STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065330	A. BUILDING _____ B. WING _____	08/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARBOR VIEW	7991 W 71ST AVE ARVADA, CO 80004

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

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of Coronavirus disease (COVID-19) and infection for three of three units. Specifically the facility failed to: -Ensure staff performed proper hand hygiene in between resident contact; -Ensure proper mask use by residents; -Ensure proper social distancing; and, -Ensure proper disinfecting of multi-use medical equipment (vital sign equipment). Findings include: I. Facility policy and procedures The Infection Prevention and Control Program, revised October 2018, was provided by the nursing home administrator (NHA) 8/19/2020 at 10:49 a.m. The policy read in pertinent part, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. -The infection program is based on accepted national infection prevention and control standards; -the elements of the infection prevention and control program consists of coordination/oversight, policies/procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infections, and employee health and safety . The Personal Protective Equipment-Using face Masks policy, revised September 2010, was provided by the NHA 8/19/2020 at 4:34 p.m. The policy read in part, Objectives: -to prevent transmission of infectious agents through the air; to protect the wearer from inhaling droplets and to prevent transmission of some infections that are spread by direct contact with mucous membranes . Equipment and Supplies: high-efficiency disposable masks, eye ware (e.g., goggles) when the use of a mask is indicated, appropriate eyewear must also be worn. Miscellaneous: be sure the face mask covers the nose and mouth while performing treatment or services for the patient, handle mask only by the strings (ties), never touch the mask while it is in use and follow established handwashing techniques . The Cleaning and Disinfection of Resident-Care Items and Equipment, revised October 2018, was provided by the NHA 8/19/2020 at 4:34 p.m. The policy read in part, Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA (Occupational Safety and Health Administration) Blood borne Pathogens Standard. Non-critical items are those that come in contact with intact skin but not mucous membranes. Non-critical resident-care items include blood pressure cuffs . Only equipment that is designated reusable shall be used by more than one resident. Intermediate and low-level disinfectants for non-critical items include: Ethyl or [MEDICATION NAME] alcohol, sodium hypochlorite (5.25-6.15% diluted 1:500 or per manufacturer's instructions); [MEDICATION NAME] germicidal detergents; [MEDICATION NAME] germicidal detergents; and Quaternary ammonium germicidal detergents (low-level disinfection only) . The Handwashing/Hand Hygiene policy, revised August 2019, was provided by the NHA 8/19/2020 at 4:34 p.m. The policy read in part, The facility considers hand hygiene the primary means to prevent the spread of infections. -All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections; -All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. The facility indicated that they do not have a policy and procedure for social distancing. II. Professional reference According to the CDC, Hand Hygiene Guidance, last reviewed 1/30/2020, accessed on 8/18/2020, retrieved online from https://www.cdc.gov/handhygiene/providers/guideline.html, recommendations for appropriated hand hygiene for infection control included in pertinent part: Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: -Immediately before touching a patient, -Before performing an aseptic task or handling invasive medical devices, -Before moving from work on a soiled body site to a clean body site on the same patient, -After touching a patient or the patient's immediate environment, -After contact with blood, body fluids, or contaminated surfaces, -Immediately after glove removal, Healthcare facilities should: -Require healthcare personnel to perform hand hygiene in accordance with CDC recommendations: -Ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled, -Ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered, -Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and, in the absence of a sink, are an effective method of cleaning hands. According to the Centers for Disease Control (CDC) website, Preparing for COVID-19: Long-term Care Facilities, Nursing Homes last updated 5/7/2020, accessed on 8/18/2020, retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html 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 their room. III. Observations On 8/18/2020 at 9:35 a.m. certified nurse aide (#3) was observed pushing four residents in wheelchairs, one at a time out of the main dining room. The residents were not wearing their face masks over their face and she did offer or encourage them to put their masks on. On 8/18/2020 at 9:55 a.m. a resident was observed sitting in the common area next to the fish tank on the Pine Ridge unit. She was not wearing a mask. There were staff in the area and no one approached her to place a mask on her. On 8/18/2020 at 10:00 a.m. a large group activity was occurring in the secured unit dining room. There were ten residents in the activity sitting in chairs or at a dining room table. There were four residents sitting in chairs next to each other and they were not six feet apart. There was a staff person conducting the musical activity and one staff member assigned one to one with one of the ten residents. CNA #1 was taking a resident's vital signs during the activity. On 8/18/2020 at 10:05 a.m. CNA #1 removed the vital sign equipment out of the dining room where she was taking a resident's vital signs and did not disinfect the equipment. On 8/18/2020 at 10:20 a.m. CNA #2 was observed taking the vital sign equipment into room [ROOM NUMBER] and taking the resident's blood pressure. She did not disinfect the equipment from prior use (see above). On 8/18/2020 at 10:30 a.m. CNA #2 was observed taking the vital sign equipment into room [ROOM NUMBER] checking the resident's blood pressure, oxygen saturations and temperature. She did not disinfect the equipment before or after use. On 8/18/2020 at 11:46 a resident was going back to her room after a window visitation with a visitor. As she walked back to her room she passed several staff in the front lobby area and hallway and no one stopped her to offer her a face mask. On 8/18/2020 at 12:00 p.m. lunch observations were made in the secure unit. There were eleven residents eating in the dining room. Two tables had three resident's sitting at them. They were not six feet apart. Two of the tables situated next to each other did not allow for proper distancing and the chairs of two residents were side by side. On 8/18/2020 from 12:05 p.m. until 12:24 p.m. Registered nurse (RN #2) was observed walking around the dining room where residents were waiting for their lunch meal. During the time frame of the observation he was observed touching residents in succession; on their shoulders, adjusting clothing and a head scarf of one resident and removing an eating utensil out of one resident's pants. He was also observed repeatedly touching his goggles, the outside of his mask and scratching his neck, ear and touching his uniform. He was observed to use an alcohol based hand rub (ABHR), which he removed from his pant pocket and sanitized his hands after each movement (above). He did not wash his hands with soap and water at any time and continued to use the ABHR. At 12:20 p.m., after touching the front of his face mask and adjusting his goggles, he went to the medication cart and poured a medication for a resident. He did not sanitize

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) or wash his hands before doing this. IV. Staff interviews and observations CNA #3 was interviewed on 8/18/2020 at 9:55 a.m. She said when residents were out of their rooms they were required to wear a face mask. She said the exception was when they ate in the dining room. She said she forgot to encourage the residents to wear a face mask when she removed them from the dining room. RN #2 was interviewed on 8/18/2020 at 10:00 a.m. during the group activity observation (above). He said that group activities were occurring daily in the secure unit. He confirmed during the activity residents that were not spaced six feet apart. He said that residents were to be socially distanced six feet apart and the residents in the group were four to four and a half feet distance. He said it was difficult to keep residents that were cognitively impaired separated, however; staff should be continuously monitoring them to ensure proper distancing. The activity associate (AA #1) was interviewed on 8/18/2020 at 10:25 a.m. She said she was assigned to the secure unit to provide activities to the residents. She said she conducted group activities in the unit once a day. She said she was not aware if group activities were allowed. She said she also provided one to one activities in resident rooms and also took residents outside in the courtyard for walks. She said that residents should have two arms-length of spacing in between one another as much as possible. She confirmed that the residents in the group activity (above) were not spaced out enough. She said it was difficult with the limited space in the dining area to keep residents properly spaced. CNA #1 was interviewed on 8/18/2020 at 11:52 a.m. she said she had received training for use of PPE (personal protective equipment). She said staff must wear a mask and goggles at all times while working with residents. She said if a resident came out of their room they needed to wear a mask and if they did not have one, staff needed to remind them to put one on. She said they had to constantly be monitoring the residents for the masks because they forget or just do not understand. CNA #2 was interviewed on 8/19/2020 at 2:00 p.m. she said that the same vital sign equipment was used for all the residents in the secure unit. She said that the equipment must be disinfected in between each use with disinfectant wipes for one minute. RN #1 was interviewed on 8/19/2020 at 4:26 p.m. The corporate nurse consultant (CNC) was also present. The CNC said that the facility was not having group activities and that they did not have a policy for that. He said the facility did properly distance their residents, however; due to the nature of their resident population being cognitively impaired it was difficult. RN #1 said staff should be performing hand hygiene before and after touching residents, objects or surfaces, after breaks, before and during delivering food to residents. She said if they touch the outside of their mask they must wash their hands with soap and water and put on a new mask. She said staff should use ABHR and then wash hands with soap and water after every third use. RN #1 said that any shared medical equipment should be disinfected after every use and they must use the germicidal disposable wipes. The CNC said that all staff were trained on how to properly use and wear a mask. RN #1 said that they are constantly doing training and have daily huddles with staff. On 8/19/2020 at 2:37 p.m., RN #1 was observed with her mask positioned just under her nose, she used her bare hand to adjust her mask back up and over the bridge of her nose. After adjusting her mask, she did not perform hand hygiene. The mask was not fitted to the bridge of her nose, so it kept slipping down exposing her entire nose. RN #1 adjusted her mask numerous times without performing any hand hygiene. At one point, a resident approached, the resident was not wearing a mask. As RN #1 attempted to convince the resident to put on a mask, her own mask continued to slide down below her nose. RN #1 tried to pull it up over the bridge of her nose, but it kept slipping below her nose as she interacted and talked with several residents and other staff. On 8/19/2020 at 2:41 p.m., RN #1 was observed talking to a male resident who was sitting in his doorway; the resident was not wearing a mask. RN #1's mask was not fitted to the bridge of her nose and it kept slipping down below her nose; she kept adjusting and pushing the mask up on her nose with her hand; after she did not perform hand hygiene. Another resident not wearing a mask approached; RN #1's mask continued to slip off her nose, exposing her entire nose. On 8/19/2020 at 2:47 p.m., CNA #4 was observed wearing a mask positioned below her nose, the mask was not fitted to the bridge of her nose. CNA #4 touched and adjusted the mask several times with her hands during the observation, but did not perform hand hygiene after handling the mask. The CNA approached two residents who had wandered into the wrong unit, to redirect them back to the units where they resided. CNA #4 reached out touching one of the resident walkers, to turn her around; then touched the second resident's arm to redirect her. CNA #4 guided both residents, using physical contact, back to the units where they resided. CNA #4 did not perform hand hygiene after touching the mask she was wearing; nor did she perform hand hygiene before, after or in-between touching either resident or their adaptive equipment. CNA #4 was interviewed on 8/19/2020 at 3:20 p.m. CNA #4 said staff were expected to wash their hands a lot. This included before and after each contact with a resident, after contact with contaminated items, before putting on and after taking off gloves and after adjusting their surgical mask. RN #1 was interviewed on 8/19/2020 at 4:26 p.m. The corporate nurse consultant (CNC) was also present. RN #1 said staff were to wear their masks properly positioned to cover their nose and mouth fully. If the mask needed to be adjusted, staff were to perform hand hygiene immediately after touching their mask and if the mask would not stay positioned they should get a new mask. V. Facility follow up A Social Distancing Education in service, dated 8/18/2020 was provided by the NHA on 8/19/2020. The Content of the education documented the following: Social distancing, also called physical distancing, means keeping a safe space between yourself and other people who are not from your household. To practice social or physical distancing, stay at least 6 feet (about 2-arm's length) from other people . -Social distancing should be practiced in combination with other everyday preventive actions; including wearing masks, avoiding touching your face with unwashed hands, [MEDICATION NAME] source control and frequently washing your hands with soap and water for at least 20 seconds to reduce the spread of diseases such as COVID-19. -We must encourage all residents to stay in their room when possible. When they do choose to spend time in common areas please ask them to wear their mask and to sit/visit 6 feet away from other residents/staff. This will be an ongoing team effort to remind everyone of these on a daily basis, but remember the little things make a big difference in quality of life and safety. VI. Status of COVID-19 in the facility The nursing home administrator (NHA) was interviewed on 8/18/2020 at 9:00 a.m. He reported the resident census was 99 and there were no COVID-19 positive residents in the facility. He said residents were placed on isolation precautions for 14 days when newly admitted and if they were readmitted from the hospital or, went out of the facility for a medical appointment.