| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065219 | A. BUILDING _____ B. WING _____ | 03/31/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| KENTON MANOR | 850 27TH AVE GREELEY, CO 80634 |

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<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide and implement an infection prevention and control program.**<br><br>Based on observations, interviews and record review, the facility failed to ensure infection control procedures were followed to prevent the potential spread of Coronavirus disease (COVID-19). Specifically, the facility failed to ensure:<br>-Two certified nurse aides (CNA) followed proper hand hygiene techniques while providing cares for one resident; and,<br>-Staff of all disciplines received all of the specific Covid-19 training provided by the facility. Findings include: I. Facility policies and procedures The following policies were provided by the nursing home administrator (NHA) on 3/25/2020 at approximately 3:30 p.m. The Infection Prevention Program Overview policy and procedure, revised February 2018, included: Goal of the infection prevention program are to provide safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease. II. Observation and staff interview CNA #1 and CNA #2 were observed on 3/25/20 at 2:45 p.m. They were in Resident #1's room transferring him to his bed and providing resident care. Both CNAs were wearing gloves; CNA #2 asked CNA #1 if there was something to wipe the floor because there was brown liquid under the resident's chair. CNA #1 pointed to the towels on the floor, CNA #2 used her gloved hand and retrieved towels from the floor to wipe up liquid then threw the towels in the corner by the door. CNA #2 doffed her gloves and donned another pair without washing her hands or using anti-bacterial hand rub (ABHR) prior to donning the gloves. CNA #1 began preparing the bed to transfer the resident into and began adjusting the bed height with the bed control using her contaminated gloved hand. She was also arranging the sheets and blankets. Both CNA #1 and CNA #2 transferred the resident to his bed and provided resident care. CNA #1 touched the bed controller three times with her gloved hand during the transfer. After the resident was in bed and care had been provided CNA #1 doffed her gloves and did not wash her hands or use ABHR and touched the bed controller a fourth time with her bare hand. CNA #2 removed her gloves and did not wash her hands or use ABHR but donned another pair of gloves. CNA #1 retrieved the trash from the room and closed the bag and then opened another bag to place dirty clothing in. Both CNAs doffed their gloves and CNA #2 carried both bags out of the room and to the hall after opening the door with her unwashed hand, and placing the bags in the trash and dirty linen. Both CNAs then went to the clean utility room door(with contaminated hands), entered the keycode, opened the door and proceeded to wash their hands inside the utility room. The CNAs both reported they had education about hand hygiene in the past and both agreed they were taught to wash their hands or use ABHR after doffing a pair of gloves and prior to donning another pair of gloves. III. Record review The 3/6/2020 infection prevention strategies training documented 40 staff had received the training. The 3/11/2020 training titled COVID-19 (coronavirus) update documented 23 of 86 employees had received the training. The 3/13/2020 infection control training documented 57 of 86 staff had received the training. The 3/16/2020 infection control training documented there were 21 staff who had not received the training. The 3/18/2020 training titled Prevent Re-hospitalization documented 10 of 16 registered nurses and licensed practical nurses had received the training. The 3/19/2020 training titled When to Stay Home documented that 15 of 86 total staff had received the training. IV. Staff interviews The staff development coordinator (SDC) was interviewed on 3/25/2020 at 3:15 p.m. She said she was responsible for all staff education throughout the facility. She said the most current education she had provided was on 3/19/2020. She said she had also completed a lot of verbal education but did not have signatures for all of the education she had provided. She confirmed that not all of the staff had received information about visitors entering the facility and their monitoring process but said she did not think it was necessary for all staff to receive this type of education. The SDC was interviewed again with the NHA and director of nursing (DON) by phone on 3/31/2020 at 9:00 a.m. The NHA said that all staff should be trained on all provided training. The SDC confirmed she was responsible for all training provided to the staff and ensuring that everyone who worked in the facility had received the proper training. |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE