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 _____	05/04/2020

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 -** 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 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 three of three halls and two of two dining rooms. Specifically, the facility failed to ensure adequate hand hygiene during tray delivery and failed to ensure proper mask usage for residents and staff. Findings include: I. Facility policy: Review of the Interim PPE USe Guidelines and Strategies to Optimize the Supply of Equipment policy, dated 4/6/2020, provided by the nursing home administrator (NHA) on 5/4/2020 at 2:00 p.m. revealed in part Face Masks .Homemade masks are not considered PPE, since their capacity to protect team members is unknown. II. Reference Review of the CDC website: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-strategies.html, updated 4/15/2020, revealed in part, Key strategies to Prepare for COVID-19 in Long-term Care Facilities (LTCFs) .Ensure all residents wear a cloth face covering for source control whenever they leave their room or are around others. Review of the CDC website: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html, updated 4/13/2020, revealed in part Standard Precautions assume that every person is potentially infected or colonized with a pathogen that could be transmitted in the healthcare setting . Patients and visitors should, ideally, be wearing their own cloth face covering upon arrival to the facility. If not, they should be offered a facemask or cloth face covering as supplies allow, which should be worn while they are in the facility .Healthcare facilities should ensure that hand hygiene supplies are readily available to all personnel in every care location. III. Observations, record review and interviews The receptionist was observed screening everyone entering the facility on 5/4/2020 at 12:00 p.m. His mask was not covering his mouth or his nose. At 1:27 p.m., the receptionist was wearing a mask, not covering his nose. The main dining room was observed on 5/4/2020 at 12:11 p.m. One of the residents was observed without a mask and coughing. Four residents were observed in the dining room and only one resident had a mask. This mask was not on the resident. Freedom hall dining room was observed on 5/4/2020 at 12:15 p.m. Three residents were at a table sitting right next to each other. They were not social distancing and they were not wearing masks. Five residents were sitting at another table and were not social distancing. They were sitting right next to each other and were not wearing masks. Licensed practical nurse (LPN) #1 was observed in the Freedom hall dining room and wearing a cloth mask. The mask was not covering her mouth or nose. She was not wearing a surgical mask. She said she did not know why the residents did not have masks. She said the residents were supposed to be sitting away from each other. Dining room service was observed on Freedom hall on 5/4/2020 at 12:21 p.m. Certified nurse aide (CNA) #3 was observed taking a tray from the cart and placing it in front of a resident. No hand hygiene was performed prior. She assisted the resident in cutting up her food. She was observed taking another tray off the cart and giving to another resident in the dining room. Afterwards, she took another tray with disposables from the cart and took the tray to a resident ' s room without hand hygiene. She then adjusted the height of the bed (HOB), touched the remote and put a straw into the resident ' s drink. No hand hygiene was observed. -At 12:28 p.m., she took another tray off of the cart and took it to room [ROOM NUMBER] with no hand hygiene. She touched the residents wheelchair handles, table and picked trash off of the floor. No hand hygiene was observed. She then proceeded to wheel this resident into the dining room and placed her next to another resident. No social distancing was observed. She got the straw out and placed it into a beverage. She also took the residents' lids off. No hand hygiene noted. The resident ' s hands were not washed before she left her room or at the dining room table. The CNA was observed to have sanitized her hands at 12:40 p.m. CNA #3 was interviewed on 5/4/2020 at 12:40 p.m. She said they sanitized the residents hands when they brought the residents to the dining room. She said most residents were capable of doing it themselves and were independent. She said she would sanitize after leaving the residents rooms. Registered nurse (RN) #1 (Infection control) staff was interviewed on 5/4/2020 at 1:01 p.m. She acknowledged the person screening should have had his mask on. She said the residents should have masks on when leaving their rooms. She also said the residents should have been at least six feet from each other. She said all staff needed to monitor. She said the staff should have been sanitizing the residents hands at meals and between tray delivery. She said the staff should have been wearing surgical masks. The TV room, open common area, was observed on 5/4/2020 at 1:22 p.m. There were three residents in the TV area. One resident had a mask on, not covering the nose. One resident had no mask. The third resident had a mask which sat below her chin. The director of nurses (DON) was interviewed on 5/4/2020 at 1:52 p.m. She said all staff should have been wearing a surgical mask. She said all staff monitored that. She said they had noticed the problem with the lack of social distancing. She said the infection control nurse was going around completing education. The NHA was interviewed on 5/4/2020 at 2:01 p.m. She said the staff was not supposed to be wearing the cloth masks. She said the staff had been educated before. She said they had also identified the problem with the lack of social distancing. She said they had also completed continued verbal education with the staff on hand hygiene.

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.