STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065408	A. BUILDING _____ B. WING _____	05/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKEWOOD VILLA	1625 SIMMS ST LAKEWOOD, CO 80215

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 follow an effective infection 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. Specifically, the facility failed to: -Ensure residents were offered hand hygiene before meals; -Ensure housekeeping performed hand hygiene between rooms, after removing gloves while cleaning a resident's room; -Ensure housekeeping followed labeled cleaning instructions on the disinfectant used to clean resident rooms; and, -Ensure housekeeping followed the proper procedural steps when cleaning a resident's room. Findings include: I. Professional standards According to the Centers for Disease and Prevention (CDC) Hand Hygiene in Healthcare Settings, last up updated 1/31/2020, retrieved from https://www.cdc.gov/handhygiene/providers/index.html, included the following recommendations: Multiple opportunities for hand hygiene may occur during a single care episode. Following are the clinical indications for hand hygiene: Use an alcohol-based hand sanitizer immediately before touching a patient, before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same 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. Wash with soap and water when hands are visibly soiled, after caring for a person with known or suspected infectious diarrhea, and after known or suspected exposure to spores. When using alcohol-based hand sanitizer, put the product on hands and rub hands together. Cover all surfaces until hands feel dry. This should take around 20 seconds. When cleaning hands with soap and water, wet hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Avoid using hot water, to prevent drying of skin. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times. II. Facility policies and procedures A. The coronavirus/COVID-19 policy, dated 4/13/2020, was provided on 5/4/2020 by the infection control specialist (ICS). The policy read in pertinent part: To provide guidance to long term care providers on how to prepare for COVID-19, emerging infectious disease (EID), whose incidence in humans has increased or threats to increase in the near future and that has the potential to pose a significant public health threat and danger of infection to the residents, families and staff of the skilled nursing center Goal: To protect our residents, families, and staff from harm resulting from exposure to emerging infectious disease while in the facility Staff will be educated on the exposure risks, symptoms, and infection prevention and control, use of PPE, transmission based precautions, and hand hygiene Environmental cleaning: the facility will follow CDC guidelines for environmental cleaning in addition to routine cleaning for the duration of the threat. B. The COVID-19 ongoing education, dated 4/15/2020, read in pertinent part: Staff will encourage resident hand hygiene upon arising, after toileting, before and after meals, and at bedtime Resident handwashing: Clothes are to be retrieved from laundry prior to meals and placed in a plastic bin. Cover with hot water, distributed for hand washing with tongs and retrieved from residents prior to meals. Dirty cloths are to be returned to laundry after meals. III. Secured unit A. Observations The all men's secured neighborhood was observed on 5/4/2020 between 10:15 a.m. and 12:15 p.m. At 10:21 a.m. four residents sat in the dining room, including Resident #1 and Resident #2. Both residents wore cloth masks covering over their nose and mouth. The residents sat at individual tables. Resident #3 sat in the front lobby. Resident #4 walked up and down halls and in and out the outside smoking area talking on a cell phone. No observations of hand hygiene offered in the dining or common areas. Between 10:21 a.m. and beginning of the lunch meal service, Resident #1 and Resident #2 touched their masks multiple times. Resident #2 touched the wheels of his wheelchair. Resident #1 used his mask he had removed to wipe his nose. There were no observations of hand hygiene offered to either resident. -At 11:38 a.m., certified nursing aide, (C.NA) #1 recorded the temperatures of four residents sitting in the lobby, as well as and the temperatures of Resident #1 and Resident #2 in the dining room. Hand hygiene was not offered. -At 11:42 a.m., licensed vocational nurse (LVN) #2 walked Resident #3 from the lobby, held his hand and guided him to his table. She did not offer hand hygiene when he was in the lobby, when entering the dining room, or after holding his hand. The LVN remained in the dining room during the duration of the lunch service, serving the plated meals. -At 11:45 p.m. Resident #3 was first to be served his meal. He was not offered hand hygiene. -At 11:47 Resident #2 continued to touch the outside of the mask, then he removed his mask. He was served his meal without hand hygiene. Five other residents sat in the dining room. They were not offered hand hygiene before meals. -At 11:50 a.m., C.NA #1 assisted Resident #5 to a table, and sanitized his hands with alcohol based hand rub (ABHR). -At 11:55 a.m., Resident #6 observed eating his meal using hands, and placing his fingers in his mouth. LVN 2 observed him placing his fingers in his mouth and encouraged him to use a spoon. There were no observations of the resident hand hygiene prior to him serving his meal or after placing his fingers in his mouth. Resident #4 exited the smoking area, still talking on his cell phone. He sat at a table in the dining room and served his meal. He was not offered hand hygiene Two other residents were served their meal in the lobby, and hand hygiene was not offered. -At 12:01 p.m., Resident #7 self-propelled his wheelchair with his hands. -At 12:02 p.m., Resident #7 was served his lunch. He did not offer hand hygiene before he was served his meal. Eight out nine residents were served in the dining room during the observation period. They were not offered hand hygiene before they were served their meal, increasing the risk of transmission based infections and [MEDICAL CONDITION] to spread to the residents. B. Staff interviews The director of nursing (DON) was interviewed on 5/4/2020 at 9:45 a.m. She indicated the facility did not have active cases of transmission based infections or viruses. She identified the facility was a secured Alzheimer's/dementia facility. The DON said it was very important for her staff to use appropriate infection control practices to prevent the entry of, and spread of transmission based infections [MEDICAL CONDITION], including COVID-19. According to the DON, most residents eat in their rooms. She said some residents eat in the dining room or lobby with tables spaced six feet apart because of the wandering nature of the population and their need for routine. LVN #1, who identified herself as the infection control specialist (ICS) was interviewed on 5/4/2020 at 12:33 p.m. She said resident hand hygiene decreases the potential spread of transmission based infections [MEDICAL CONDITION]. Resident hand hygiene occurs on rise, before going to bed at night, after cares, before meals and throughout the day. Hand hygiene could be done at the resident sink, with alcohol based hand rub (ABHR) or by using the facility's portable hand washing process to include a plastic bin, warm water and soap and fresh towels. The ICS said residents should receive hand hygiene just before they eat because of the high risk that they touched potentially contaminated surfaces. LVN #2 was interviewed on 5/4/2020 at 12:39 p.m. She said resident hand hygiene should be offered upon waking, after toileting and before meals. Hand hygiene for lunch occurred between 10:00 a.m. and 11:00 a.m. daily. She said if a resident was observed touching contaminated surfaces in the dining room, she would assist him out of the dining room and hand wash his hands with soap and water in his room. She said hand sanitizer should not be used on residents for hand hygiene. According to the LVN she said she did not provide hand hygiene to Resident #3 after guiding him

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) by the hand to his table because she felt her hands were clean. The LVN said staff have a portable hand washing process for residents in common areas. She said tongs were used so staff does not have to directly touch the clean surface of the towels offered to the resident. She said the portable hand washing in a plastic bin would not be conducted in the dining room because hand washing would be done outside the dining area. CNA #1 was interviewed on 5/4/2020 at 1:20 p.m. According to the CNA, hand washing with soap and water before meals should occur in resident's rooms if they are eating in their rooms. She said hand hygiene should occur before the resident was served in the dining room. She said residents should be offered hand hygiene in the dining room with either the ABHR or through the portable hand washing process. She said it was important to provide hand hygiene just as they are served their meal because staff may not know all the potentially contaminated surfaces the resident might have touched since their hands were last washed in their rooms. The nursing home administrator (NHA) was interviewed on 5/4/2020 at 4:33 p.m. He said staff education on appropriate infection control practices was ongoing. Education on practices included resident hand hygiene. Resident hygiene in an Alzheimer's/dementia facility had been difficult, however staff needed to continue to make every effort to ensure residents' hands stayed clean. According to the NHA, staff should attempt to provide hand hygiene throughout the day, after care and before every meal. The NHA stated hand hygiene should occur in the dining room, common areas, and resident rooms. The resident hand hygiene observations were reviewed with the NHA. He said it was normal practice of the facility to provide hand hygiene in the dining just before meal service to prevent or decrease the potential spread of infections from contaminated surfaces. He said he regretted that it did not occur during the observation period or according to an interviewed staff member. He said the facility would address the concern and correct it. IV. Improper room cleaning A. Facility policy The Isolation plan for coronavirus disease 2019(COVID-19), dated 4/20/2020, was provided by the director of nursing(DON) on 5/4/2020 at 10:00 a.m. It documented in pertinent parts, cleaning handout for Center housekeeping staff. Help keep residents safe: preventing and stopping the coronavirus is our top priority. How we clean the center is an important part of this starting now: hand washing stations or alcohol-based hand rubs available at all entry ways, frequent cleaning of surfaces like door knobs, countertops, handrails. Follow routine procedures for laundry, food service utensils and medical waste. Supervisors should observe to ensure cleaning is being done correctly. B. Observation On 5/4/2020 at 10:35 a.m., housekeeper (HK) #1 was observed. She exited room [ROOM NUMBER] after cleaning and removed her gloves at her cleaning cart. She donned clean gloves and did not perform hand hygiene. She pushed her cart in front of room [ROOM NUMBER]. She removed her disinfectant (Fuzion) from her cart and proceeded to room [ROOM NUMBER] which was shared with three residents. She started with the bathroom first. She sprayed the disinfectant in the toilet, around the toilet, the grab bars and wall in the bathroom. She went to her cart and returned to the bathroom in approximately one minute and started to clean the toilet using the commode brush (She did not allow the disinfectant to stay on the surface for two minutes. She wiped down the toilet, grabbed bars and the walls with a rag. She mopped the floor and exited the bathroom. She went to her cart and removed her gloves. She donned a clean pair of gloves and did not perform hand hygiene. She sprayed the sink with the disinfectant and immediately wiped it down (again she did not allow the disinfectant to remain on the surface for two minutes), removed another white cloth and went to the sink. She sprayed the disinfectant in and around the sink. She sprayed the disinfectant on a piece of paper towel and wiped down one of the resident bedside tables. She mopped the floor and left the room. She did not clean the other two resident care areas. C. Record review The instruction label on the disinfectant bottle documented: to disinfect, spray six to eight inches from surface until surface is thoroughly wet. Allow this product to remain wet for two minutes. Then wiped. An in-service entitled Preventing Cross contamination after resident care was provided by the ADON on 5/4/2020 at 1:00 p.m. It documented 4/30/2020, we disinfect using Fuzion (a type of disinfectant) we leave it on for two minutes and wipe it down. D. Interviews On 5/4/2020 at 11:15 a.m., HK #1 was interviewed. She said she received training on COVID-19. She said she was provided training to perform hand hygiene between rooms and also to perform hand hygiene every time she removed gloves. She said she had a bottle of hand sanitizer in her cleaning cart but forgot to perform hand hygiene. She said she was not aware how long the disinfectant would remain on the surface before cleaning. She said her normal process when cleaning was to start cleaning the bathroom first. She said she was trained to clean the bathroom first. The ADON who was also the infection control preventionist was interviewed on 5/4/2020 at 11:20 a.m. She said the staff were trained on hand hygiene. She said the training included: hand hygiene before entering and after leaving the resident's room and after removing gloves. She said HK #1 should have performed hand hygiene between rooms and after she removed gloves. She said HK #1 should have cleaned the resident's bedroom before cleaning the toilet. She said the normal process would be to clean the bedroom before cleaning the bathroom. She said she would immediately provide training to HK #1 to prevent the process from reoccurring into the next room. The plant manager (PM) was interviewed on 5/4/2020 at 11:32 a.m. He said he was responsible for housekeeping. He said the house keepers were trained on COVID-19 and how to clean and disinfect the resident's room. He said the process was to start from the resident's bedroom, then move to the bathroom.(clean to dirty) He said hand hygiene should be done between rooms and when gloves were removed. He said they should follow the instruction label on the disinfectant when cleaning. He said the house keepers were provided training on the dwell time of the disinfectant. He said HK #1 should have performed hand hygiene before entering the next room to clean and whenever she removed her gloves. He said HK #1 should have sprayed the disinfectant and allowed it to stay on the surface for two minutes as instructed on the label. He said if the instruction on the label was not followed, the surface would not be properly disinfected and could post a risk of spreading infection. He said he would re-educate HK #1. E. Facility follow-up On 5/4/2020 at 1:00 p.m., an in-service form was provided by the PM. It documented HK #1 was re-educated on the following: Sanitize hands before entering room, after each glove change and upon leaving room and clean from clean to dirty, top to bottom.