STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065202	A. BUILDING _____ B. WING _____	07/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CEDARS HEALTHCARE CENTER	1599 INGALLS ST LAKEWOOD, CO 80214

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 -** Immediate jeopardy **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 ensure infection control practices were established and maintained to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of Coronavirus (COVID-19) and other communicable diseases and infections. Specifically, the facility failed to ensure staff applied appropriate personal protective equipment (PPE) when entering the room of a resident who tested COVID-19 positive, as well as when entering the room of a recently admitted resident in quarantine. In addition, the facility failed to implement symptom-based strategy and exclude an employee from work following her report of signs and symptoms of COVID-19. These failures created the likelihood of serious harm, the spread of highly infectious COVID-19 to facility residents on two or four facility units, if not immediately corrected. Findings include: I. Status of COVID-19 in the facility The first known positive COVID-19 case at the facility was Resident #1 on 6/30/2020, according to the director of nursing (DON) in an interview on 7/8/2020 at 12:35 p.m. She said Resident #1 left the facility to go shopping, so he was tested for COVID-19 on 6/24/2020. His results came back positive on 6/30/2020. She said after Resident #1 was confirmed positive for [MEDICAL CONDITION], the facility isolated the resident, notified the local health department, and implemented testing for all the residents in the facility 7/1/2020-7/2/2020. She said the facility also re-educated staff on proper isolation precautions including PPE use; however, not all staff received the education. She said there were no other residents with symptoms of COVID-19 or with positive results, although some residents' results were still pending. II. Immediate Jeopardy A. Findings of immediate Jeopardy 1. Failure of staff to don appropriate PPE prior to entering a COVID-19 positive resident's room and the room of a recently admitted resident who was on 14-day quarantine. a. On 7/8/2020 at 1:58 p.m., agency registered nurse (RN) #1 donned a gown and gloves outside the room of Resident #1, who had tested positive for COVID-19 on 6/30/2020. She wore a surgical mask, gown and gloves; she did not don an N95 respirator or other respirator-type mask and she did not don any eye protection. She knocked and entered the resident's room. At 2:02 p.m., RN #1 exited the room wearing only a surgical mask and she immediately went down the hallway and entered room [ROOM NUMBER] to answer the call light. b. On 7/8/2020 at 12:58 p.m., the call light was on outside of Resident #4's room. There was an isolation cart outside the room. The resident's door was open and Resident #4, who was admitted to the facility 6/26/2020 and resided in bed A, was in his wheelchair with his back to the door. At 1:02 p.m., agency certified nurse aide (CNA) #1 entered the room wearing a surgical mask; she did not don any PPE. When the resident asked for ice water, the CNA reached across the resident for his water pitcher and exited the room. She walked down the hallway toward the dining area of the Freedom unit, returning to Resident #4's room with a pitcher of ice water. 2. Failure to implement symptom-based strategy and exclude an employee from work following her report of signs and symptoms of COVID-19. On 6/28/2020 at 6:36 a.m., agency CNA #4 reported to the facility that she had a fever the day before (6/27/2020). She also reported she had a new cough, shortness of breath (SOB) and had been around her cousin who was in close contact with an individual who tested positive for COVID-19. Review of the facility schedules and interviews with staff revealed CNA #4 worked at the facility on 6/30/2020 and 7/1/2020, during the period, per the CDC, she was to be monitored for symptoms. The above failures in infection control practices created an immediate jeopardy situation with the likelihood of serious harm to residents, staff, and others if not corrected immediately. On 7/9/2020 at 6:15 p.m. the nursing home administrator (NHA) and DON were notified the above failures created a situation of immediate jeopardy in infection prevention and control (F880). B. Plan to remove the immediate jeopardy On 7/10/2020 at 9:36 a.m., the NHA provided a plan to remove the immediate jeopardy. The plan read: Proposed removal Plan -Facility staff failed to wear PPE in a room with a resident who is COVID positive. Residents that are COVID positive, potentially could be affected by this statement of alleged deficient practice, therefore, this plan of correction is written to address all such residents. One resident (Resident #1), was identified during the survey. On 7/9/2020 at 9:30 p.m., NHA, DON, staff development coordinator (SDC) and/or qualified designees initiated re-education to the licensed staff, CNAs, dietary, housekeeping, laundry, maintenance and administrative staff on the expectation and importance to wear PPE in a room with a resident who is COVID positive. Staff members who are on vacation or currently off shall be provided re-education upon return to work. Re-education will also include documentation return demonstration of proper PPE donning and utilization. The facility will track training to ensure that all facility and agency staff receive training at the beginning of their shift. Training will continue every shift until all staff have received the mandated training. The NHA is responsible to ensure compliance is achieved and maintained. -The facility failed to ensure proper screening was completed for an employee who stated signs/symptoms of COVID No specific recipients were identified in this alleged statement of deficient practice. Therefore, this plan is written to address all residents residing in the facility. Employees shall continue to be screened prior to starting of their work assignments. Employees who have been identified with signs/symptoms of COVID shall not be allowed to pass the screening desk, sent home and the findings shall be noted on the screening tool. Immediately, the screener shall notify the NHA, DON, SDC, and/or qualified staff member shall follow-up directly with the team member for additional inquiry and follow-up of their condition, need for further action and/or removal from the shift assignment. All staff assigned to complete employee, resident and visitor screening will have mandatory re-education, provided by the NHA, DON, SDC and/or qualified designee, regarding the pre-shift screening process. Re-education will include directives to immediately notify the NHA and DON, or qualified designee, of any identified signs/symptoms during a screen. Re-education was initiated on 7/9/2020 at 9:30 p.m., and will continue every shift until all staff have received the mandated training. The NHA, DON, SDC initiated re-education of licensed staff and managers regarding what to do in the event an employee demonstrates signs/symptoms during a shift, including immediate notification to the NHA, DON, and/or infection control preventionist (ICP), so appropriate follow-up action can be completed with the identified individual in a timely fashion. This shall include but not limited to, refusal for admittance back into the facility until notification of clearance has been provided by the NHA, DON, Medical Director and/or qualified designee. Re-education was initiated on 7/9/2020 at 9:30 p.m. and will continue every shift until all staff have received the mandated training. Daily, during stand-up, the screening tool shall be reviewed by the NHA and discussed with the DON, SDC, ICP and/or other department heads. This will include validating employees that have been identified with signs/symptoms of COVID have been redirected out of the facility; and, notification has been provided to the employee and/or department head for removal off the schedule until appropriate action and follow-up has been taken. Non-compliance with the screening process and guidelines will be immediately addressed, including disciplinary action up to suspension and/or termination as appropriate. The NHA is responsible to ensure compliance is achieved and maintained. -The facility staff failed to wear PPE in a resident's room that was a new admission and on isolation precautions for 14 days. Residents that are on isolation precautions, potentially could be affected by this statement of alleged deficient practice, therefore, this plan of correction is written to address all such residents. One resident (Resident #4), was identified during survey. On 7/9/2020 at 9:30 p.m., the NHA, DON, SDC, and qualified designees, initiated re-education to licensed staff, CNAs, dietary, housekeeping, laundry, maintenance and administrative staff on the expectation and importance to wear

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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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) PPE in a room with a resident who is on isolation precautions for 14 days. Staff members who are on vacation or currently off shall be provided re-education upon return to work. Re-education will also include documented return demonstration of proper donning of PPE prior to entering a resident's room who is on isolation precautions. Re-education will continue every shift until all staff have received the mandated training. The DON is responsible to ensure compliance is achieved and maintained. C. Removal of immediate jeopardy On 7/10/2020 at 1:15 p.m., the NHA and DON were notified the immediate jeopardy was lifted, based on observations and interviews that showed implementation of the facility's plan above; however, deficient practice remained at an E level scope and severity (a pattern with the potential for more than minimal harm). III. Failure of staff to don appropriate PPE prior to entering a COVID-19 positive resident room and the room of recently admitted resident on 14-day quarantine. A. Professional reference and facility policy 1. Professional reference The Centers for Disease Control and Prevention, Preparing for COVID-19 in Nursing Homes, retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html (updated 6/25/2020) read, in pertinent part: Residents with known or suspected COVID-19 should be cared for using all recommended PPE, which includes use of N95 or higher level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front sides of the face), gloves, and gown. Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown. Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP (health care providers) should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission . 2. Facility policy The Coronavirus (COVID-19) Droplet precautions policy and procedure, dated 3/16/2020, provided by the NHA on 7/9/2020 at 1:15 p.m., read, in pertinent part: This procedure provides guidelines for droplet precautions for residents with known or suspected novel Coronavirus (COVID-19) generated during coughing, sneezing, talking, and/or while performing procedures. A. Persons Under Investigation for COVID-19: 1. Place a mask on resident. 2. Place resident in a private room and close the door . 8. Wear a mask. 9. Wear clean gown when entering the room . 14. Use disposable dinner ware . dispose of in the Resident's room. B. Persons Testing Positive for COVID-19: 1. Follow the procedure outlined above in section A. 2. Follow guidance of local Department of Public Health for consideration of transport to an acute care facility and recommended next steps. B. Resident #1 - failure of staff to don appropriate PPE prior to entering a COVID-19 positive resident room [ROOM NUMBER]. Resident status Resident #1, age 46, was admitted on [DATE]. According to the July 2020 computerized physician orders [REDACTED]. The 4/28/2020 minimum data set (MDS) assessment revealed the resident was cognitively impaired with brief interview for mental status (BIMS) score of 11 out of 15. He did not exhibit any behaviors. He required supervision with bed mobility and toileting, and limited one-person assistance with transfers, dressing and locomotion on the unit. He was always continent of bowel and bladder. Record review revealed Resident #1 was detected with COVID-19, per a COVID-19/Coronavirus lab test dated 6/29/2020. 2. Observation and interview 7/8/2020 On 7/8/2020 at 1:58 p.m., registered nurse (RN) #1 donned a gown and gloves outside of Resident #1's room. The RN wore a surgical mask, gown and gloves; however, she did not don a N95 respirator or other respirator-type mask and she did not don eye protection. She knocked and entered Resident #1's room. At 2:02 p.m., RN #1 exited the room wearing only a surgical mask and she immediately went down the hallway and entered room [ROOM NUMBER] to answer the call light. Registered nurse (RN) #1, interviewed on 7/8/2020 at 2:08 p.m., said she worked for an agency and had worked at the facility for seven weeks PRN (as needed) but full time hours. She said Resident #1 was on droplet precautions but recently had tested negative for COVID-19. She was not sure of the facility's infection control protocol, but said the resident was not off isolation and, therefore, assumed all PPE was needed to enter the resident's room. She said this meant the appropriate PPE for Resident #1 was a gown, gloves, eyewear (per the RN, the facility did not have any face shields), and N95 mask. Nonetheless, RN #1 confirmed that prior to entering Resident #1's room (see above), she did not don eyewear (goggles) or apply a N95 mask. -She said she did not use her N95 mask because it was locked in the nursing cart, although she said she had used it earlier when she gave Resident #1 his lunchtime medication. She then walked to the main nursing station down another hallway where the N95 mask was visible in her backpack. -She said she did not put on any goggles when entering Resident #1's room because goggles were missing from the isolation cart. She said the last time she saw the goggles on the isolation cart was when she went into the room at 12:30 p.m. (At 2:18 p.m., RN #1 placed goggles on the isolation cart outside Resident #1's door along with additional PPE). In a subsequent interview on 7/14/2020 at 12:20 p.m., RN #1 said she returned to work at the facility on 7/9/2020 7/10/2020, and at that time she received education on donning and doffing PPE and on droplet precautions. She said on 7/8/2020, her N95 mask was in her backpack because she had just gone on break. She said she was unsure if she had received any training on reuse of N95 masks and assumed she could reuse them. She said when she returned to work at the facility she received training to throw her N95 mask away after use. C. Resident #4 - failure of staff to don appropriate PPE prior to entering the room of a recently admitted resident on 14-day quarantine. 1. Resident status Resident #4, age 80, was admitted to the facility on [DATE]. According to the July 2020 CPO, his [DIAGNOSES REDACTED]. Due to his recent admission, a MDS assessment had not been completed. The admission assessment, dated 6/26/2020, documented the resident was alert and oriented to person, place, time and situation. He required two-person assistance with transfers. 2. Observations and interview On 7/8/2020 (12 days after Resident #4's admission) at 12:58 p.m., the call light was on outside of Resident #4's room. There was an isolation cart outside the room. The resident's door was open and Resident #4, who resided in bed A, was sitting up in his wheelchair with his back to the door. There was a sit-to-stand lift (mechanical lift) observed in the room blocking the door to the bathroom. There was no one in bed B. At 1:02 p.m., CNA #1 entered the room wearing only a surgical mask. Prior to entering the room, she did not don a gown, gloves or eyewear. When the resident asked for ice water, the CNA reached across the resident for his water pitcher and exited the room. She walked down the hallway toward the dining area of the Freedom unit, returning to Resident #4's room with a pitcher of ice water. CNA #1, interviewed on 7/8/2020 at 1:03 p.m., said she was an agency CNA and had worked the day shift at the facility for three months. She said the only PPE needed when caring for Resident #4 was her mask and gloves. CNA #2 was interviewed on 7/8/2020 at 1:08 p.m. She said she was familiar with Resident #4. She confirmed there were two residents residing in Resident #4's room and said the isolation cart outside the room was for the resident in bed B who was on [MEDICAL TREATMENT]; staff were to use a mask, gown and gloves at all times. She knew the resident in bed A had been in the hospital, but she was not sure if he was still on isolation. D. Additional interviews and documentation regarding PPE use 1. The DON and the staff development coordinator/infection control preventionist SDC/ICP were interviewed on 7/8/2020 at 4:05 p.m. a. The DON said RN #1 should have used all full PPE when entering Resident #1's room on 7/8/2020, as the resident was on droplet precautions. The DON said the facility had conducted updated COVID-19 education for staff on 7/1/2020 following the discovery of Resident #1's positive test for COVID-19 on 6/30/2020. She said RN #1 had not received this education as she had not been working on the unit that day. b. Review of documentation on the 7/1/2020 education revealed 16 staff had received the education. Out of the 16, only seven direct care staff participated (four nurses, two CNAs, and one occupational therapist). Neither RN #1 nor CNA #1 participated in the training. There was no evidence of additional training for staff who had not participated in the 7/1/2020, or for agency staff who worked intermittently since 7/1/2020. c. The SDC/ICP said she tried to follow-up with agency staff by catching them during their shifts, to ensure they received updates and education on COVID-19. She said she observed staff and used return demonstration, along with spot checks for proper infection control practices, as needed. IV. Failure to ensure staff did not work during the recommended 72-hour symptom-based strategy monitoring period, after exhibiting symptoms of COVID-19. A. Professional reference and facility policy 1. Professional reference The Centers for Disease Control and Prevention, Return to Work Criteria for HCP with suspected or Confirmed COVID-19, retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html (updated 5/5/2020), read, in pertinent part, Symptom-based strategy. Exclude from work until: At least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); and, at least 10 days have passed since symptoms first appeared. 2. Facility policy The facility's Coronavirus (COVID-19) policy and procedure (dated 3/16/2020) read in pertinent part, Coronavirus (COVID-19) may be characterized by mild to severe respiratory infection. Symptoms may appear 2-14 days after exposure and may include: 1. Fever 2. Cough 3. Shortness of breath 4. Sore throat 5. Gastrointestinal illness (e.g. nausea, vomiting, and diarrhea). -It may be reasonable to suspect a COVID-19 if any of the following criteria are met: Residents or team members exhibit signs of a fever, respiratory illness, sore throat, shortness of breath, gastrointestinal symptoms and have had exposure to

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) at-risk individuals diagnosed with [REDACTED]. Complete the Team Member portion of the Team Member, Resident, and Visitor Screening Tool and Log. If a team member answers yes to any of the screening questions, s/he is instructed to return home . -Team Members, In the event that a team member has had known exposure (close contact) to an individual with COVID-19, the team member is instructed to self-isolate for a period of 14 days from the date of known exposure. Refer to the Coronavirus (COVID-19) Team Member Guidelines and the Coronavirus (COVID-19) Team Member Decision Tree for further guidance. Team members are instructed that they may resume work in accordance with the recommendations outlined within Return to Work Guidelines. B. Record review Review of facility screenings revealed on 6/28/2020 at 6:36 a.m., agency CNA #4 reported to the facility that she had a fever the day before (6/27/2020). She also reported she had a new cough, shortness of breath (SOB) and reported she had been around her cousin who was in close contact with an individual who tested positive for COVID-19. Review of the facility schedule and interview with staff revealed CNA #4 did not work at the facility 6/28 and 6/29/2020; however, she worked on 6/30/2020 and 7/1/2020, during the CDC 72-hour symptom-based strategy monitoring period. C. Interviews on facility screening and CNA #4 The NHA, DON, SDC/ICP and human resources/payroll representative (HRP) were interviewed on 7/9/2020 at 5:05 p.m. 1. The HRP said she was responsible for reviewing the employee/visitor screening logs. She said she was supposed to review them daily to ensure no staff were working with signs and symptoms of COVID-19. She said at times, she is not able to review the logs because she is too busy. She said she did not follow-up with the logs the week of 6/28/2020. 2. The DON said on 6/28/2020, there were several staff call outs and the supervisor working that day had pulled staff from other areas. She said if staff had signs or symptoms of COVID-19, they were sent home. Then, staff was keep the facility updated on their symptoms or inform the facility if they were assessed by a physician. She said she was not working the week CNA #4 reported signs and symptoms of COVID-19; that week, the MDS coordinator (MDSC) was responsible to follow-up with staff members who had symptoms of COVID-19. She said she had spoken with the MDSC during survey on 7/9/2020, and the MDSC told her that she was not notified CNA #4 had symptoms of COVID-19, so there was no follow-up. The DON said the management team should have followed up to ensure no staff member was working with signs and symptoms of COVID-19. The DON said when she spoke to CNA #4 during survey on 7/8/2020, the CNA told her she had asthma, chronic cough and was always SOB. She said the CNA stated had visited with her cousin and could not say if he was positive for COVID-19. The DON said she had contacted the weekend supervisor (WS) during survey on 7/9/2020, who told her several staff had called out on 6/28/2020, so she (WS) helped on the floor and pulled the restorative CNA to help work the floor. She said she did not remember which staff member was sent home on 6/28/2020, she only remembered there was a CNA sent home because the CNA had signs and symptoms of COVID-19. She had acknowledged to the DON that she had not notified the DON or any other manager of a CNA having COVID-19 signs and symptoms and this was why no one followed up to ensure the CNA did not return to work. 3. Medical records staff (MR) was interviewed on 7/9/2020 at 5:20 p.m. She said she covered at the receptionist area on 6/28/2020. She confirmed the facility screening form on 6/28/2020 that included a report of fever and possible COVID-19 exposure belonged to CNA #4. She said she was told by the WS to not let CNA #4 in the facility and to send her home. 4. The scheduler at the outside staffing agency where CNA #4 was employed was interviewed on 7/15/2020 at 10:35 a.m. She said she scheduled all agency staff to work at multiple facilities. She said CNA #4 reported to her she traveled out of town and visited with family that tested positive for COVID-19. She said she had to take her off the schedule for the week of 7/12/2020 and she required her to be tested for COVID-19. She said the CNA's test results were pending. She confirmed CNA #4 did not work at the facility 6/28/2020 and she called in on 6/29/2020. She verified, however, that CNA #4 did work at the facility on 6/30/2020 and on 7/1/2020. 5. CNA #4 was interviewed on 7/16/2020 at 11:38 a.m. She said on 6/28/2020, she was screened by the facility for COVID-19. She said that morning her temperature was 100.1 degrees and she reported she had a fever the previous day (over 100 degrees), a new cough, but her SOB was not new because she always had SOB. She said she reported she had visited with her cousin who had been exposed to someone who was positive COVID-19 in the last few days. She said she was sent home for her symptoms and she did not work the following day, but worked Tuesday and Wednesday (6/30/2020 and 7/1/2020). She said no one at the facility told her to self-quarantine; she said she was not provided any education to not return to work for 72 hours or until she did not have any symptoms of COVID-19 and was not told to test herself for COVID-19 until later instructed by the agency to get tested . 6. The medical director was interviewed on 7/10/2020 at 10:30 a.m. He said he rounded at the facility frequently at least twice a week to provide guidance to the facility staff. He said he attended quality assurance performance improvement (QAPI) meetings monthly. The most recent meeting was 6/17/2020. He said he was aware of staff were not following PPE infection control process, not following the CDC guidelines and said he gave guidance on proper use of PPE, and shared the latest recommendations regarding COVID-19. He said agency staff needed to follow the facility protocols, and he expected the facility to provide training with latest recommendation on appropriate procedures. He said the facility tested all their residents this last week for COVID-19 and all were negative so far. He said he was aware of the immediate jeopardy situation. He said shortly after the June QAPI meeting, they discussed Resident # 1 noncompliance with facility directive not to leave the facility. He said the DON told him Resident #1 left the facility to go shopping, so he told the facility to isolate the resident immediately. He said the DON was out of town but he spoke with managerial staff at the facility and told them to isolate the resident. He said a couple of months ago the facility tested all their staff for COVID-19 and all were negative, but they had not completed any staff testing since then. He said moving forward, the facility planned to complete weekly testing for COVID-19 for eight weeks. V. Facility follow-up after survey exit The facility provided documentation of staff education via email on 7/15/2020 at 1:05 p.m. The documentation revealed, initially, 44 staff were educated on droplet precautions, proper use of PPE with return demonstration, and employee and visitor screening from 7/9/2020 to 7/10/2020. There were also 20 agency staff who had signed they received education on droplet precautions and PPE with return demonstration from 7/9/2020 to 7/13/2020.