STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065366	A. BUILDING _____ B. WING _____	**04/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PINE RIDGE EXTENDED CARE CENTER	**119 BASTILLE DR PAGOSA SPRINGS, CO 81147**

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 implement proper Coronavirus disease (COVID-19) infection control standards for three of four resident hallways. Specifically, the facility failed to: -Implement proper use of personal protective equipment (PPE) in relation to mask and glove use; -Store portable oxygen concentrators in a hygienic manner; and, -Distribute resident water cups hygienically utilizing proper hand hygiene to minimize the risk of possible cross-contamination. Findings include: I. Facility policy and procedure: The Infection Control Program policy, no date of inception or revision, provided by the nursing home administrator (NHA) on 4/6/2020 at 2:00 p.m. read, there was an active facility wide infection control program with effective measures to control and prevent infections acquired or brought into the facility from the community or other health care facilities. Policies addressed preventative/control procedures, including disinfection practices, sterile supply, environmental services, engineering and maintenance, food sanitation, and waste management, which were integral parts of the program. The COVID-19 policy, effective March 10, 2020, provided by the NHA on 4/6/2020 at 2:00 p.m. read, since December 2019, Covid-19(COVID-19) has emerged as a potentially significant pandemic organism threatening to cause significant morbidity and death, particularly among the elderly and those with significant comorbidities. This facility has established this evolving policy to supplement our standard infection prevention protocols. Covid-19 appears to be transmitted from person to person by aerosolized transmission and it is theoretically possible that hand to mouth transmission may occur. Effective immediately, all staff were to be re-educated in regard to hand washing (including when, how, and how often), standard infection prevention, appropriate use of PPE (which items to use and when) with an emphasis on masks, and any emerging changes related specifically to Covid-19 as they are identified. II. Professional reference According to the Centers for Disease Control and Prevention (CDC) Key Strategies to Prepare for COVID-19 in Long-term Care Facilities (LTCFs), retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-strategies.html. Ensure all health care providers wear a facemask or cloth face covering for source control while in the facility. Cloth face coverings are not considered personal protective equipment (PPE) because their capability to protect healthcare personnel (HCP) is unknown. Cloth face coverings should NOT be worn instead of a respirator or facemask if more than source control is required. III. Observations A. PPE and oxygen concentrator On 4/6/2020 at 2:10 p.m., a portable oxygen concentrator was observed on the floor inside the door of resident room [ROOM NUMBER]. An unknown staff member was observed in the room, and she closed the door at that time. On 4/6/2020 at 2:15 p.m., Licensed practical nurse (LPN) #1 was observed leaving a resident room on the 300 resident hallway with gloves on and supplies in her hands. She was observed entering the medication room, there was no hand hygiene performed after exiting the residents room and before entering the medication with contaminated gloves on. On 4/6/2020 at 1:45 p.m., the director of nursing (DON) was observed standing outside resident room [ROOM NUMBER] speaking in the direction of another staff member with her mask pulled down exposing her face. LPN #2 was observed in the medication room off the 300 resident hallway with her mask pulled down on 4/6/2020 at 1:58 p.m. Her mask was still down at 2:05 p.m., while she was at her computer station charting. On 4/6/2020 at 2:21 p.m., an unknown staff member was observed sitting at the nursing station attached to the DON ' s office and adjacent to a resident common area with residents present and her mask pulled down under her chin exposing her nose and mouth. On 4/6/2020 at 2:06 p.m., the medical records specialist (MRS) was observed in her office adjacent to the resident common area with residents present with her mask pulled down under her chin exposing her nose and mouth. B. Unhygienic of water passing to residents On 4/6/2020 at 1:48 p.m., an unknown dietary aide was observed collecting water cups from resident rooms on the 100 hallway. She went from resident room [ROOM NUMBER] and across the hall to resident room [ROOM NUMBER] without performing hand hygiene between resident rooms. On 4/6/2020 at 2:30 p.m., the dietary director (DD) was observed passing waters on the 300 hallway. The DD picked up soiled used water cups from residents and then disturbing fresh water cups. The staff member went from room [ROOM NUMBER], 308, and 307 without performing hand hygiene between resident rooms and contaminating the fresh/clean water cups. IV. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 4/6/2020 at 2:10 p.m. She said portable oxygen tanks were not to be stored on the floor as that was very unsanitary. LPN #1 was interviewed on 4/6/2020 at 1:50 p.m. She said the facility has provided her education on proper PPE use, which included wearing masks at all times in the facility. She said she has had specific education on hand hygiene, PPE usage, transmission based precautions, and COVID-19. LPN #2 was interviewed on 4/6/2020 at 1:58 p.m. She said they have been provided education on PPE usage, and it was ok to pull masks down in non-resident areas of the facility like the medication room. The MRS was interviewed on 4/6/2020 at 2:06 p.m. She said they have been educated on PPE usage and were to wear a mask in the facility at all times. Housekeeper (HSK) #1 was interviewed on 4/6/2020 at 2:04 p.m. He said he had been working at the facility for about two weeks and had been educated to wear a mask at all times while in the facility. The DD was interviewed on 4/6/2020 at 2:30 p.m. He said he was not performing hand hygiene while disturbing resident water cups and fresh water and when he went from room to room, but he probably should have been. The DON and NHA were interviewed by phone on 4/7/2020 at 10:00 a.m. The NHA said staff should be wearing masks while in the common areas of the facility and in resident rooms, but it was ok to pull their mask down if they were by themselves in the office or in the medication room. She then said staff should not be pulling the masks down during their shift while in the facility. The DON said staff entered the facility through a back entrance near the time clock, and there was a sign there with PPE that said do not pass this point without a mask on. The DON said portable oxygen tanks were to be stored in resident rooms when not in use and not stored on the floor. She said staff were to perform hand hygiene after exiting every resident room and there were sinks available for handwashing and hand sanitizer on the walls, and this applied to all staff including dietary. She said nurses should not walk down the hallway with gloves on, and that dietary staff were to perform hand hygiene after leaving a resident room and touching soiled water cups and before going into a resident room with a new cup.

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