STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065252	A. BUILDING _____ B. WING _____	07/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARKMOOR VILLAGE HEALTHCARE CENTER	3625 PARKMOOR VILLAGE DR COLORADO SPRINGS, CO 80917

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#2) of four residents reviewed for pressure ulcers received care consistent with professional standards of practice to prevent pressure injuries. Specifically, the facility failed to consistently implement repositioning interventions to help reduce the risk of developing a pressure injuries for Resident #2. Findings include: I. Observations revealed staff failed to implement existing care plan interventions of frequent repositioning. -During the continuous observation no staff were observed to assist Resident #2 in transfer from her wheelchair to her recliner or help with redistribution of her weight. 7/29/2020 The resident was observed continuously on 7/29/2020 from 11:13 a.m., to 2:28 p.m. On 7/29/2020 at 11:13 a.m., the resident was sitting in her wheelchair (w/c) next to her bed reading the newspaper. She was leaning to her left as she sat in her w/c. -At 11:43 a.m., Resident #2 was sitting in his w/c next to her bed. The resident was seated in an upright position with the resident leaning to her left. Staff did not intervene to reposition or support the resident. -At 12:17 p.m., the resident was sitting next to her bed watching television (TV). She was leaning to her left. -At 12:46 p.m., the resident was seated in her w/c in the same position as above sleeping next to her bed and in front of the television (TV). -At 1:14 p.m., a certified nurse aide (CNA) entered the resident ' s room with a meal tray. The CNA placed the meal tray on the resident ' s bedside table and placed it in front of the resident ' s w/c. The CNA handed the resident her service wear and opened two small pepper packets and assisted the residents pouring the pepper on her food. The CNA exited the resident ' s room and did not offer or encourage the resident to reposition or support the resident. -At 1:34 p.m., the resident was done with her meal. She pushed the bedside table away from her and was sitting next to her bed watching TV. -At 2:03 p.m., the resident was seated next to her bed watching TV in the same position leaning to her left. No staff were observed to ask if Resident #2 if she wanted to be repositioned or asked if a resident wanted to be offloaded in bed. -At 2:24 p.m., Resident #2 was in the same position seated in her w/c next to her bed watching TV. -At 2:32 p.m., Resident #2 was observed sitting in her recliner. Her w/c was next to her bed. -At 2:48 p.m., Resident #2 pressed her call light. -At 2:53 two CNA ' s entered the resident ' s room. They closed the door and provided perineal care. -At 3:01 p.m., both CNA ' s exited the room. II. Resident interview Resident #2 was interviewed on 7/30/2020 at 8:23 a.m. The resident said, Yes I transferred myself yesterday because if I didn ' t I would be in my w/c all day. She said, Staff do not come in to transfer or put me in bed until I ask them too. III. Professional reference According to the National Pressure Ulcer Advisory Panel, Pressure Injury Prevention Points, April 2016, 8/ , retrieved from: http://www.npuap.org/wp-content/uploads/2016/04/Pressure-Injury-Prevention-Points-2016.pdf, the following recommendations were identified: -Cleanse the skin promptly after episodes of incontinence. -Reposition weak or immobile individuals in chairs hourly. -Ensure the heels are free from the bed. -Use heel offloading devices or [MEDICATION NAME] foam dressings on individuals at high-risk for heel ulcers. IV. Resident status Resident #2, age 82, was admitted on [DATE]. According to the July 2020 CPO, [DIAGNOSES REDACTED]. According to the 7/1/2020 minimum data set (MDS) assessment, the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. The resident had no behavioral symptoms. She required extensive assistance for bed mobility, transfers, grooming and toilet use. The MDS revealed the resident was a one to two person assist for transfers and toileting. She was occasionally incontinent of the bladder and frequently incontinent of the bowel. V. Record review The care plan, initiated 4/9/19 and revised 7/1/2020, identified the resident had potential for pressure injury development related to (R/T) generalized weakness, occasional bladder/frequent bowel incontinence and requiring extensive assistance for meeting her bed mobility needs. Interventions include educating the resident /family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulation/mobility, good nutrition and frequent repositioning. The residents/family/caregivers of any new area of skin breakdown. Instruct/assist to shift weight in W/C often. Monitor/document/report PRN any changes in skin status. Teach the resident/family the importance of changing positions for prevention of pressure ulcers. Encourage small frequent position changes. VI. Staff interview CNA #4 was interviewed on 7/29/2020 at 3:02 p.m. CNA #4 said she was not familiar with Resident #2 as she usually works on the first floor. CNA #4 said, I transferred her to the toilet and placed her back into her recliner. CNA #4 said the resident was sitting in her recliner when she answered the resident ' s call light. CNA #4 said the resident was a one person transfer. She said Resident #2 would transfer herself at times. She said all residents ' are required to be toileted or repositioned every two hours and before or after meals per residents ' care plans. Registered nurse (RN) #2 was interviewed on 7/29/2020 3:24 p.m. She said it would be her expectation the resident would have been repositioned every two hours. She said a negative outcome for Resident #2 not being repositioned would be the potential for skin breakdown and pressure ulcers. CNA #3 was interviewed on 7/29/2020 at 9:15 a.m. She said all residents should be repositioned and provided perineal care every two hours and as needed. The director of nursing (DON) was interviewed on 7/26/18 at 12:26 p.m. She said the resident likes to be up in her wheelchair. The DON was told of the observations of the resident on 7/229/2020. She said, Resident #2 should have been repositioned every two hours and as needed (PRN). She said staff should have checked in on the resident frequently. She said a negative outcome would be the resident could have skin break down or fall.
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, record review and interviews, the facility failed to effectively follow an infection control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection of two of three floors. Specifically, the facility: -Failed to ensure staff followed Neutropenic (exist to prevent infection in all patients who are immunocompromised) precautions to prevent infections to the resident before entering and exiting Resident #220's room; -Failed to ensure residents had face covering while out of their rooms; and, -Failed to follow proper housekeeping protocols to prevent cross contamination, and maintain proper cleaning standards and procedures. Findings include I. Reference The CDC, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated July 15, 2020, retrieved from: 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. (7/23/2020) It read in pertinent part: Personal Protective Equipment (PPE): HCP who enter the room of a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator (or facemask if a respirator is not available), gown, gloves, and eye protection. Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses. Facilities should have policies and procedures describing a recommended sequence for safely donning and doffing PPE. The PPE recommended when caring for a patient with suspected or confirmed COVID-19 includes the following: Respirator or Facemask (Cloth face coverings are NOT PPE and should not be worn for the care of patients with suspected or confirmed COVID-19 or other situations where use of a respirator or

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) facemask is recommended.): -Put on an N95 respirator (or equivalent or higher-level respirator) or facemask (if a respirator is not available) before entry into the patient room or care area, if not already wearing one as part of extended use strategies to optimize PPE supply. Other respirators include other disposable filtering facepiece respirators, powered air purifying respirators (PAPRs), or [MEDICATION NAME] respirators. -N95 respirators or respirators that offer a higher level of protection should be used instead of a facemask when performing or present for an aerosol generating procedure. See appendix for respirator definition. Disposable respirators and face masks should be removed and discarded after exiting the patient's room or care area and closing the door unless implementing extended use or reuse. Perform hand hygiene after removing the respirator or facemask. Gowns: -Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. Disposable gowns should be discarded after use. Cloth gowns should be laundered after each use. A. Facility policies and procedures The Infection Control Precautions policy and procedure, last revised August 2019, was provided by the director of nursing (DON) on 7/30/2020 at 8:12 a.m., which included in pertinent part: Transmission based precautions are initiated when a resident develops signs and symptoms of a transmissible infection: arrives for admission with symptoms of an infection: or has laboratory confirmed infection, and is at risk for transmitting the infections to other residents. Transmission based precautions may include contact precautions, droplet precautions, or airborne precautions. B. Observations On 7/29/2020 at 11:14 a.m., room [ROOM NUMBER] had an isolation cart next to the door. The sign next to the door stated, No person with infection may enter the room, keep the door closed, no flowers, fruits or vegetables allowed. Wash hands upon entering the room and leaving room. Wear a mask, gown and gloves when touching resident, use resident ' s designated or disposable equipment. -At 1:14 p.m., a female certified nurse aide entered room [ROOM NUMBER]. She had a meal tray and placed it on the bedside table of the resident closest to the door. She then walked over to the other resident and pulled the curtain toward the head of the resident. She retrieved a glass from the resident asking if she wanted juice. She then pulled the curtain toward the foot of the bed. She exited the room. She did not follow precautions upon entering or exiting the resident's room per neutropenic precautions. -At 1:22 p.m., certified nurse aide (CNA) #1 was observed entering room [ROOM NUMBER]. CNA #1 had the resident ' s meal tray. He pulled the curtain toward the head of the residents ' bed. He placed the meal tray on the bedside table of the resident. He repositioned the resident to a sitting position who required the precautions. He assisted the resident with her service ware. He asked the resident if she wanted a clothing protector, to which she replied, yes. CNA #1 exited the room and returned with a clothing protector and a glass of juice. He placed the clothing protector onto the resident. He pulled the curtain closed and exited the residents room. He did not follow precautions upon entering or exiting the resident's room per neutropenic precautions. C. Staff interview Certified nurse aide (CNA) #1 was interviewed on 7/29/2020 at 1:25 p.m. He said the resident had an issue with her blood. He said when staff enter the room we are supposed to wash our hands, put on a gown and gloves so we don ' t give her any type of infection. CNA #1 said, I did not follow any of the precautions. Registered nurse (RN) #1 was interviewed on 7/29/2020 at 1:34 p.m. She said the resident next to the window had a [DIAGNOSES REDACTED]. She said we have reverse precautions so staff did not give her an infection because she had such a low immune system. She said staff were supposed to wash their hands upon entering and exiting the residents ' room. She said they are supposed to put on a gown, and gloves as well before entering the resident ' s room. She said all staff entering room [ROOM NUMBER] required to don full PPE. The director of nursing (DON) was interviewed on 7/30/2020 at 12:26 p.m. The DON was told of the observations above. She said staff need to wash their hands before entering the room and should put on gloves before going into the room. She said staff need to put on a gown, gloves and a mask before entering the residents room. She said you also need to wash your hands after exiting the resident's room. She said a negative outcome for staff not following Neutropenic precaution would be the spread of infection to the resident. Follow up on 7/30/2020 at 9:12 a.m., RN #1 said all staff had been re-educated on the use of PPE upon entering room [ROOM NUMBER]. II. Failed to ensure residents had face covering while out of their rooms I. CDC recommended guidelines 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 accessed on (7/17//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 On 7/29/2020 at 11:08 a.m.-12:30 p.m. continuous observation of the facility revealed seven residents ' were sitting in various places in the common area on the third floor. Three staff members were observed walking by residents ' and did not educate or ask residents to put on a mask. On 7/29/2020 at 11:10 a.m., two residents ' were sitting in their wheelchairs in the dining room on the third floor hall. Both residents ' did not have their face masks on. On 7/29/2020 at 11:16 a.m., two residents ' were observed sitting in their wheelchairs watching television (TV) on the third floor. One resident was sleeping in her wheelchair. Both residents ' did not have masks. On 7/29/2020 at 11:22 a.m. Four residents were sitting in various places in the common area on the second floor hall. All four did not have on any face mask. Certified nurse aide (CNA) #1 was observed walking by all residents and did not educate or ask residents ' if they wanted to put a mask on. On 7/29/2020 at 11:23 a.m. One resident was sitting in her wheelchair in the dining room on the second floor. She did not have a mask on. On 7/29/2020 at 12:38 p.m., a male resident was being wheeled down the hall on the second floor by a CNA #4. The resident did not have a mask on. Staff did not educate or ask residents if he wanted to put a mask on. On 7/29/2020 at 2:46 p.m., a female resident on the second floor was observed walking up and down the hall with no mask on or visible. The resident walked by registered nurse #2. RN #2 did not educate or ask residents if she wanted a mask. On 7/29/2020 at 3:03 p.m., six residents were sitting in various places in the common area on the second floor. All residents ' were not wearing masks. No staff were observed in the area. On 7/30/2020 at 9:00 a.m., three residents were observed sitting in the common area on the second floor. All three residents ' did not have masks on. CNA #2 was observed talking to the two residents sitting on the couch. B. Staff interviews Certified nurse aide (CNA) #2 was interviewed on 7/30/2020 at 10:35 a.m. She said we try to keep social distance because they don ' t understand they cannot be sitting next to each other. She asked all residents ' to put on their mask one. She said some will wear them and some will not. She said we really could not do anything if they did not want to wear them. She was told of the observation with the residents ' earlier. She said she did not ask the residents if they wanted a mask but she should have encouraged them to put on a mask. RN #1 was interviewed on 7/30/2020 at 9:12 a.m. She said it was difficult to have the residents wear their masks because there are some residents ' who will wear them and some who will not and we know the residents who do not wear them. She said the residents ' have the right to refuse them but they should have been encouraged to wear their masks. The director of nursing (DON) was interviewed on 7/30/2020 at 12:26 p.m. She said all residents should have a mask on when they are out of their rooms. She said we encourage all residents ' to wear their masks and perform hand hygiene. The DON was told of the observations above. She said staff should have educated the residents and should have offered masks. She said a negative outcome would be the spread of infections and disease. III. Housekeeping A. Observations of improper housekeeping practices On 7/30/2020 at 10:25 a.m., Housekeeper (HSK) #1 was observed cleaning room # 217. Housekeeper HSK#1 put on gloves, and entered the resident ' s room. HSK #1 grabbed the trash bag from the residents ' restroom and removed the trash liner from the roommates trash can. She twisted the trash bag to seal them and exited the residents ' room. She lifted the trash can lid with her gloved hand and placed the trash bags into the trash can. She wiped her hands on the side of her pants. HSK #1 then opened the drawer on her cart and removed two spray bottles, toilet brush and a rag. She reentered the residents ' room and proceeded to the restroom. She removed the commode chair from above the toilet and placed it to the side. She sprayed the mirror with the window cleaner and immediately wiped the mirror. She then sprayed the sink and then sprayed with the disinfectant and immediately wiped the sink with the rag. She did not allow dwell time after spraying the sink. She then sprayed the toilet bowl, tank, and seat. She did not spray the base of the commode. She placed the bottle of disinfectant on the floor next to the sink. She immediately used the toilet brush and proceeded to scrub the toilet bowl and hit the side of the toilet bowl to remove the water from the toilet bowl. She then immediately started to wipe the toilet seat, and tank. She then proceeded to use her gloved hand and wipe the inside the toilet with her rag. The dwell time for the disinfectant on the toilet was one minute and ten seconds. HSK #1 then sprayed the commode chair and immediately wiped the chair surface. She removed the chair bowl with her gloved hands and proceeded to wipe the inside and outside of the bowl with the rag. She replaced the bowl onto the chair. She then proceeded to wipe the toilet seat and arms of the toilet chair. She placed the commode chair back over the toilet. She exited the residents ' room and placed the rag into a plastic bag on her cart. She placed the window cleaner

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) into the drawer on her cart. She did not change her gloves, wash or sanitize her hands during this process. She then grabbed a mop handle and microfiber pad from her cart. She reentered the residents ' and proceeded to spray the floor in the restroom with the disinfectant and dropped the microfiber mop on the floor. She proceeded to immediately mop the restroom floor. She then exited the restroom and proceeded next to the window. She sprayed the disinfectant onto the floor and immediately started mopping the floor around and under the residents ' bed. HSK #1 then proceed to spray and mop her way out of the room. She pulled the small dresser away from the wall. The dirt and trash could be observed from the doorway. She used the mopped to push the dirt and trash toward the middle of the room. HSK #1 said, This had not been cleaned for some time because it was dirty. She pushed the dirt and trash working her way out of the room. She mopped under and around the second bed and pushed the dirt and trash out into the hall. She placed a wet floor sign on the floor and removed the micro fiber from the mop handle and placed it into the plastic bag and placed the mop handle on the side of her cart. She proceeded to grab the broom and dustpan to sweep up the dirt and trash she removed from the room. She removed her gloves and sanitized her hands. B. Staff interviews HSK #1 was interviewed on 7/30/2020 at 10:43 a.m. She said the procedure when cleaning a residents ' room was to knock and introduce yourself and ask to clean the room. She said then we remove the trash and then start cleaning the sink and bathroom. She said then we work from the window out of the room. She said the dirt behind the dresser hadn ' t been cleaned for some time. She said the dressers should be pulled away from the walls weekly. She said the dwell time for the sanitizer was three minutes. The environment supervisor (ES) was interviewed 7/30/2020 at 11:57 a.m. The ES was informed of the observation above. He said we follow the CDC checklist for our room cleaning. He said housekeepers should knock and introduce self-prior to entering the resident ' s room. He said the housekeepers are supposed to go from clean to dirty, which was starting from the window working out towards the door with the restroom being the last task. He said then they should clean all horizontal items in the resident ' s room. He said they should change their cleaning rags after every task and they should wash their hands and change gloves. He said it was his expectation that the housekeeper would have followed facility procedure when cleaning the residents' rooms. He said the dwell time for disinfectant was three minutes and should be followed as it is very important when disinfecting all of the rooms. He said a negative outcome for not following cleaning procedure and lack of dwell time would be cross contamination and spread of infection or disease.