STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065108	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLAS AT SUNNY ACRES, THE	2501 E 104TH AVE THORNTON, CO 80233

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary environment and to help prevent the development and transmission of communicable diseases and infections such as Coronavirus disease (COVID-19). Specifically, the facility failed to: -Ensure visitors wore the appropriate personal protective equipment (PPE) while visiting a resident in isolation with droplet precautions; and -Ensure proper hand hygiene procedures were followed. Findings include: I. Professional references According to the Colorado Department of Public Health and Environment, COVID-19 Preparation and Rapid Response: Checklist for Long-Term Care Facilities, Residents admitted or readmitted to the facility should be placed under observation for 14 days with transmission-based precautions according to CDC guidance. According to the Centers for Disease Control (CDC) website, Preparing for COVID-19: Long-term Care Facilities, Nursing Homes https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html (Retrieved 5/7/2020): Enter the room of a patient with known or suspected COVID-19 should adhere to standard precautions and use of respirator, gown, gloves and eye protection. When available, respirators should be prioritized for situations where respiratory protection is most important and the care of patients with pathogens requiring airborne precautions. -The PPE recommended when caring for a patient with known or suspected COVID-19 includes: respirator or facemask, eye protection, gloves, and gowns. -HCP should perform hand hygiene by using ABHR (alcohol based hand rub) with 60-95% alcohol or washing hands with soap and water for at least 20 seconds. II. Failure to ensure a visitor wore PPE while visiting a resident in isolation with droplet precautions A. Observations During a continuous observation on 5/19/19 beginning at 9:27 a.m. a resident room was observed with an isolation cart outside in the hallway. The signage on the door indicated the resident was in isolation. A visitor was observed inside the resident's room in direct contact with the resident. She left the resident's bedside and stood in the hallway, outside the doorway. The visitor was wearing a facial mask. She did not don any other PPE as indicated by the signage on the door. Multiple staff members were observed walking past and engaged verbally with the visitor. The staff did not request or remind the visitor to don appropriate PPE for a resident in isolation with droplet precautions. B. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 5/19/2020 at 9:38 a.m. She said the facility did not allow visitors into the facility, except in [MEDICATION NAME] care situations. She said the director of nursing (DON) had to make the final approval for visitors. The social worker (SW) was interviewed on 5/19/2020 at 10:15 a.m. She said the resident who had a visitor was a resident of the memory care unit. She said the resident had recently been readmitted to the facility from the hospital. She said the resident was placed in isolation with droplet precautions for 14 days as a precautionary measure for COVID-19. She confirmed the visitor inside the resident's room was only wearing a face mask. She said she did not know why the visitor was not wearing the appropriate PPE. She said the visitor should don full PPE prior to entering the room. She said gloves, gown, face mask and goggles were required to enter the resident's room for any staff and visitors. At 10:18 a.m. the SW said the DON told her the resident's family had been provided education earlier that week to don full PPE prior to entering the resident's room. She said a nurse would enter the resident's room and provide additional education to the resident's family. The nursing home administrator (NHA) was interviewed on 5/19/2020 at 11:17 a.m. He said the facility followed the visitation recommendations as directed by the CDC. He said the facility allowed visitors in [MEDICATION NAME] care situations. He said visitors should wear appropriate PPE, such as a gown, gloves, mask and goggles/face shield when entering a resident room in isolation with droplet precautions. He said education had been provided to this particular visitor by the nursing staff earlier in the week. He said staff should have reminded the visitor to don the appropriate PPE prior to entering the room. He said the nursing staff would provide additional education to the visitor. II. Failure to ensure proper hand hygiene A. Observations During a continuous observation on 5/19/19 beginning at 9:27 a.m., the following was observed: -A CNA was observed obtaining ABHR from the wall unit in the resident area hallway. She rubbed it in for four seconds. She was observed walking down the hallway. Before entering a resident's room, she obtained more ABHR. She rubbed it in for six seconds and entered the resident's room. She cleared the breakfast tray, obtained an item for the resident and exited the room. She put the breakfast tray on the cart, obtained ABHR and rubbed it in for seven seconds. During a continuous observation on 5/19/2020 beginning at 11:29 a.m. the following was observed: -At 12:20 p.m. a CNA was observed delivering lunch trays to resident rooms. She entered a resident's room and delivered the lunch tray. She exited the room and obtained ABHR. She rubbed it in for seven seconds. -She entered another resident's room and delivered a lunch tray to one of the residents. She asked the other resident if she wanted to use the restroom and have lunch. The resident refused and she left the room. She did not use hand hygiene after leaving the room. -She entered another resident room with the lunch tray. She delivered the tray and left the room. She obtained ABHR and rubbed it in for four seconds. B. Staff interviews CNA #1 was interviewed on 5/19/2020 at 9:38 a.m. She said ABHR should be rubbed in until it evaporated. She said she was not sure how many seconds were required to rub in the ABHR. The NHA was interviewed on 5/19/2020 at 11:17 a.m. He said the staff should follow the CDC guidelines for the proper hand hygiene use, including the time to rub in ABHR.

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.