STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06A190	A. BUILDING _____ B. WING _____	05/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SPANISH PEAKS VETERANS COMMUNITY LIVING CENTER	23500 US HWY 160 WALSENBURG, CO 81089

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.** Based on observations and interviews, the facility failed to maintain an infection and prevention control program to provide a safe environment to help prevent the development and transmission of COVID-19. Specifically, the facility failed to: -Offer, encourage, or assist residents in with the use of personal protective masks when they were in common areas of the facility; -Ensure adequate hand hygiene was performed; and -Use proper personal protective equipment (PPE) protocol when caring for residents on isolation. Findings include: I. Hand washing A. Professional reference 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. B. Facility Policy The hand hygiene policy was provided by the nursing home administrator (NHA) on 5/1/2020. The policy read in pertinent parts, Hand hygiene includes, washing hands with antimicrobial or plain soap or using antiseptic hand rub or sanitizing wipes. Our facility acknowledges that strict adherence to hand hygiene practices will significantly decrease the spread of infection. Hand Hygiene will be performed in an effort to control infection, transfer of contaminants and reduction of viable microorganisms. The importance of Hand Hygiene compliance should also be stressed to patients, residents and visitors. Alcohol-based hand sanitizers are the most effective products for reducing the number of germs on the hands of healthcare providers. Alcohol-based hand sanitizers are the preferred method for cleaning your hands in most clinical situations. C. Observations On 4/30/2020 at 1:25 p.m., certified nursing aide (CNA) #1 was observed to bring Resident #1 some ice and afterwards sanitized his hands with alcohol based hand rub (ABHR) for less than six seconds. On 4/30/2020 at 1:37 p.m., CNA #4 was observed to use ABHR for eight seconds. An observation on 4/30/2020 at 1:39 p.m., revealed CNA #2 approached Resident #3 who did not have a mask on, she put a mask on him and afterwards sanitized her hands with ABHR for less than six seconds. An observation on 4/30/2020 at 1:48 p.m., revealed CNA #2 sanitized her hands with ABHR for less than six seconds and then proceeded to assist the resident with personal care. An observation on 4/30/2020 at 2:01 p.m., revealed CNA #1 sanitized his hands with ABHR for less than five seconds as he went from Resident #8's room to Resident #9's room. On 4/30/2020 at approximately 2:15 p.m., housekeeper #1 (HSK) was observed to leave a resident room. She then used ABHR and failed to rub her hands for 20 seconds. C. Interview The director of nurses (DON) and the nursing home administrator (NHA) were interviewed on 5/1/2020 1:00 p.m. The DON said the staff were trained on handwashing and that they needed to wash their hands for 20 seconds. She said when training occurred, competencies were also completed. II. Personal Protective Equipment (PPE) A. Facility Policy The COVID-19 isolation plan policy was provided by the nursing home administrator (NHA) on 5/1/2020. The policy read in pertinent parts, All recommended PPE should be worn during care of residents under observations. PPE plan includes use of an N 95 or higher-level respirator (or facemask if a respirator is not available), eye protection (such as goggles or a disposable face shield that covers the front and sides of face), gloves and gown. Cloth face coverings are not considered PPE. B. Observations and interview On 4/30/2020 at 2:00 p.m., a licensed nurse was observed to enter an isolation room. The licensed nurse did not have a gown on as she entered the room. On 4/30/2020 at approximately 2:15 p.m., HSK #1 was observed to enter a isolation room using only a surgical mask and a pair of gloves. The HSK #1 was observed to clean the room without the proper PPE. The HSK #1 was interviewed on 4/30/2020 at approximately 2:30 p.m. The HSK #1 said she had not been trained on how to clean an isolation room. She was not aware that she needed to wear full PPE when she cleaned the isolation rooms. The HSK supervisor was interviewed on 4/30/2020 at approximately 2:30 p.m. The HSK supervisor said the HSK #1 was a new employee and that she had not had the training on isolation rooms. He agreed HSK #1 should of had the training prior to working on the floor. The director of nurses (DON) and the nursing home administrator (NHA) were interviewed on 5/1/2020 1:00 p.m. The NHA said PPE will now be covered on the abbreviated orientation . C. Additional observations on PPE An observation on 4/30/2020 at 2:30 p.m., revealed Resident #11's room had a dispenser for personal protective equipment (PPE) which hung outside of his door. CNA #4 stood in the open doorway of Resident #11's room, removed her gown and gloves while she stood in the doorway and put them in a bin within his room. She then retrieved a brown paper bag, which was among other brown paper bags on the PPE dispenser, and placed the blue surgical mask she wore while in Resident #11's room into the brown paper bag. She put the brown paper bag, which contained the blue mask she used, back with the other brown paper bags on the PPE dispenser. She sanitized her hands with ABHR for less than five seconds. She pulled a yellow surgical mask out of her pocket and donned it and did not sanitize her hands after she donned the yellow surgical mask. An observation on 4/30/2020 at 2:31 p.m., revealed CNA #4 returned to Resident #11's room with ice cream and had an unidentified staff member hold it for her. She removed her yellow surgical mask, put it in her pocket, sanitized her hands with ABHR for less than five seconds, put on a gown and gloves she retrieved from the PPE dispenser outside Resident #11's door, and retrieved a blue surgical mask from the brown paper bag on the PPE dispenser outside Resident #11's door, and entered his room with the ice cream. An observation on 4/30/2020 at 2:35 p.m., revealed the medical director (MD) was present during this observation. CNA #4 stood in the open doorway of Resident #11's room, removed her gown and gloves while she stood in the doorway and put them in a bin within his room. She then retrieved a brown paper bag, which was among other brown paper bags on the PPE dispenser, and placed the blue surgical mask she wore while in Resident #11's room into the brown paper bag. She put the brown paper bag, which contained the blue mask she used, back with the other brown paper bags on the PPE dispenser. She sanitized her hands with ABHR for less than five seconds. She pulled a yellow surgical mask out of her pocket and donned it and did not sanitize her hands after she donned the yellow surgical mask. D. Staff interviews CNA #4 was interviewed on 4/30/2020 at 2:38 p.m. She said residents were to wear masks when outside of their rooms; staff were to encourage them to wear a mask if they did not have one on when outside of their rooms. Staff were to sanitized hands before and after resident care. Staff stored their blue masks in brown paper bags

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 -** Some	(continued... from page 1) outside of Resident #11's door and used them before they went in his room. Each brown paper bag had the staff 's name written on them so they would know which mask was theirs. She put her yellow masks in her pocket when she wore her blue mask. She worked with Resident #11 and other residents in his hallway during her shift. The MD was interviewed on 4/30/2020 at 2:45 p.m. He said Resident #11 was on isolation after his return from the hospital. Although he had a negative test for COVID-19, the facility put him on isolation because it could be a false negative. He observed CNA #4 exit Resident #11's room with a blue surgical mask and saw where she stored it. Staff were to use full PPE to include an N95 mask (not a surgical mask) to enter his room. He was not aware staff entered Resident #11's room without an N95 mask; the facility had not told him about it. Residents were to remain on isolation for 14 days after admission for protection and prevention from COVID-19. Staff were to sanitize their hands before and after resident care, before and after donning/doffing PPE, PPE was to be discarded in the resident's room for residents who were on isolation, the door must remain shut when doffing PPE. He did not feel good about staff storing their masks in paper bags on the PPE dispenser. The facility needed to reeducate CNA #4 and the other staff at this time to protect other residents. It was possible other residents could be infected when staff enter isolation rooms with surgical masks and not N95 masks, and when staff do not perform proper hand hygiene. The director of nurses (DON) and the nursing home administrator (NHA) were interviewed on 5/1/2020 1:00 p.m. The DON said the staff were trained on how to donn and doff PPE. She said the staff had been trained on what the droplet precautions required for PPE. III. Face masks for residents A. Professional reference The Center for Disease Control (CDC), Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings (4/30/2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations. html#minimize, (Update April 13, 2020) Patients may remove their cloth face covering when in their rooms but should put them back on when leaving their room or when others (e.g., HCP, visitors) enter the room. Screening for symptoms and appropriate triage, evaluation, and isolation of individuals who report symptoms should still occur. A. Observations An observation on 4/30/2020 at 1:25 p.m., revealed CNA #1 entered Resident #1's room, approached him, was less than two feet away from him, spoke with him and did not make attempts to assist or encourage him to place a mask or tissue over his nose and mouth. An observation on 4/30/2020 at 1:28 p.m., revealed CNA #5 approached Resident #2, was less than two feet away from him, spoke with him and made no attempts to assist or encourage him to place a mask or tissue over his nose and mouth. An observation on 4/30/2020 at 1:50 p.m., revealed Resident #6 wore his mask under his nose while in a common area with two other male residents; the activity assistant (AA) was in the common area as well and made no attempts to assist or encourage him to place the mask over his nose and mouth. An observation on 4/30/2020 at 1:53 p.m., revealed Resident #7 was in the dining room with his mask off; AA stood less than three feet from him as she spoke with him and made no attempt to assist or encourage him to place his mask over his nose and mouth. An observation on 4/30/2020 at 2:13 p.m., revealed Resident #10 did not have a mask on, he left the dining room and walked passed staff and they made no attempt to provide, assist or encourage him to wear a mask to place the mask over his nose and mouth.