STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065092	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLA MANOR CARE CENTER	7950 W MISSISSIPPI AVE LAKEWOOD, CO 80226

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 maintain an effective infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection such as COVID-19 for four of six units observed for infection control practices and four (#1,#2, #5 and #6) of four residents reviewed for resident screening. Specifically, the facility failed to ensure: -Adequate hand hygiene/glove use for staff and hand hygiene for residents; -Personal protective equipment (PPE) was used correctly; -Resident care equipment was cleaned; -Residents #1, #2, #5 and #6 were screened timely for signs and symptoms of COVID-19; -Isolation procedures were followed for Resident #1; and -Staff screening was completed per protocol. Findings include: I. COVID-19 status in the building The director of nurses (DON) was interviewed on 6/18/2020 at 3:50 p.m. She said they currently had no positive COVID-19 residents or staff in the building. She said they had 20 deaths confirmed from COVID-19, overall. Review of the COVID-19 positive resident list, provided by the DON on 6/18/2020 at 12:30 p.m. revealed positive cases occurred in the time frame from 5/2/2020 through 5/28/2020. II. Hand hygiene and glove use A. Facility policy and CDC reference Review of the CDC website: https://www.cdc.gov/handhygiene/providers/guideline.html, last revised 1/30/2020 (retrieved 6/24/2020), revealed in part, Healthcare personnel (HCP) should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: immediately before touching a 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. Review of the hand hygiene for residents policy, revised 4/16/2020, provided by the DON on 6/18/2020 at 5:35 p.m. revealed in part, Staff will encourage and assist the resident as needed to ensure proper hand hygiene through hand washing or the use of an alcohol-based hand rub .hand hygiene should be offered/performed .prior to the handling and/or consumption of food and drink. Review of the coronavirus (COVID 19) policy, revised 5/22/2020, provided by the DON on 6/17/2020 at 9:07 a.m. revealed in part, Perform proper hand hygiene with soap and water or alcohol-based hand rub (ABHR) before and after all resident contact .contact with blood, body fluids, or visibly contaminated surfaces; before applying gloves; after removing gloves; prior to removal of face shield/eye protection and/or respirator during the doffing of PPE process .after touching or adjusting face mask or face covering .before performing a procedure. B. Certified nursing assistant (CNA) #5 breakfast observation and interview CNA #5 was observed on 6/17/2020 at 8:13 a.m. passing out trays for breakfast. She went over to the food cart and picked up a tray. She brought the tray into room [ROOM NUMBER] and placed it on the resident's bedside table. She left the room and walked back to the food cart, without sanitizing. She picked up another tray and brought it to room [ROOM NUMBER]. She placed the tray onto the resident's bedside table. CNA #5 moved the resident in her wheelchair by grabbing the resident's wheelchair handles. She moved the call light and grabbed the resident's wheelchair handles again. She proceeded to put on gloves. No hand washing or sanitizing was completed. She fixed the resident's tray with her gloved hands. She moved the residents menu off to the side. She reached down and grabbed the residents shoes with her gloved hands and then moved the table towards the resident. CNA #5 moved the table around for the best fit. She grabbed the resident's feet to place on the bar underneath the table. She moved things off of the resident's table to make room for her tray. She grabbed the resident's silverware. She grabbed the resident's head band and placed it on the residents head. She grabbed the residents spoon and opened the residents juice carton. She completed all the above tasks with the same pair of gloves. She took the gloves off at 8:19 a.m. She proceeded to wash her hands in the residents sink for less than 10 seconds. She grabbed another pair of gloves and put them on. She moved the resident's table around again and moved the resident's feet to place on/over the bar underneath the table. She moved items around on the resident's tray with the same pair of gloves. Staff did not offer or assist the resident with hand washing or sanitizing prior to the meal. CNA #5 took another tray into room [ROOM NUMBER]. She moved items on the resident's table and placed the tray down on the bedside table. No hand washing was observed. He put gloves on and proceeded to move beverages around. She set up the resident's tray. She picked up the resident's toast with her gloved left hand. She cut up the resident's food. She touched the tissue box and stacks of paper with her gloved hands. She placed a napkin on the resident. She adjusted the beverages and placed a straw into the residents drink to mix up the beverage. No hand washing or sanitizer use was observed. The resident was not offered hand washing or sanitizer prior to the meal. CNA #5 put on another pair of gloves and proceeded to help the resident's roommate to the bathroom. The DON was interviewed on 6/18/2020 at 3:50 p.m. She said they had trained staff on hand hygiene and sanitization. She said they had sanitizer at each isolation cart, nursing cart, nursing station and dispensers throughout the halls. She acknowledged staff needed to complete hand hygiene between residents. She acknowledged gloves were used for one task and done. She said they had completed ongoing education with the staff. C. Observations and interviews On 6/17/2020 at 6:16 a.m., certified nurse aide (CNA) #4 was observed delivering ice to residents in the lower numbered rooms on the 500 unit. CNA #4 entered resident rooms, picked up their used plastic water cups, carried the cups to the ice chest, removed the cup lids and filled the cups with ice. When requested, by the resident, the CNA filled the water cups with tap water from the resident's in room sink. The CNA replaced the lids and left the cup for the resident. On occasion the CNA was observed arranging items on a resident bedside table so the resident could reach their water cups. CNA #4 did not perform hand hygiene in-between resident contact, after handling potentially contained items in the resident's room or before going to the next resident's room to fill their water cups. On 6/17/2020 at 7:45 a.m., CNA #4 was observed on the other end of the unit 500 delivering ice to residents. She continued ice delivery in the same manner as described in the above observation without performing hand hygiene before or after each resident contact. On 6/17/2020 at 8:00 a.m., licensed practical nurse (LPN) #2 was observed delivering a room tray to a physically dependent resident who needed assistance eating. The nurse setup the resident's tray and began feeding the resident. LPN #2 did not offer or assist the resident to hand hygiene before the resident started to eat the meal. On 6/17/2020 from 8:02 a.m. to 8:30 a.m. breakfast service was observed. CNA #1 and CNA #2 were observed delivering room trays to resident's on the 500 unit. Neither CNA reminded or offered to assist the resident's to perform hand hygiene before they were served and ate their breakfast. Neither CNA performed hand hygiene for themselves in between resident contact; even after, handling and rearranging the resident's personal items on their bedside tables and setting up the resident's meal; including the handling the bed controller to raise the bed and positioning the bedside table so the resident's meal was in reach. On 6/17/2020 at 8:15 a.m., LPN #1 was observed delivering a breakfast tray to a resident in isolation with droplets and contact precautions. LPN #1 put on full personal protective equipment and entered the resident's room with his meal. She did not offer to assist the resident with hand hygiene before serving his breakfast. While inside the room with gloved hands the LPN handled the resident's bed controller to raise the head of his bed, the joystick of his electric wheelchair to move it and positioned his bedside table so he could reach and eat his meal. After handling potentially contaminated items in the resident's room she raised up her protective isolation gown and with her unwashed gloved hand brushed against her uniform. She then put her unwashed gloved hands in one pocket then the other to find a pen. She removed and handled several items inside of her pocket and placed the items back inside her pocket before finding a pen. Upon exiting the room

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** - Many	(continued... from page 1) the LPN sanitized the pen she used but not her uniform top or the other items in her pocket that she handled. On 6/18/2020 from 11:58 a.m. to 12:25 a.m., lunch service was observed. CNA #3 and CNA #5 were observed delivering room trays to resident's on the 500 unit. CNA #3 who delivered all but five room trays. CNA #3 did not remind or offer to assist any resident's to perform hand hygiene before they were served and ate their breakfast. On 6/18/2020 from 12:05 a.m. to 12:22 a.m. LPN #1 was observed taking meal trays into two separate residents who were in isolation with droplet and contact precautions. LPN #1 did not remind or offer either resident an opportunity to perform hand hygiene before they were served or ate their lunch meal. LPN #2 was interviewed on 6/ 20 at 3:10 p.m. LPN #2 said residents were to be reminded and/or assisted to wash their hands after using the bathroom, upon getting up in the morning before going to bed, before meals, and when visibly dirty. D. Additional hand hygiene observations and interviews On 6/17/2020, from 8:12 a.m. to 8:21 a.m., several staff members were observed delivering breakfast trays to rooms 302, 304, 305, 306 and 308. They did not offer the residents a way to sanitize their hands prior to eating. -At 8:23 a.m., certified nurse aide (CNA) #6 was seen delivering a breakfast tray to isolation room [ROOM NUMBER]. She did not offer the resident a way to sanitize his hands prior to eating. -At 8:38 a.m., three alcohol based hand rub (ABHR) dispensers were seen on the wall of the 300 hall. One of the dispensers was empty. Housekeeping aide (HA) #1 said housekeeping was responsible for ensuring the ABHR dispensers were kept full for staff use. When he notified HA #2, assigned to hall 300, the dispenser needed to be filled, she said, We don't have any more hand sanitizer. The nursing home administrator (NHA) was interviewed on 6/17/2020 at 8:50 a.m. She said, We have plenty of ABHR, I don't know why they don't ask or look for it. HA #2 was interviewed on 6/17/2020 at 8:55 a.m. She said, I assumed we were out of hand sanitizer because when I looked for it in my closet, there was none there. She said she did not ask anyone where to find it, so the dispenser on the 300 hall remained empty. She acknowledged the housekeeping department was responsible for ensuring the dispensers were full at all times. The maintenance director (MD) was interviewed on 6/17/2020 at 8:55 a.m. He said, If the housekeepers were in need of supplies and could not find them, they were to ask me to replenish their supply. The ABHR dispensers should never be empty. Resident #7 was interviewed on 6/18/2020 at 12:25 p.m. He said he was not offered hand sanitization prior to eating his meals. Resident #8 was interviewed on 6/18/2020 at 12:40 p.m. She said when her meal trays were brought in by staff, they did not offer her hand sanitization prior to eating the meals. The DON was interviewed on 6/18/2020 at 4:00 p.m. She said staff were to offer residents a way to sanitize their hands prior to meals. She said hand hygiene should routinely be offered before and after meals, whether it was washing with soap and water or using ABHR. III. PPE usage A. Facility policy and CDC reference Review of the CDC website: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, updated 6/22/2020 (retrieved 6/23/2020), revealed in part, HCP should wear a facemask at all times while they are in the facility .Make necessary PPE available in areas where resident care is provided. Review of the coronavirus (COVID 19) policy, revised 5/22/2020, provided by the DON on 6/17/2020 at 9:07 a.m. revealed in part, All facility associates should wear a facemask/face covering while they are in the facility for the duration of the state of emergency in their state .Implement a process for decontamination and reuse of PPE such as face shields and goggles. Review of the PPE policy, revised 5/29/2020, provided by the DON on 6/18/2020 at 5:35 p.m. revealed in part, Mask ties should be secured on the crown of head (top tie) and base of neck (bottom tie). If the mask loops, hook them appropriately around your ears . Review of the undated Droplet/Contact Precautions, and PPE signage, provided by the DON, on 6/18/2020 at 5:30 p.m., read in pertinent part: Remove face protection before room exit, clean and disinfect reusable equipment, and please remove personal protective equipment consistently when exiting the room in this order; -Gloves -Gown -Perform hand hygiene -Goggles/face shield -Mask or N95 respirator B. Observations and interviews On 6/17/2020 at 5:35 a.m. unit 500 was observed. Two residents were on isolation with droplet and isolation precautions. The entry points to both rooms were clearly marked with signage to alert staff of necessary precautions. The precaution signs read in pertinent part: Stop - contact precautions - everyone must: Put on gloves before room entry discard gloves before room exit. Put on a gown before room entry, discard gown before room exit. Use dedicated and disposable equipment .Make sure your eyes, nose and mouth are fully covered before room entry. Remove face protection before room exit. On 6/17/2020 at 6:35 a.m. CNA #4 was observed entering a room where a resident was in isolation with droplet and contact precautions. There was an isolation supply cart continuing disposable gowns, gloves, a face shield, surgical masks, biohazard trash bags just outside of the room. The CNA put on gloves, a disposable gown. She did not put on any eye protection, face shield or did she apply a secondary surgical mask over her N95 mask to protect the N95 mask from being contaminated with the resident's respiratory secretions. After providing care and getting the resident out of bed, CNA #4 continued to wear her N95 mask to care for other residents throughout the shift. CNA #4 was interviewed on 6/17/2020 at 7:55 p.m. She said the facility provided staff with a reusable face shield and disposable surgical masks to wear when providing care to a resident on isolation precautions. The face shield was to protect the staff eyes if the resident were to cough and the second mask kept the N95 mask from becoming contaminated. Staff were instructed to use full PPE while providing resident care to those in isolation. The face shields were stored inside of the isolation cart for staff use. LPN #2 was interviewed on 6/18/2020 at 3:10 p.m. LPN #2 said staff were to wear full PPE including a face shield and an extra mask on top of N95 mask when they entered the room of a resident in isolation. Once care was complete they were to dispose of the outer mask and remove and sanitize the face shield for reuse. The director of nursing (DON) was interviewed on 6/18/2020 at 4:00 p.m. The DON said all staff were to wear an N95 mask when in the facility. When entering an isolation room she expected staff to wear full PPE including a face shield and a second surgical mask, both were to be removed when exiting the resident's room after providing care. C. Additional observations and interviews On 6/17/2020 at 6:02 a.m., CNA #6 was seen on the 100 hall wearing an N95 mask with the top strap over the top of her head and the bottom strap dangling below her chin. She had a pair of goggles on top of her head. She exited the building wearing the N95 mask and the goggles. At 6:06 a.m., she re-entered the building from the basement stairs with the PPE still on. -At 6:08 a.m., CNA #5 was seen wearing a pair of goggles on top of her head entering and exiting multiple resident rooms on the 100 hall. -At 6:10 a.m., an isolation cart was seen outside room [ROOM NUMBER]. Signage was posted near the door for contact/droplet isolation. The door to the room was open. There was a face shield lying loose on top of the cart alongside gloves and oxygen tubing. There were no surgical masks, on top of or in the isolation cart, for the staff to use. -At 8:23 a.m., CNA #6 prepared to deliver a breakfast tray to isolation room [ROOM NUMBER]. She was still wearing the goggles on top of her head. She did not sanitize her hands and without applying gloves, reached up and slid the goggles down over her eyes. She was wearing an N95 mask and did not place a surgical mask over it prior to entering the isolation room. After placing the disposable dinnerware onto the resident ' s over-bed table she went to the doorway, stepped out in the hall,wearing full PPE, and placed the empty tray on top of the isolation cart, outside the door. The tray was not placed in a plastic bag. She re-entered the room, removed her gloves, and washed her hands. She then grabbed the isolation gown, from the front, around the neck and pulled it, snapping the ties at the neck and behind her back. She did not remove or disinfect the goggles, exited the isolation room and entered non-isolation room [ROOM NUMBER], also wearing the same N95 mask, to assist those residents with breakfast and to take their lunch meal order. -From 8:28 a.m. to 8:41 a.m., CNA #6 was seen entering non-isolation rooms [ROOM NUMBER] to obtain residents ' meal orders. She still wore the same N95 mask and goggles she wore when she exited isolation room [ROOM NUMBER]. -At 8:38 a.m., HA #1 was seen wearing an N95 mask with the top elastic strap above his head and the bottom strap dangling below his chin. On 6/18/2020 at 11:40 a.m. CNA #6 was seen near the nurses station, wearing an N95 mask with the lower elastic strap again dangling below her chin. -At 12:35 p.m., two face shields were seen lying loose on top of an isolation cart outside room [ROOM NUMBER], as well as an open paper bag that contained an N95 mask. -At 3:05 p.m., CNA #7 was observed on the 300 hall passing ice water to residents. She was wearing a cloth mask over an N95 mask. The N95 mask did not have a top elastic strap and the bottom strap was dangling below her chin. She was interviewed and said she was using the cloth mask to keep the N95 mask in place because it was loose and missing the top strap. She said the N95 mask she had was different from the the ones they have here. She said she wore the N95 mask and the cloth mask over it because it was more comfortable for her that way. She said she had the N95 mask since the beginning of May and she had been out sick because she developed COVID-19 symptoms, and recently came back to work. She said she had not told anyone she needed a new N95 mask. She thought there were more downstairs, but I couldn ' t find one. The DON was interviewed on 6/18/2020 at 4:00 p.m. She said the N95 masks were reused and changed after five working shifts. They were to be kept in paper bags in the break room, labeled with the staff member ' s name. She said the facility had plenty of N95 masks and if a staff member needed a new one they should ask for one. She said staff were to wear a surgical mask over the N95 mask if they entered an isolation room and they were to discard it before exiting the room. She said both straps of the N95 mask were to be used with the top strap over the top of the head and the lower strap behind the neck. She said staff were not to wear a cloth mask over an N95 mask or at any time while on duty. She said the goggles and face shields were to be disinfected after use

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) in an isolation room and stored in a paper bag or a drawer of the isolation carts. On 6/18/2020 at 5:58 p.m., an unknown nurse was seen seated at the nurse ' s station with her N95 mask below her nose with the top elastic strap dangling in front of her face and the bottom strap behind her neck. D. Facility follow-up On 6/18/2020 at 6:15 p.m., after the DON was made aware of the above breaks in infection control, she said CNA #7 was provided a new N95 mask and the unknown nurse at the nurse ' s station, wearing her N95 improperly, was educated on the correct way to wear the mask. IV. Resident care equipment A. Facility policy Review of the CDC website: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, updated 6/22/2020 (retrieved 6/24/2020), revealed in part, Develop a schedule for regular cleaning and disinfection of shared equipment, frequently touched surfaces in resident rooms and common areas. Review of the coronavirus (COVID 19) policy, revised 5/22/2020, provided by the DON on 6/17/2020 at 9:07 a.m. revealed in part, Assign dedicated resident care equipment to the cohort unit. Cleaning and disinfection of shared equipment should be performed between residents and the equipment should not leave the cohort unit. Review of the cleaning and disinfection of non-critical patient care equipment, revised 3/13/2020, provided by the DON on 6/18/2020 at 5:35 p.m. revealed in part, non-critical patient care equipment is cleaned daily and before and after re-use . B. Observations and interviews On 6/17/2020 at 7:11 a.m., CNA #1 was observed taking resident vital signs. CNA #1 took the entire reusable vital sign rolling cart and equipment (blood pressure cuff and machine, thermometer and pulse oximetry machine with rolling cart) into two resident rooms where residents were on isolation with droplet and contact precautions. The CNA did not clean or sanitize the entire vital signs rolling cart or all parts of the equipment that she took into either of the isolation rooms before taking the equipment into the room of a resident not in isolation. Both rooms were clearly marked with signs that read in pertinent part: Stop -Use dedicated and disposable equipment. CNA #1 was interviewed on 6/17/2020 at 7:25 a.m. CNA #1 said they did not have a separate blood pressure cuff for resident's on isolation, so she had to take the whole vital signs cart into the resident's room. Because the resident was in isolation the whole machine had to be cleaned after using it in the isolation rooms. LPN #2 was interviewed on 6/18/2020 at 3:10 p.m. LPN #2 said when a resident was in isolation or was COVID-19 positive, staff should use the disposable tempa dots thermometers, a dedicated stethoscope, blood pressure cuff and pulse oximetry device to monitor the resident's vital signs. If staff took the whole vital signs cart into the resident's room they should clean and sanitize the whole cart and equipment on the cart and all items on the cart before taking the vital signs cart into any other resident's room. LPN #1 was interviewed on 6/18/2020 at 3:22 p.m. LPN #2 said the unit had dedicated vital signs equipment for residents in isolation, but stethoscopes were not easy to use. She preferred to bring the entire vital signs cart into the resident's room because it was better quality. After use in an isolation room the entire cart and all equipment had to be cleaned and sanitized properly before being reused with any other resident. The DON was interviewed on 6/18/2020 at 4:00 p.m. The DON said staff were to use dedicated vital signs equipment when monitoring resident's on isolation. They should not be taking reusable medical equipment into a resident's room while they were in isolation. V. Staff screening A. Facility policy and CDC reference Review of the CDC website: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, updated 6/22/2020 (retrieved 6/23/2020), revealed in part, Screen all HCP at the beginning of their shift for fever and symptoms of COVID-19. Actively take their temperature and document absence of symptoms consistent with COVID-19. Review of the coronavirus (COVID 19) policy, revised 5/22/2020, provided by the DON on 6/17/2020 at 9:07 a.m. revealed in part, All associates will be actively screened at the beginning of their shift in accordance with current guidance .This screening will include questions about COVID-19 symptoms, and if they work in another location where COVID-19 has been identified. The associate must also have their temperature actively taken to rule out fever .Associate screening to be increased to twice a shift, once at the start and once at the end of the shift. B. Observations and interviews Licensed practical nurse (LPN) #3 took the survey team to the facility conference room on 6/17/2020 at 5:35 a.m. without COVID-19 screening. LPN #3 completed COVID-19 screening at 5:58 a.m. (approximately 18 minutes after entering the facility). The front entrance was observed on 6/17/2020 at 6:19 a.m. There were two staff members near the front desk. One staff member was taking her own temperature and filling out the screening form in a book at the front desk. She said she worked in laundry. CNA #2 was standing behind her. They said they entered the facility from the back door and walked to the front entrance for screening. CNA #2 said a nurse was supposed to take their temperature. The laundry employee said they needed to document their temperature with a witness. She passed a pen to CNA #2 without sanitizing. There was no nurse present to take the staff temperatures. The two staff members proceeded into the facility. No hand hygiene was observed. Review of the sign at the front desk on 6/17/2020 at 6:25 a.m. revealed Please ask a nurse to take your temperature or take your own temperature using the attached dots. Place the dotted side under your tongue for one minute. When they change color, you will be able to read your temperature. Thank You. The front entrance was observed again on 6/17/2020 at 6:34 a.m. A staff member was at the front desk taking his own temperature and filling out a section in the screening book. He was wearing a disposable gown. He said he worked in dietary. No nurse was present to complete his screening. He did not have a witness and proceeded into the facility without hand hygiene. The executive director (ED) was interviewed on 6/17/2020 at 7:30 a.m. She said the staff was not supposed to enter the facility from the back door. She said they were supposed to enter the facility using the front entrance. She said when the receptionist was not at the front desk, staff was supposed to get a nurse for screening. She acknowledged the dietary employee performed improper practice. She acknowledged the survey team should not have been allowed to enter the facility without being screened. She said they reinforced sanitizing and had a dispenser at the entrance. The DON was interviewed on 6/18/2020 at 3:50 p.m. She said staff should have been screened by someone else. She said staff was not supposed to self screen. She said the screener filled out the signs and symptoms sheet and took the staff's temperature. She said the book was stored at the nursing station after hours. She said they took staff temperatures twice; when they came into the facility and again when they left. She said she was not aware of the sign displayed at the front desk. She said the receptionist put the sign out for the staff. She said the sign was not accurate and should not have been followed. She said they completed continued education with the staff. VI. Isolation procedures A. Facility policy and CDC reference Review of the CDC website: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, updated 6/22/2020 (retrieved 6/23/2020), revealed in part, Residents in the facility who develop symptoms consistent with COVID-19 could be moved to a single room pending results of [DIAGNOSES REDACTED]-CoV-2 testing .While awaiting results of testing, HCP should wear an N95 or higher level respirator (or facemask if a respirator is not available), eye protection .gloves, and gown when caring for these residents. Review of the coronavirus (COVID 19) policy, revised 5/22/2020, provided by the DON on 6/17/2020 at 9:07 a.m. revealed in part, If fever or symptoms consistent with COVID-19 are present, immediately isolate and implement appropriate transmission based precautions. This resident should be prioritized for testing .Residents who develop symptoms or are moved to the unknown unit secondary to an exposure to a positive resident should remain in a private room for the duration of the 14 days. Prioritize for testing .Healthcare personnel at risk of exposure to an individual presenting with signs and symptoms and exposure criteria consistent with COVID-19 should also adhere to infection control precautions (contact and droplet), including eye protection. B. Observations Review of the resident rooms in isolation revealed: -room [ROOM NUMBER]- the isolation cart had no gowns, no masks and no sanitizer. -room [ROOM NUMBER]- the isolation cart had no masks. C. Resident #1 1. Resident status Resident #1, age 74, was admitted on [DATE]. According to the June 2020 computerized physician orders [REDACTED]. The 5/11/2020 minimum data set (MDS) exam revealed the resident had intact cognition with a brief interview for mental status (BIMS) score of 14 out of 15. His primary medical condition category reason for admission was debility of cardiorespiratory condition. Active [DIAGNOSES REDACTED]. He was on oxygen therapy. 2. Record review Resident #1s care plan read in pertinent part: -Requires droplet isolation due to new onset of a cough, initiated: 4/2/2020. Goal: Symptoms will resolve without complication. Signs of infection will not worsen or spread to others. Interventions: May remove from isolation when a resident has gone 72 hours symptom free. The electronic medical record revealed Resident #1 developed a chronic nonproductive cough starting 4/1/2020. He was immediately placed in isolation with respiratory droplet precautions due to a chronic cough while the interdisciplinary team (IDT) examined the potential root cause of his symptoms. The resident believed his symptoms were due to allergies and the IDT ruled out a [DIAGNOSES REDACTED]. The resident was removed from isolation on 4/6/2020, despite continued symptoms. The resident cough continued and progressed over the next 30 days. The Resident's family reported his cough was progressively worsening and the resident was tested for COVID-19 on 5/7/2020. The resident's symptoms developed; his coughing continued, he experienced respiratory distress with a significant drop in oxygen saturation levels dropped and he developed a temperature. On 5/8/2020 the resident was sent to the hospital for evaluation and treatment of [REDACTED]. He was prescribed antibiotic therapy. On 5/19/2020 lab test results, returned a confirmed [DIAGNOSES REDACTED]. -4/2/2020, 1:03 a.m., Resident #1 was prescribed [MEDICATION NAME] syrup 10 milligrams (MG) every six hours as needed for coughing. -4/2/2020, 1:03 a.m.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065092	A. BUILDING _____ B. WING _____	**06/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLA MANOR CARE CENTER	**7950 W MISSISSIPPI AVE LAKEWOOD, CO 80226**

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	(continued... from page 3) resident received 10 MG of [MEDICATION NAME] syrup to resident for coughing. -4/2/2020, 1:03 p.m., resident received 10 MG of [MEDICATION NAME] syrup to resident for coughing. -4/2/2020, 7:36 p.m., resident received 10 MG of [MEDICATION NAME] syrup to resident for coughing. -4/3/2020, 3:06 a.m., health status note: Resident stated on cough syrup for non-productive cough. -4/3/2020, 10:18 a.m., resident received 10 MG of [MEDICATION NAME] syrup to resident for coughing. -4/3/2020, 4:57 p.m., resident received 10 MG of [MEDICATION NAME] syrup to resident for coughing. -4/4/2020, 8:53 a.m., resident received 10 MG of [MEDICATION NAME] syrup to resident for coughing. -4/4/2020, 4:51 p.m., resident received 10 MG of [MEDICATION NAME] syrup to resident for