized physician orders [REDACTED]. The 7/7/2020 minimum data set (MDS) assessment revealed the resident had cognitive impairments and his cognitive skills for daily decision making were severely impaired. He required extensive assistance of one staff for bed mobility, transfers, dressing, toilet use and personal hygiene. 2. Observation On 7/21/2020 from 9:36 a.m. to 10:00 a.m., Resident #4 was observed inconsistently wearing his mask: -At 9:36 a.m., Resident #4 came out of his room in his wheelchair and was not wearing a mask. -At 9:40 a.m., CNA #4 noticed the resident and assisted him back to his room. -At 9:50 a.m., the resident came back out of his room in his wheelchair. He was not wearing his mask. -At 9:51 a.m., CNA #4 retrieved the resident's mask from his room and helped him put it on. -At 9:53 a.m., Resident #4 moved around the unit in his wheelchair. He took off his mask. -At 9:54 a.m., CNA #4 shut the main doors to the unit to keep the resident from leaving. -At 9:55 a.m., CNA #4 assisted the resident to put his mask back on. -At 10:00 a.m., Resident #4 wheeled himself back into his room and sat in front of the door. -At 10:03 a.m., the resident took off his mask. C. Hand hygiene being offered at meal time On 7/21/2020 from 11:31 a.m. to 11:45 a.m. the following observations were made on Unit F, a memory care unit: -At 11:31 a.m., lunch was delivered to the unit. -At 11:35 a.m., CNA #6 delivered a food tray out to room [ROOM NUMBER]. She did not offer hand hygiene to the resident. -At 11:40 a.m., CNA #6 delivered a lunch tray to room # 8. She did not offer the resident hand hygiene to the resident. -At 11:45 a.m., CNA #6 delivered a food tray to an unidentified resident in the dining room. She did not offer the resident hand hygiene. D. Management interview The director of nursing (DON) was interviewed on 7/22/2020 at 2:53 p.m. She said the residents should be wearing masks when out of their room and when staff were providing care. She included that she would provide more training for the staff in regards to residents wearing masks and hand hygiene being offered to residents before meals. She said the charge nurses were supposed to remind the staff about masks and hand hygiene in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065229	A. BUILDING _____ B. WING _____	**07/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MINNEQUA MEDICENTER	**2701 CALIFORNIA ST PUEBLO, CO 81004**

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