STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065147	A. BUILDING _____ B. WING _____	**04/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHEYENNE MOUNTAIN CENTER	**835 TENDERFOOT HILL RD COLORADO SPRINGS, CO 80906**

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 and interviews, the facility failed to ensure effective infection prevention and control practices were followed in order to prevent the potential spread of Coronavirus (COVID-19) and infectious diseases. Specifically, the facility failed to: -Ensure staff followed accepted hand hygiene practices when removing personal protection equipment (PPE) upon exiting a room under isolation precautions. -Ensure proper storage of reusable PPE; -Prevent potential cross contamination when removing items from a room under isolation precautions; -Monitor resident compliance with social distancing recommendations when in seated in congregated areas; and, -Ensure product instructions were followed when cleaning handrails. Findings include: 1. PPE and hand hygiene Certified nurse aide (CNA) #2 prepared to enter a room under isolation precautions on 4/9/2020 at 11:55 a.m. He performed hand-hygiene by using alcohol based hand rub (ABHR) before donning personal protective equipment (PPE). In the process, he removed the surgical-style mask he was wearing and placed it in his pocket. He donned an N95 respirator mask, finished donning the rest of his PPE and entered the room. When his assignment was completed (see below for additional concerns), CNA#2 removed the disposable PPE he was wearing inside the room and exited. He performed hand hygiene using ABHR and then removed the N95 by placing his hand on the outer surface of the N95 mask. Without performing additional hand hygiene, CNA #2 placed the N95 inside a paper bag in the isolation cart, retrieved the surgical mask from his pocket and put it on. 2. Cross-contamination A. Observations CNA #2 was observed on 4/9/2020 at 11:55 a.m. as he addressed resident care in a room under isolation precautions. At 12:05 p.m., CNA #2 summoned nurse aide (NA)#1 to refill a portable oxygen canister for the roommate of the resident under isolation. NA#1 donned gloves and carried the canister to the oxygen central supply room to refill the canister. She returned shortly after and gave the canister to CNA #2. CNA #2 exited the room under isolation precautions after doffing the disposable PPE. He carried a lunch tray from the room and placed it on top of the isolation cart so he could change from the N95 respirator he wore in the room. He took the tray to the room tray cart to be returned to the kitchen. B. Interview NA #1 was interviewed on 4/9/2020 at 12:15 p.m. NA #1 said she did not wipe down the portable oxygen canister with an approved disinfectant before placing it on top of the oxygen supply container to be refilled. CNA #2 was interviewed on 4/9/2020 at 12:18 p.m. CNA#2 said he should not have placed the room tray on the isolation cart because it could have been contaminated by being in the isolation room. He said he was not sure what to do with it but knew he could not walk down the hall while wearing the N95 respirator. CNA#2 said he did not wipe down the portable oxygen canister before giving it to NA#1 but did use a sanitizing wipe when it was returned to the room. 3. Social distancing Four residents were observed in the smoking area on 4/8/2020 at 12:20 p.m. Two residents facing the hallway/doorway window were seated within inches of each other smoking a cigarette. The other two residents were seated within inches of each other facing away from the hallway/doorway window and were also smoking a cigarette. Staff passed the window/doorway, with all four residents in view, and did not stop to redirect the residents to practice safe social distancing. On 4/8/2020 at 12:30 p.m., two residents were observed seated directly next to each other in the memory care unit television room. Registered nurse (RN)#2 was seated at the nurses station, in view of the residents, approximately 20 feet away. RN#2 did not redirect the residents to be seated at a safe social distance from each other. Furniture on the memory care unit was not placed at least six feet apart in order to encourage safe social distancing by the cognitively impaired residents on the unit. RN#2 said the two residents were friends and it was difficult to keep them apart. She approached the two residents and asked one to move to a nearby seat. The resident complied without any resistance and did not attempt to return to her former seat. Three residents were observed in the smoking area directly outside of the recreation/activities room on 4/9/2020 at 11:35 a.m. A staff member was present. Two residents were seated next to each other and were smoking a cigarette. The staff member did not redirect the residents to practice safe social distancing. 4. Housekeeping A. Facility policy The COVID-19 infection control policy, effective 3/27/2020, documented the facility would clean and disinfect patient .environment, especially high touch surfaces using an EPA approved (emerging [MEDICAL CONDITION] pathogens claims are recommended for use against COVID-19), hospital grade disinfectant. B. Product information Product information for AiRx 75 Bacterial, retrieved from https://cdn2.hubspot.net/hubfs/ /RX-75%20TECHNICAL%20REPORT% 9.pdf, revealed the disinfectant was effective in killing [DIAGNOSES REDACTED] related coronavirus with a contact time of two minutes. C. Observation and interview On 4/8/2020 at 12:10 p.m., housekeeper (HK) #1, a contractual employee, was observed with a wiping cloth and a spray bottle as he wiped the handrails in each hallway. He said the disinfectant spray in the bottle was AiRx 75 Bacterial. HK #1 said the disinfectant was effective against COVID-19 and should sit for ten minutes. He said he received his training from the contract company. HK #1 proceeded to clean hand rails in halls 1100 and 1200 by wiping the cloth over the contact surface without spraying the solution onto the rail. 5. Leadership interview Survey findings were shared with the nursing home administrator (NHA) and the director of nursing (DON) on 4/9/2020 at approximately 1:15 p.m. The nursing home administrator (NHA) was interviewed on 4/13/2020. The NHA said residents who were outside of their rooms were expected to wear a surgical mask and keep a distance of at least six feet from each other. The NHA said staff and residents were re-educated to ensure residents practiced safe social distancing when smoking. The NHA also said staff on the memory care unit believed residents could be closer to each other as long as they were masked. She said staff were re-educated and more staff were assigned to the unit to help redirect those with cognitive impairment. The NHA said all staff were expected to perform effective hand hygiene and use sanitizer when changing out of PPE. She said staff should store their masks appropriately when changing into N95 respirators and should not place the masks in their pocket. The NHA said re-education was completed immediately with staff and monitoring when residents were under isolation precautions would be increased. The NHA said any item removed from a room under isolation precautions should be wiped down with an appropriate sanitizing wipe. The NHA said re-education was completed immediately. The NHA said high contact surfaces were cleaned once each shift and staff should follow manufacturer's instructions for use of disinfectants. She said the staff were re-educated to provide a two minute dwell time after spraying before wiping services.

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.