STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065384	A. BUILDING _____ B. WING _____	04/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SANDROCK RIDGE CARE AND REHAB	943 W 8TH DR CRAIG, CO 81625

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** - 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 properly maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections such as [MEDICAL CONDITION] disease (COVID-19) in three of three neighborhoods. Specifically, the facility: -Failed to ensure staff sanitized medical equipment during the staff/visitor screening process; -Failed to maintain social distancing and encourage face mask use and hand hygiene with the 13 residents who resided on the memory care unit; -Failed to ensure staff practiced proper hand hygiene during hydration pass to prevent cross-contamination; -Failed to ensure prevention of cross-contamination during resident room cleaning. Findings include: I. Professional reference According to the Colorado Department of Public Health and Environment COVID-19 Preparation and Rapid Response Checklist for Long-Term Care Facilities, revised 4/24/2020, in pertinent part: -All essential visitors must be screened when entering the building. -Restrict all residents to their rooms as much as possible. -If residents must leave their room, they should perform hand hygiene, limit their movement within the facility, wear a cloth face covering, and perform social distancing (stay at least 6 feet from others). -All group activities should be cancelled. -Communal dining should be cancelled unless assistance is required. Maintain a 6-foot distance from other residents during supervised meals. -Limit staff movement: cohort staff to a unit when possible, including across multiple shifts. -Standard precautions should always be followed. -Reinforce adherence to infection prevention and control measures, including hand hygiene. -Ensure adequate hand hygiene supplies: Put alcohol-based hand sanitizer in every resident room (ideally both inside and outside of the room). -Ensure adequate supplies and procedures for environmental cleaning and disinfection. -Ensure that all non-dedicated, non-disposable resident care equipment is cleaned and disinfected according to manufacturer's instructions after each use (e.g. pulse ox). II. Screening Observations of the visitor screening process on 4/27/2020 at 1:15 p.m. revealed a sign-in table inside the front door, where staff took temperatures and checked pulse oximetry levels to screen everyone entering the building for COVID-19 symptoms. Staff was observed to sanitize the thermometer after pressing it to the surveyor's temple and across the forehead, but did not sanitize the pulse oximetry clip after use. The staff set the pulse oximetry clip back on the table as if ready to re-use, and sanitized it only after being reminded to do so. An observation on 4/27/2020 at approximately 3:20 p.m. revealed a second staff person used the pulse oximetry clip on a staff person who was leaving the building, then handed it to the nursing home administrator (NHA) to use on a person who was waiting outside to enter the building. The NHA was notified that the pulse oximetry clip had not yet been sanitized, and he sanitized it himself using a disposable disinfectant wipe. III. Memory care unit Observations on 4/27/2020 from approximately 1:45 p.m. to 3:15 p.m. revealed 13 residents resided on the memory care unit (MCU). One resident was observed frequently ambulating the length of the hallway in his wheelchair, using his left hand to propel himself using the handrails. He was not wearing a mask. The nursing staff member who followed behind him was wearing a mask, but was not observed sanitizing the handrail or offering hand hygiene to the resident. There were no hand sanitizers in the resident rooms. There was one hand sanitizer on the wall at the entrance to the MCU, and another at the opposite end of the hall outside the shower room. There was one common/dining area on the MCU, where residents gathered. Many of the residents sat very close together and none were wearing masks. Two female residents, one in a dining room chair and one in a wheelchair, sat shoulder-to-shoulder next to each other without masks. A female resident sat at a four-top table directly across from a male resident, closer than six feet from each other and facing each other. The female resident was coughing intermittently. Neither resident wore a mask. Two certified nurse aides (CNAs) were observed taking resident temperatures and checking their oxygen saturation levels with a pulse oximetry clip. The staff wore masks but the residents were gathered closely around the staff waiting their turn to have their vitals taken. The residents were not wearing masks and staff were not encouraging social distancing. On 4/27/2020 at 2:50 p.m., an activity staff member entered the MCU with a refreshment cart and announced to the residents that it was time for an activity, and they were serving ice cream. Although there was a hand sanitizer pump on the refreshment cart, residents were not encouraged to clean their hands before the activity, and residents were gathered closely together, closer than six feet apart, without masks. Some staff when interviewed said housekeeping wiped down handrails and surfaces regularly. Another staff said nursing staff wiped down handrails twice per shift. On 4/27/2020 at 2:55 p.m., the MCU unit coordinator was interviewed. She said it was difficult to practice social distancing and mask use for the residents on the MCU because of their dementia. She said they had dedicated staff who helped sanitize surfaces before and after use by high-risk residents, and cleaned a lot. However, handrail cleaning was not observed after residents touched the handrails. The unit coordinator then left the unit and was observed walking throughout the open unit in the facility. Likewise, the CNAs and activity staff were observed walking and working throughout the facility. Therefore, the MCU did not have dedicated staff. IV. Housekeeping Housekeeper (HK) #1 was observed cleaning rooms on the MCU on 4/27/2020 at approximately 2:00 p.m. She donned gloves but did not wash or sanitize her hands before doing so, and had just cleaned another resident room. She started in the bathroom of a double-occupancy resident room, swabbing the toilet with a cloth soaked in a Virex II 256 disinfectant, which had a dwell time of 10 minutes. She acknowledged with the method she used, the disinfectant might dry on the surface before it had time to disinfect. She said they were out of spray bottles which saturated the surface more thoroughly with disinfectant, and they had been out of spray bottles for about a month. She said she usually had hand sanitizer on her cart, but had been out of it since just after lunch that day. She said the housekeeping supervisor was trying to get more supplies. As HK #1 cleaned the bathroom after the disinfectant dwell time, she draped the dirty cleaning cloths across the plastic holder for the toilet bowl cleaner and toilet brush, which she had set on the floor in the bathroom. When she was finished, she tossed the dirty rags in a plastic bag and put the plastic holder on top of her cart, right next to a box of clean gloves. HK #1 did not change gloves between cleaning the toilet, sink and dressers in the residents' room, although she changed cleaning cloths. She used the same cleaning cloth to clean the call buttons and cords in the double-occupancy room, potentially cross-contaminating with her soiled gloves and the same cloth for both resident bedroom areas. As she swept the floor, HK #1 used a dustpan with a long handle, which she set on the floor and took room to room. Likewise, the toilet brush went room to room in a plastic holder that also held toilet bowl cleaner. She swept the bathroom floor first, into the resident bedroom area. After cleaning the resident room, she doffed her gloves and used hand sanitizer before entering the dining/common area. She acknowledged the potential for cross-contamination in the observations above, and said she was the only housekeeper in the building at the time. The housekeeping supervisor was interviewed at approximately 3:30 p.m. on 4/27/2020. The observations above were reviewed with her. She reiterated what HK #1 had said about the supply shortage, and acknowledged the potential for cross-contamination during resident room cleaning. She said their cleaning system needed to be improved to prevent cross-contamination. V. Hydration pass On 4/27/2020 from 3:00 p.m. to 3:15 p.m., a nurse aide (NA) and CNA were observed working from a hydration cart in the hallway on the open unit. They were not wearing gloves and were not [MEDICATION NAME] hand hygiene to prevent cross-contamination. They were observed going in and out of resident rooms, bringing soiled mugs

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) and cups to the hydration cart and placing them on the bottom shelf, bringing water pitchers to the cart to fill them with ice and water, removing and handling the soiled lids as they went, then returning the water pitchers to the residents' bedsides, without washing or sanitizing their hands in between. One of the aides was observed touching her hair to brush it away from her face. There was no hand sanitizer on the hydration cart and the cooler of ice was uncovered. There was no hand sanitizer on the walls in the resident rooms or between the resident rooms. Only one hand sanitizer on the wall was within view. Both aides acknowledged it would be helpful to have hand sanitizer on the hydration cart, but they did not have any. They also acknowledged the potential for cross-contamination due to a lack of hand hygiene between resident rooms and roommates. They said the lid to the cooler was gone because the hinges were broken and the lid kept falling off, so they removed it completely. They pointed to the lowest shelf on the hydration cart where they had placed the cooler lid. They acknowledged they needed a new cooler. VI. Staff interviews The director of nursing was not in the facility and unavailable for an interview. The nursing home administrator (NHA) was interviewed on 4/27/2020 at approximately 4:00 p.m. and a second time by phone at approximately 4:00 p.m. on 4/30/2020. When the above detailed concerns were reviewed with him, he acknowledged the above failures as he had observed some of them himself. He said staff had been trained in all the identified areas already and he would ensure further training and monitoring were conducted. He said they had rearranged furniture on the MCU to maintain social distancing and had educated staff regarding resident social distancing, mask use, hand wipes and frequent cleaning of high-touch surfaces such as handrails. He said there should be a more frequent cleaning process. He said they would re-educate staff, who had already been educated in these areas, and would implement audits to monitor and ensure infection control practices were followed. He said he would like to have seen better hand hygiene, more housekeeping guidance and collaboration, and resident social distancing. He said they would implement more education and monitoring.