STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065379	A. BUILDING _____ B. WING _____	10/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOMFIELD SKILLED NURSING AND REHABILITATION CTR	12975 SHERIDAN BLVD BROOMFIELD, CO 80020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **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 (COVID-19) and infection for three out of five units. Specifically the facility to: -Ensure housekeeping staff cleaned high-touch surfaces in resident rooms and follow manufacturer kill time during routine daily cleaning; -Ensure laundry staff used appropriate hand hygiene when delivering clean laundry room to room on a unit with multiple COVID positive residents; -Ensure staff doffed personal protective equipment (PPE) before exiting an isolation room and disposing of it properly; -Ensure staff were cohorted to a unit in presence of COVID-19 in the facility; and, -Ensure staff cleaned reusable face shields when exiting an isolation room. Findings include: I. Improper environmental cleaning A. Professional standards The Centers for Disease Control and Prevention (2020) Preparing for COVID-19 in Nursing Homes, updated 6/25/2020, retrieved on 10/12/2020 from: https://www.cdc.gov/coronavirus/2019-ncop/hcp/long-term-care.html, revealed in part For environmental cleaning and disinfection: develop a schedule for regular cleaning and disinfection of shared equipment, frequently touch surfaces in resident rooms and common areas. B. Facility policy and procedures The Pandemic COVID-19 Room Cleaning Protocol, undated, was provided by the nursing home administrator (NHA) on 10/12/2020 at 2:46 p.m. It read in pertinent part: The purpose was to ensure rooms were disinfected during a pandemic. Ensure that environmental cleaning and disinfection procedures were followed consistently and correctly. Routine cleaning and disinfection on frequently touched surfaces or objects for appropriate contact time. Clean and disinfect the room in accordance with standard cleaning procedures. C. Manufacturer's recommendations According to the manufacturer's recommendations, retrieved from https://www.clorox.com/how-to/disinfecting-sanitizing/cold-flu-other-diseases/help-prevent-the-spread-of-the-human-novel-coronavirus-2019-ncov/, Clorox Clean Up Cleaner and Bleach has demonstrated effectiveness [MEDICAL CONDITION] similar to [DIAGNOSES REDACTED]-CoV-2 on hard non porous surfaces. The manufacturer's recommendations read the product could be used against [DIAGNOSES REDACTED]-CoV-2 when used as directed. The directions for use, read in pertinent part: Spray six to eight inches from surface and allow product to penetrate Let stand for 30 seconds. Wipe with a wet sponge or cloth and rinse with water, no scrubbing required D. Observation and interviews HK#1 1. Observations On 10/12/2020 at 1:15 p.m., housekeeper (HK) #1 was observed preparing to enter room [ROOM NUMBER]. She used alcohol based hand rub (ABHR) and donned gloves. She removed disinfectant spray from the cleaning cart. She entered the room and sprayed the vanity, sink, bookshelf and window sill. She emptied the trash and placed the trash and disinfectant back on the cart. She removed two clean rags. She placed new bags in the trash can and used the first rag to wipe the vanity and sink, which were in the residents bedroom. She used the second rag to wipe the bookshelf and the window sill. She placed both soiled rags in a trash bag hanging on the cleaning cart. She unlocked the cart and removed the disinfectant spray bottle. She reentered the room and sprayed the over bed table. She walked back to the cleaning cart and locked the disinfectant in the cart. She removed a clean rag and wiped down the bedside table. She placed the soiled rag in the trash bag and removed her gloves. She used ABHR and donned clean gloves. She again removed the disinfectant from the locked cart and entered the bathroom. She sprayed the shower, toilet, handrails, and toilet paper dispenser. She emptied the trash and placed the trash bag and the disinfectant back in the cleaning cart. She removed the broom and swept the bedroom. She placed the broom back on the cart and removed the toilet brush. She entered the bathroom with the toilet brush and scrubbed the inside of the toilet. She placed the toilet brush back into the cart. She removed her gloves, used ABHR, and donned clean gloves. She removed three clean rags from the cart. She used the first rag to wipe the handrails and the toilet paper dispenser. She used the second rag to wipe down the shower and the third rag to wipe down the toilet from top to bottom. She placed the three dirty rags in the trash bag on the cart and removed her gloves. She used ABHR and donned clean gloves. She mopped the bedroom and the bathroom last. She exited the room, removed her gloves, used ABHR and proceeded to room [ROOM NUMBER]. She failed to clean and disinfect highly touched areas such as door knobs, light switches, closet handles, night stand, call light, television remote, and bed controller. HK #1 was observed preparing to enter room [ROOM NUMBER]. She used ABHR and donned gloves. She used ABHR and donned gloves. She removed disinfectant spray from the cleaning cart. She entered the room and sprayed the vanity, sink, window sill, top of the AC and the over bed table. She emptied the trash and placed the trash and disinfectant back on the cart. She removed two clean rags. She placed new bags in the trash can and used the first rag to wipe the vanity and sink, which were in the residents bedroom. She used the second rag to wipe the window sill, AC and the over bed table. She placed both soiled rags in a trash bag hanging on the cleaning cart. She unlocked the cart and removed the disinfectant spray bottle. She reentered the room and sprayed the over bed table. She walked back to the cleaning cart and locked the disinfectant in the cart. She removed a clean rag and wiped down the bedside table. She placed the soiled rag in the trash bag and removed her gloves. She used ABHR and donned clean gloves. She again removed the disinfectant from the locked cart and entered the bathroom. She sprayed the shower, toilet, handrails, and toilet paper dispenser. She emptied the trash and placed the trash bag and the disinfectant back in the cleaning cart. She removed the broom and swept the bedroom. She placed the broom back on the cart and removed the toilet brush. She entered the bathroom with the toilet brush and scrubbed the inside of the toilet. She placed the toilet brush back into the cart. She removed her gloves, used ABHR, and donned clean gloves. She removed three clean rags from the cart. She used the first rag to wipe the handrails and the toilet paper dispenser. She used the second rag to wipe down the shower and the third rag to wipe down the toilet from top to bottom. She placed the three dirty rags in the trash bag on the cart and removed her gloves. She used ABHR and donned clean gloves. She mopped the bedroom and then bathroom. She exited the room, removed her gloves, used ABHR and proceeded to room [ROOM NUMBER]. She failed to clean and disinfect highly touched areas such as door knobs, light switches, closet handles, night stand, call light, television remote, and bed controller. 2. Interviews HK #1 was interviewed on 10/12/2020 at 1:45 p.m. She said she had COVID-19 training but was not trained to clean high touch surfaces. She said she did not speak much English so she could not say what the training included and there was no one to translate for her. The NHA was interviewed on 10/12/2020 at 2:46 p.m. He said currently there was no housekeeping supervisor and he was responsible to supervise housekeeping. He said all high touch surfaces in the resident rooms should be disinfected daily with routine room cleaning. He said HK#1 understood English and had received training on proper room cleaning techniques and provided the in-service training. The director of nursing (DON) was interviewed on 10/13/2020 at 9:25 a.m. She said she was not sure what the housekeeping policy stated for disinfecting high touch surfaces nor if the housekeepers were assigned to designated floors. She said the infection control preventionist (ICP) could answer those questions. The ICP was interviewed on 10/13/2020 at 9:30 a.m. She said housekeepers are assigned to designated floors. She said there was a dedicated housekeeper and cleaning cart on the COVID unit. She said everything in a resident room should be cleaned except the inside of their closet and their personal belongings. She said housekeepers were expected to clean high touch surfaces with every routine room cleaning. She said a negative outcome would be the spread of infection. She said audits were done on a regular basis as well as in-services and training. She said housekeeping had a recent in-service related to the recent

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) outbreak of COVID-19. She said they used computer based training and in-service training. She said HK#1 had a sister who worked at the facility and translated for her. She said re-education would be provided to the housekeepers immediately. E. Observations and interviews HK#2 1. Observations On 10/13/2020 at 9:20 a.m., housekeeper (HK) #2 was observed cleaning room [ROOM NUMBER]. She sprayed a disinfectant on the surface of a clean cloth. HK #2 proceeded to quickly wipe the cloth over the top surfaces of a dresser, and the closet doors. She did not wipe down or apply disinfectant to the high touch surfaces of the closet door handle or the dresser drawer handles or allow the disinfectant to remain wet on the surfaces before wiping the product off with the cloth. -At 9:23 a.m., HK #2 used the same cloth to wipe down the surface of the bedside table. She did not directly apply the disinfectant to the surface of the bedside table as recommended by the manufacturer or allow the product to sit on the surface of the table for 30 seconds before wiping of the product. HK #2 brushed a small piece of paper off the table and on the floor as she wiped it down. She picked up the paper off the floor, touching the surface of the floor with her gloved hand and disposed of it. She did not change her gloves or perform hand hygiene after she disposed of the paper. She proceeded to wipe the resident's bedside table with the same gloved hand that she used to pick the paper off the floor. 2. Staff interviews HK#2 was interviewed on 10/13/2020 at 9:35 a.m. HK #2 identified the disinfectant used to wipe down the high touch surfaces of the bedside, the closet and the dresser, was Clorox Clean Up. She said the disinfectant had to remain on the surface wet for one minute to be effective. HK #2 said she was trained to change her gloves after change in task and after touching any potential contaminated surfaces. The NHA was interviewed with the director of nursing (DON) on 10/13/2020 at 12:28 p.m. The NHA said he was in process of hiring a housekeeper director. He said he currently oversaw the housekeeping department. Observations of the housekeeper were shared with the NHA. According the NHA, HK#2 did not properly disinfect the high touch surfaces of the resident's room. The director of nursing (DON) said she was part of the facility's infection prevention (IP) committee. The committee was responsible for monitoring the infection control practices of staff including observations of the housekeepers. She said she was not familiar with the specific housekeeping cleaning procedures to determine if appropriate practices were conducted. The DON and NHA agreed that the IP committee members should be cross-trained on housekeeping cleaning procedures to help determine if there was a potential break in infection control such as dwell times and high touch surface cleaning. II. Improper hand hygiene A. Professional standard According to the Centers for Disease and Prevention (CDC) Hand Hygiene in Healthcare Settings, last up updated 1/31/2020, accessed on 10/16/2020, retrieved from https://www.cdc.gov/handhygiene/providers/index.html, included the following recommendations: Multiple opportunities for hand hygiene may occur during a single care episode. Clinical indications for hand hygiene included: Use an alcohol-based hand sanitizer immediately before touching a patient, before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids or contaminated surfaces, and immediately after glove removal. Wash with soap and water when hands are visibly soiled, after caring for a person with known or suspected infectious diarrhea, and after known or suspected exposure to spores. B. Observations Laundry aide (LA) #1 was observed on 10/13/2020 between 9:03 a.m. to 9:09 a.m. on the 3rd floor. She delivered laundered personal clothing to non-isolated rooms #340, #341, #347, #336, #336, #331 and #332. On each delivery of clothing she made, she retrieved the prehung clothing from the linen cart and entered the room without performing hand hygiene. LA #1 opened the closet doors, touching the closet door handle. She placed the items in the closet, collected the empty hangers, and exited the room. She did not perform hand hygiene on exit of each room. In two of the observed rooms, she opened and closed the resident's door, touching the outer surface of the door handle. LA #1 entered and exited the rooms without performing hand hygiene after touching the high touch surfaces such as the closet door handles, the room door handles, and the hangers used for clean resident clothing. C. Staff interviews The nursing home administrator (NHA) was interviewed on 10/12/2020 at 4:05 p.m. He said ongoing monitoring and audits have been conducted with staff in attempts to identify the potential practices that could have led to the spread of COVID-19. He said trends identified hand hygiene and high touch services as potential sources of concern. According to the NHA, staff members were provided education on the spot if a concern was identified. LA#1 was interviewed on 10/13/2020 at 9:10 a.m. She said she was trained to wash her hands with soap and water or use alcohol based hand rub (ABHR) before and after entering a resident's room. LA #1 acknowledged that she should have performed hand hygiene when delivering resident laundry on entrance and exit of each resident room mentioned in the above observations. The director of laundry (DOL) was interviewed on 10/13/2020 at 10:44 a.m. According to DOL, LA #1 delivered laundry to every floor. She did not deliver laundry to rooms on isolation precautions. The DOL said laundry staff were trained to perform hand hygiene every time they entered and exited a room. The DOL said she recently has had help in the housekeeping department and has not been able to assist and supervise LA #1 with the delivery of personal laundry as often as she wanted to. She said laundry staff were at risk for potentially spreading transmission based infections [MEDICAL CONDITION] if they did not properly perform hand hygiene when delivering laundry. The DOL said LA #1 confirmed with the DOL that did not perform hand hygiene during the 10/13/2020 laundry delivery observation on the third floor. The DOL said she would provide her staff increased hand hygiene education pertaining to entering and exit of resident rooms and after touching high touch surfaces. She said she would also research ways to disinfect shared resident use items such as hangers. The infection control preventionist (ICP) was interviewed on 10/13/2020 at 11:58 a.m. She reviewed the previous hand hygiene trainings provided LA #1. The ICP said LA #1 was last trained in September 2020 to ensure hand hygiene was performed on entry and exit of a resident's room to prevent the potential spread of transmission based infections [MEDICAL CONDITION]. The ICP said staff needed to take hand hygiene seriously. She said LA #1 would need increased supervision and education to ensure hand hygiene was effectively performed. D. Record review The IPC provided the infection control trainings with LA #1 on 10/13/2020 at 11:58 a.m. LA #1 received the following trainings: -3/31/2020, COVID-19 update; -5/8/2020-5-12/2020, Hand washing and Hand Sanitizer: -6/29/2020, COVID-19 quiz; and, -9/2/2020, COVID-19: The Importance of Appropriate Hand Hygiene. III. Cohort staff to a unit in the presence of COVID-19 A. Record review and interview HK #2 was interviewed on 10/13/2020 at 9:35 a.m. The HK identified her position as a floater. She worked on multiple units throughout the week. According to the HK#2, she cleaned resident rooms on units with and without the presence of COVID-19 within a couple days of each other. The NHA was interviewed on 10/13/2020 at 9:45 a.m. He said the facility used consistent staffing. The NHA explained that core staff would only work on their assigned unit and not work unit to unit. He said he would not want staff to work on covid unit and then be assigned to a non-COVID unit the preceding day or week. The NHA said a staff member would have to wait for 14 days without working on a unit with the presence of COVID-19, to be assigned to work on a unit without the presence of COVID-19. He said staff had a high risk of spreading transmission based infections [MEDICAL CONDITION]. He said he would not want an asymptomatic staff member to potentially spread COVID-19 from unit to unit. -At 10:38 a.m., the housekeeping staff schedule was reviewed with the NHA. He confirmed HK #2 was on a rotating schedule to provide coverage while housekeepers assigned to one unit were scheduled off. He said HK #2 worked units with COVID-19 and non-Covid units within the same week. The DOL was interviewed on 10/13/2020 at 10:44 a.m. The laundry staff schedule was reviewed with the DOL. According to the DOL, laundry staff responsible for the delivery of resident laundry would not cohort to one unit. She said her staff responsible for the laundry delivery would go floor to floor, and room to room. She said they would not deliver laundry to residents in isolation but acknowledged the risk of potentially spreading transmission based infections from one floor to another. IV. Proper personal protective equipment (PPE) disposal The Waste Disposal policy revised January 2012, was provided by the NHA on 10/12/2020 at 5:02 p.m. via email. The policy read in pertinent part: All infectious and regulated waste shall be handled and disposed of in a safe and appropriate manner. All infectious and regulated waste destined for disposal shall be placed in closable leak-proof containers or bags that are color-coded or labeled as herein described. The Infection Preventionist and Environmental Services Director will ensure that waste is properly disposed of If outside contamination of the container or bag is likely to occur, a second leak-proof container or bag which is closable and labeled (or color-coded) shall be placed over the outside of the first container or bag and closed to prevent leakage during handling, storage, and transport A. Observation On 10/12/2020 at 12:53 p.m., and isolation cart was observed next to room [ROOM NUMBER]. A sign on the door identified the room was under droplet precautions. -At 12:58 p.m., licenced practical nurse (LPN) #1 was observed in room [ROOM NUMBER], on the memory care unit. LPN #1 wore a face shield, an N95 mask under a surgical mask, a gown and pair of gloves. He doffed his gown and gloves in a receptacle bin inside #354 near the door. The bin was designated for PPE disposal. LPN #1 exited the room. He did not remove his surgical mask over his N95 mask, nor did he disinfect the face shield he used to provide care for the isolated resident in room [ROOM NUMBER]. LPN #1 entered the hallway and walked to his nursing cart and then entered a room designed for resident equipment storage. He removed his surgical mask inside the room and washed his hands. He did not disinfect his face shield. On 10/13 at 9:22 a.m. HK #2 was

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) observed to remove a clean PPE gown from an isolation cart next to a room designated on isolation with droplet precautions. The HK donned the gown over her person and prepared to clean the room. The HK #2 was informed the resident inside the isolation room was receiving personal care and to clean at another time. The HK doffed the gown and rolled it up. She placed the gown on top of clean gowns inside the isolation cart. B. Staff interview LPN #1 was interviewed on 10/12/2020 at 12:53 p.m. The LPN said room [ROOM NUMBER] was under droplet precautions because she had tested positive for COVID-19. He said PPE should be disposed of in the designated PPE bin after use. He confirmed that he disposed of his surgical mask inside a non-designated waste receptacle in the storage room. He acknowledged that she should have disposed of the mask inside the isolation room and not enter the hallway still wearing PPE used in the isolation room. He was not observed to interact with a resident or enter another resident's room with the surgical mask used in the isolation room. LPN #1 said he wore the same face shield throughout the day on the memory care unit and then would be disposed of at the end of his shift. He did not express a need to disinfect the face shield after exiting a room on droplet precautions. ICP was interviewed with the director of nursing DON on 10/12/2020 at 2:15 p.m. According to the ICP, a surgical mask over a N95 mask in an isolation room, was used to protect and conserve the integrity of the N95 masks. Staff were trained to dispose of all PPE inside the isolation room, including the outer surgical mask. She said the outside surface of the surgical mask could be contaminated by airborne particles of transmission based infections [MEDICAL CONDITION] (TBI). She said the PPE used in an isolation room should not leave the room until proper disposal and removal of the waste. She said PPE from a COVID-19 positive room was removed by trained CNA's when the waste was full in the designated bin. The IPC said PPE should not be disposed of outside the room to prevent the potential spread of [MEDICAL CONDITION]. ICP said staff should wear eye protection in an isolated room with droplet precautions. The shield should be disinfected with alcohol wipes and allowed to dry for 30 seconds, after use in the isolated room to prevent the spread (TBI). HK #1 was interviewed on 10/13 at 11:13 a.m. She said housekeepers did not collect the used PPE in isolation rooms. HK #1 said the certified nurse aides (CNAs) collected the used PPE waste. CNA #1 and CNA #2 were interviewed on 10/13 at 11:25 a.m. on the third floor memory care unit. According to the CNA's, they were trained never to exit an isolation room wearing the same PPE used to care for a resident on droplet precautions for COVID-19. PPE must be disposed of in a bin designated for PPE near the inside entrance of the isolation room to prevent the potential spread of transmission [MEDICAL CONDITION] and infections such as COVID-19. CNA #1 and CNA #2 said PPE waste in isolation rooms had a potential to shed COVID-19 virus particles so they were trained to carefully remove the waste double bagging it and then taking directly to the dumpster without allowing any potential cross-contamination. CNA #2 said if the ppe was placed discreetly in a non-isolation waste bin, they would not know to take the special precautions on double bagging and direct removal out of the facility. HK #3 was interviewed on 10/13/20 at 11:40 a.m. She said she was not trained to properly handle soiled PPE used in an isolation room. She said the CNA's removed the PPE waste. She said she only handled receptacle bins in non-isolated rooms. HK #3 she collected the waste from the bins and placed the bag directly in her housekeeping cart. The waste is not double bagged or taken directly to the dumpster. She said she would be concerned if PPE was placed in a waste bin not deemed for isolation use because she would not know how to handle it differently. HK #3 said she could potentially put herself at risk for contamination of [MEDICAL CONDITION]. The NHA was interviewed on 10/13/2020 at 11:45 a.m. He said all waste should be treated as if contaminated but soiled PPE from a COVID-19 isolation room was treated differently and had an increased risk of exposure. CNA's handle PE waste to limit the number of staff handling the soiled PPE out of an isolation room. The DON was interviewed on 10/13/2020 at 12:28 p.m. HK #2 should have placed the gown inside the isolation room's designated PPE disposal after she placed it on her person and returned to the clean PPE isolation cart. The DON said additional education would be provided to staff. V. Status of COVID-19 in the facility The nursing home administrator (NHA) was interviewed on 10/12/2020 at 10:30 a.m. He said the facility had nine COVID-19 positive residents, one presumptive positive COVID-19 resident, and two COVID-19 positive staff members on two of the three floors. One of the COVID-19 positive residents was on the third floor memory care unit, six on the third floor long term care unit, and two on the second floor long term care unit. Of the nine positive residents, four identified residents on the third floor long term care unit completed their quarantine.