STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065358	A. BUILDING _____ B. WING _____	07/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF WESTMINSTER	7751 ZENOBIA CT WESTMINSTER, CO 80030

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

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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, record review 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 COVID-19 in three of three units. Specifically, the facility: -Failed to ensure blood glucose meters (meters used to check blood glucose) were stored appropriately to prevent contamination and staff were knowledgeable of disinfectant dwell times (time the surface must remain wet with the product to be effective), for blood glucose meters used on multiple residents; -Failed to ensure equipment (vital sign) was disinfected appropriately, staff were knowledgeable of disinfectant dwell times, and disinfectant chemicals were labeled; -Failed to ensure employees used alcohol based hand rub (ABHR) appropriately and completed hand hygiene; and, -Failed to ensure housekeeping staff performed hand hygiene and changed gloves between contaminated surfaces, and between resident rooms. Findings include: I. Status of COVID-19 in the facility The nursing home administrator (NHA) was interviewed on 7/21/2020 at 10:00 a.m. He reported the resident census was 78 and there were no COVID-19 positive residents in the facility. He said the facility had one positive staff member and the entire Aspen unit was in isolation due to possible exposure to the positive employee. He said new admissions or readmissions were also isolated on the Aspen unit. II. Failed to ensure blood glucose meters were stored appropriately to prevent contamination and staff were knowledgeable of disinfectant dwell times for blood glucose meters used on multiple residents A. Professional reference According to the Centers for Disease Control and Prevention (CDC) Injection Safety, Infection Prevention during Blood Glucose Monitoring and Insulin Administration,2/2011 retrieved 7/23/202 from:https://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html The CDC has become increasingly concerned about the risks for transmitting [MEDICAL CONDITION] virus (HBV) and other infectious diseases during assisted blood glucose monitoring and insulin administration.CDC is alerting all persons who assist others with blood glucose monitoring and/or insulin administration of the following infection control requirements: Whenever possible, blood glucose meters should not be shared. If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions. If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared. Meters requiring preloading of the test strip may come in direct or close contact with the resident's fingerstick wound. Subsequent residents can be exposed when the meter is used on them.Staff hands can become contaminated with blood that is transferred to the meter when they obtain the reading. Blood remaining on the meter can be transferred to subsequent residents through staff hands when they perform the next procedure. An evaluation of instrument storage areas in hospitals found that 20% of areas where blood glucose meters were stored were contaminated with blood. If the blood glucose meter becomes contaminated through inappropriate storage, subsequent patients could be exposed to infectious agents, even if the meter itself does not have direct patient contact. B. Facility policy and procedure The Cleaning and Disinfecting of the Glucometer (blood glucose meter) policy, revised 4/7/2020, was received from the director of nursing (DON) on 7/22/2020 at 12:26 p.m. The policy documented in pertinent part, After you have taken the glucometer reading, place a barrier on the table surface, place the glucometer on the barrier, remove your gloves, perform hand hygiene, and put on fresh gloves, follow the options below for cleaning and disinfecting the glucometer prior to leaving the resident room. Use a commercially available EPA registered disinfectant wipe that has [MEDICAL CONDITION].[MEDICAL CONDITIONS] and an emerging pathogen kill claim. Ensure the glucometer remains wet for the duration of the time required according to the manufacturer. Remove gloves, perform hand hygiene prior to exiting the room. Take the glucometer in a cup back to the med cart. The facility should consider dedicating a glucometer for each resident who is in isolation if they require routine blood glucose monitoring. C. Observations and interviews On 7/21/2020 at 12:01 p.m., licensed practical nurse (LPN) #1 was observed going into room [ROOM NUMBER] on the Aspen isolation unit with a blood glucose meter and vital sign equipment. She came out of the room approximately five minutes later with the vital sign equipment. The blood glucose meter was not observed at this point. She went to her medication cart and removed keys from her pocket and the blood glucose meter. She said she had checked the residents vital signs and blood sugar. She placed the blood glucose meter directly on top of the medication cart. She then took a wipe from an orange topped container and wrapped the blood glucose meter in the wipe without wiping it, and placed it in a cup. She said she did not know the dwell time of the wipe, but thought it was about five minutes. She then took the container of wipes and began reading it. The container was labeled Sani Wipe Bleach. The dwell time was documented as four minutes. -LPN #1 potentially contaminated the top of the medication cart and did not disinfect it, and placed a blood glucose meter she had just used on a resident in her pocket. On 7/21/2020 at 12:31 p.m., registered nurse (RN) #2 was observed at the medication cart on the Silverton unit. In the medication cart, a blood glucose meter, labeled [MEDICATION NAME] EZ, was observed resting on top of medication including insulin, in the top drawer of the medication cart. RN #2 said the cart had only one blood glucose meter and it was used to check multiple resident's blood glucose levels. She did not know how many. She said she cleaned the blood glucose meter with a purple top Sani Wipe after each resident. She said the dwell time for the purple Sani wipes was one minute. However, the container of purple top Sani Wipes documented a two minute dwell time to be effective. The RN failed to demonstrate knowledge of the proper dwell time of the disinfectant used on the blood glucose meter and failed to store the blood glucose meter to prevent cross contamination of other medications and supplies in the medication cart. On 7/21/2020 at 12:34 p.m. RN #2 was observed at one of two medication carts on the Durango unit. She opened the first cart and there was a blood glucose meter sitting on top of insulin, alcohol wipes and a tube of medication. She said she used the one blood glucose meter for multiple residents. She said she did not know how many residents. She said she cleaned the blood glucose meter with the purple top Sani Wipes after each use. -However, no wipes were observed on the cart or in it. RN #2 said she was out of wipes. She further said she thought the dwell time of the purple top wipes was four minutes. The second medication cart on the Durango unit, was opened by LPN #2 on 7/21/2020 at 12:45 p.m. In the top drawer was a blood glucose meter, resting on top of clean test strips. She said she used the purple top disinfectant wipes to clean the blood glucose meter and they had a five minute dwell time. She said only one person on her unit used the blood glucose meter in the Durango medication cart #2. -However, on 7/22/2202 at 12:26 p.m. the DON provided documentation that three residents used the blood glucose meter on this medication cart. On 7/21/2020 at 1:00 p.m. three medication carts on the Aspen, isolation unit were observed. The blood glucose meter used by LPN #1 at 12:01 p.m. was still resting in a plastic cup wrapped in a wipe. In both of the other two carts, the blood glucose meters were in the top drawer resting on top of test strips. The DON was interviewed with the infection preventionist (IP) on 7/22/2020 at 12:30 p.m. She provided documentation that there were seven residents sharing three blood glucose meters on Apen, the isolation unit. On the Durango unit, she documented she had six residents sharing two blood glucose meters and on Silverton she had eight residents sharing one blood glucose meter. She said he did not have the manufacturer's instructions for disinfection of the blood glucose meter, Optimum EZ. She said the manufacturer would not give it to them. The DON said the blood glucose meters should never be put into nurse pockets due to risk of contamination. She said they should be stored wrapped in a tissue or a pouch on the cart to prevent contamination of other

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** - Many	(continued... from page 1) items in the cart. The DON said the blood glucose meters should be cleaned according to the facility policy between each use since they do not have the manufacturers instructions. The regional director of clinical services (RDCS) was interviewed on 7/22/2020 at 12:33 p.m. She said the manufacturer had refused to give their company the instructions for disinfecting and cleaning the blood glucose meter. She said company wide they would be switching to a new blood glucose meter and would be rolling out the new blood glucose meters and providing education this week. She said the blood glucose meters should be stored in pouches and the staff would be provided education regarding storage this week. In addition, the RDCS said the facility would start stocking two blood glucose meters on each cart, so that there was one available for use while the other was being disinfected. In addition, she said the nurse should not have carried blood glucose meters in their pocket. -The facility failed to ensure the blood glucose meters were stored without contaminating other surfaces and that the staff were knowledgeable of the dwell times of disinfectants to kill blood borne pathogens and other organisms. III.Failed to ensure equipment (vital sign) was disinfected appropriately, staff were knowledgeable of dwell times (time the surface must remain wet with the product to be effective), and disinfectant chemicals were labeled A. Professional reference The Centers for Disease Control (CDC) Hand Hygiene in Healthcare Settings, last up updated 6/22/2020, retrieved 7/15/2020 from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-strategies.html. It read in pertinent part, Environmental Cleaning and Disinfection: Develop a schedule for regular cleaning and disinfection of shared equipment. Ensure EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment. B. Facility policy and procedure The Cleaning and Disinfecting of Non-Critical Patient CAre Equipment policy, revised 3/13/2020, documented in pertinent part, non-critical, reusable patient care equipment is cleaned daily and before and after use with an EPA registered hospital disinfectant or other approved disinfectant based on the manufacturer. C. Observations and interviews On 7/21/2020 at 12:01, LPN #1 was observed going into room [ROOM NUMBER] with a vital sign tower, including a blood pressure cuff, thermometer and pulse oximetry used to check blood oxygen levels. She came out of the room approximately five minutes later with the tower. She sprayed a solution on a cloth and wiped the front screen of the tower. LPN #1 said she was using a product:Virex. She said the dwell time for the Virex was four minutes. She then pushed the cart partially down the hall and went back to her medication cart without cleaning all surfaces of the equipment. On 7/22/2020 at 10:23 a.m. certified nurse aide (CNA) #3 was interviewed after she used vital sign equipment. She said she cleaned the equipment with bleach and let it dry for about 10 to 15 seconds before she used it on someone else. She pulled a spray bottle out of a bag hung on the vital sign tower. The bottle was not labeled with any chemical information. It said, ironing board spray. The CNA said he did not know what it was because it had not been labeled. She said it could be bleach or Virex. She said it needed to be labeled so we know how to use it CNA #3 said she thought the maintenance department was responsible for mixing the bleach and filling the bottles. The CNA went down the hall to a hoyer lift and pulled a bottle out of a bag. The bottle said bleach, no other information. On 7/22/2020 at 10:28 a.m., a vital sign tower was observed across from the nurses station. In a bag hanging on the vital sign tower was a spray bottle of light yellow solution. There was no label. The DON was at the nurse station. She said she thought the solution was bleach. She said the bottle should have been labeled so the staff knew how to use the chemical and what to do if a resident or staff person was exposed to the chemical. She said she did not know the dwell time of the bleach solution. The DON looked at LPN #1, who said four minutes. The DON said we will have to work on this. The maintenance director (MD) was interviewed on 7/22/2020 at 11:08 a.m. He said he mixed the bleach solution with one part bleach and nine parts water. Then he said one part bleach and ten parts water. He then picked up the unlabeled bottle from the bag hanging on the vital sign cart. He said the light yellow solution was bleach. He said he filled it with bleach to the 100 milliliter (ml) mark and then with water to the 550 ml mark. However, the bottle was filled past the 550 ml mark, up the neck of the bottle almost to the top. He said this one was diluted too much. As the MD was reviewing the unlabeled bottle, and holding it up in the air, chemicals sprayed out of the bottle onto the surveyor's face, neck and clothing during the interview. The MD said that is why they need to be labeled. The DON and IP were interviewed together on 7/22/2020 at 11:08 a.m. The DON said the dwell time for the bleach solution was five minutes and the Virex was 10 minutes. The DON said the vital sign equipment should be cleaned after each use with the bleach solution and the correct dwell time. The NHA was interviewed on 7/22/2020 at 11:59 a.m. He said the DON and IP had given the wrong dwell time for the bleach solution. He said it should be 10 minutes. He said the Virex was also a 10 minute dwell time, and provided information from the manufacturer which documented a 10 minute dwell time for the Virex. The NHA said the bleach solution was a 10 minute dwell time for a solution of 2400 ppm (parts per million) solution, with a ratio of 1:33. He said he was using a 7800 ppm solution and therefore was unsure if it was a 10 minute dwell time. The NHA provided documentation of the CloroxPro bleach. The documentation indicated a five minute dwell time for Coronavirus at 2400 ppm. The NHA said he would be educating the staff to use a dwell time of ten minutes, and he would investigate further. -The facility failed to label chemicals to ensure staff knew which product they were using. In addition, the facility failed to ensure the staff were aware of the proper dwell times, and followed dwell times for disinfectant chemicals used. IV. Failed to ensure employees used alcohol based hand rub (ABHR) appropriately and completed hand hygiene A. Professional reference The Centers for Disease Control (CDC), Clean hands save lives, When and How to Wash Your Hands last updated 4/2/2020, retrieved 7/23/2020 from: https://www.cdc.gov/handwashing/when-how-handwashing.html. It read in pertinent part, How to use hand sanitizer. Apply the gel product to the palm of one hand (read the label to learn the correct amount). Rub your hands together. Rub the gel over all the surfaces of your hands and fingers until your hands are dry. This should take around 20 seconds. During the Coronavirus Disease 19 (COVID-19) pandemic, keeping hands clean is especially important to help prevent [MEDICAL CONDITION] from spreading. B. Facility policy and procedure The Hand Hygiene policy, revised 5/7/2020, was received from the DON on 7/22/2020 at 12:26 p.m. The policy documented in pertinent part, when to perform hand hygiene, before and after all resident contact, after contact with potentially infectious material, before and after gloves, after touching your face mask or face covering. C. Observations and interviews On 7/21/2020 at 11:25 a.m., CNA # 2 was observed in room [ROOM NUMBER] on the isolation unit. She removed her cloth gown and placed it in a dirty linen container. She said the gown had gotten urine all over it and smelled. She then walked out of the room. She did not perform hand hygiene. She walked to the nurses desk in the center of the unit and began sorting papers. She said they were the meal tickets. She then put them in her pocket. CNA #2 was asked if she should have washed her hands or used ABHR after touching the gown with urine on it in room [ROOM NUMBER]. She said I forgot. She then went to a room labeled shower, punched in a code on the door and closed the door behind her. On 7/21/2020 at 11:31 a.m., CNA #2 was observed in the hallway of the isolation unit. She pulled her cell phone out of her pocket, returned it to her pocket, adjusted her face mask and entered room [ROOM NUMBER]. She did not perform any hand hygiene. She put on a gown and gloves. On 7/21/2020 at 11:51 a.m., RN # 1 was observed passing resident meal trays to resident rooms on the isolation unit. She applied hand sanitizer to the palms of her hands and rubbed them together. She failed to sanitize the outside of her hands, fingers, thumb or nails. On 7/21/2020 at 11:55 a.m., RN #1 came out of room [ROOM NUMBER] of the isolation unit, and again rubbed hand sanitizer to only the palms of her hands and rubbed them together. She did not cover her fingers, thumb or nails. She then shook both hands in the air to dry as she walked to the nurses station. On 7/21/2020 at 12:08 p.m., CNA #1 entered room [ROOM NUMBER] again, she did not perform hand hygiene, she placed a gown on and gloves. The DON and IP were interviewed on 7/22/2020 at 11:08 a.m. The IP said the staff should wash their hands or use ABHR before and after resident care, glove use, and contact with contaminated items or areas. The IP said this included touching or using their cell phones. She said they should apply hand rub to their hands and rub all surfaces until completely dry. She said the staff should not shake their hands in the air to dry the hand sanitizer, but should rub their hands together until the hand sanitizer was dry. V. Failure to ensure housekeeping followed appropriate cleaning procedures and hand hygiene A. Facility policy and procedures The Housekeeping services policy, revised 6/10/2020, was provided by the director of nursing (DON) on 7/22/2020 at 12:27 p.m. It read, in pertinent part, Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. For higher risk areas, change cleaning cloths between each patient zone. Remove all personal protective equipment (PPE) and perform hand hygiene before exiting the patient room. B. Observations Housekeeper (HK) #1 was observed on 7/21/2020 from 10:56 a.m. to 11:45 a.m. The following observations were made: -At 10:56 a.m. HK #1 finished cleaning room D151, she came out of the bathroom and used the same mophead to clean the entry and front of the room. She grabbed the dirty mophead off the bottom of the mop with her gloved hand and threw it in a dirty rag bag. She then proceeded to the dining room area to clean. She failed to dispose of her dirty gloves and perform hand hygiene. -At 11:06 a.m. HK #1 mopped the dining room floor, then again grabbed the dirty mophead off the bottom of the mop and threw it in the dirty rag bag. She then grabbed a

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 2) clean mop head and proceeded to clean the rest of the dining room floor. She was still wearing the same gloves. -At 11:10 a.m. HK #1 entered room D154, with the same gloves. She sprayed the toilet bowl cleaner on the brush then took the brush into the bathroom to clean the toilet. She then swept the floor in the room and removed debris from the bottom of the broom with her same gloved hands. She grabbed a clean mop head and proceeded to clean the floor. She mopped the back of the room then took the mop into the bathroom to mop the floor. She then came out of the bathroom with the same mophead across the middle and front of the room. -At 11:42 a.m. HK #1 entered room D155, with the same gloves still. She grabbed a clean mop head and proceeded to clean the floor. She mopped the back of the room then took the mop into the bathroom to mop the floor. She then came out of the bathroom with the same mophead across the middle and front of the room. HK #1 failed to change her gloves and perform hand hygiene while cleaning three different rooms and the dining room. C. Interviews HK #1 was unavailable for an interview. The maintenance director (MD) was interviewed on 7/21/2020 at 1:55 p.m. He said HK #1 was new to the facility and trained for three days with another housekeeper. He said she was then released to clean rooms on her own, however, she had not had her review with him yet to ensure she was cleaning correctly. He said he had been gone and unable to watch her. He said housekeepers should remove their gloves and perform hand hygiene after every room. He said the toilet bowl cleaner should be sprayed directly on the toilet when cleaning. He said he trained housekeepers to use a separate mophead for the bathroom to ensure there was no cross-contamination. He said he usually does a review of housekeepers after two weeks to determine if they need additional training, however, he was unable to do that with HK #1. He said he would do additional training with her to ensure she cleans rooms in proper order and performs hand hygiene. The infection preventionist (IP) was interviewed on 7/22/20 at 11:16 a.m. She said she was not involved in housekeeping practices but would change that in the future to ensure there were no breaks in infection control.