STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065009	A. BUILDING _____ B. WING _____	05/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST PAUL HEALTH CENTER	1667 ST PAUL ST DENVER, CO 80206

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 maintain an infection control program designed to prevent the spread of COVID-19. Specifically, the facility: -Failed to ensure residents who left the facility grounds were screened and offered hand hygiene upon return to the facility. -Failed to ensure Resident #2 did not receive a visitor. -Failed to ensure residents wore masks or face coverings when out of their rooms. -Failed to ensure housekeeping staff performed hand hygiene before donning gloves and after doffing gloves. -Failed to ensure housekeeping followed the proper procedural steps when cleaning a resident's room. -Failed to ensure a resident was provided a clean face mask after cross-contamination. -Failed to ensure gloves were removed after cleaning a room on isolation precautions to ensure high touch surfaces such as shared equipment and door handles were not cross-contaminated -Failed to ensure personal protective equipment (PPE) was donned properly to ensure full torso coverage. -Failed to properly store PPE to prevent the growth of bacteria. Findings include: I. Facility policy and procedure The Covid-19 management policy and procedure, dated [DATE]20, was provided by the nursing home administrator (NHA) on 5/5/2020 at 11:00 a.m. It read in pertinent part: Covid-19 management will help prevent the spread of [MEDICAL CONDITION] which is believed to spread through direct person-to-person contact, inhalation of [MEDICAL CONDITION] and contact with surfaces contaminated with [MEDICAL CONDITION]. Cleaning contaminated hands, using appropriate personal protective equipment (PPE) and cleaning and disinfecting the environment will be used to help prevent the spread of microorganisms. Our community will use Covid-19 management practices to protect our residents, visitors and staff from infection. All personnel in the community are responsible for following the Covid-19 management policy and procedure and will be educated upon hire, annually and as needed on the importance of preventing the transmission of infections. Residents, families and visitors will be educated regarding the importance of preventing infections. Increased hand hygiene using soap and water and or alcohol-based hand rub (ABHR) will be encouraged for staff and residents prior to meals and frequently during the day. Face masks may be worn by all employees while in the community and recommended for use by residents based on the current requirements by [ORG] (CDPHE) and Center for Disease Control (CDC). II. Mask use, visitation, screening and hand hygiene A. Observations On 5/5/2020 at 10:39 a.m., several residents were in the dining room. One resident was observed sitting in her wheelchair with her head bent over with her eyes closed. There was no mask or face covering on the resident. Licensed practical (LPN) #1 walked to the resident. She asked the resident if she would like to go to her room to lie down. The resident said she would like to stay in the dining room. LPN #1 walked away. She did not offer the resident a mask or a face covering. On 5/5/2020 at 10:43 a.m., activity assistant (AA) #1 was observed in the dining room. She was observed talking to a resident approximately three feet apart. There was no mask or face covering on the resident. AA #1 did not offer the resident a mask or face covering. About ten minutes later, assistant director of nursing (ADON) #1 walked to the resident and offered the resident a mask. The resident was observed to put the mask on. On 5/5/2020 at 11:16 a.m., Resident #2 was observed in the parking lot. He was observed within two feet from his son. They were both smoking. The resident said his son was visiting with him. The resident had a mask but was tucked under his chin. He said his son was not allowed in the facility so he would meet him in the parking lot. He said sometimes they would go to the corner store to buy cigarettes. He said when he returned to the facility, the staff at the door did not screen him or offer him hand hygiene. On 5/5/20 at 11:20 a.m., two residents were observed to exit the facility. Hospitality assistant (HA) #1 who was the screener was at the door. He did not discourage the residents from leaving the facility and provided education why it was important to remain in the facility as much as possible. The residents were observed in the parking lot and later left the facility grounds via wheelchairs. At 11:35 a.m., the residents returned to the facility and were in the parking lot. At 11:38 a.m., the residents were observed at the entrance door. Both residents returned to the facility. HA #1 did not screen the residents or offer hand hygiene to prevent the spread of Covid-19. B. Interviews LPN #1 was interviewed on 5/5/2020 at 10:39 a.m. She said she was provided training on Covid-19. She said she was aware when residents were out of their rooms to wear a mask or face covering. She said yesterday (5/4/2020) she offered the resident a mask but she refused to wear it. She said she did not offer her a mask today, but would continue to offer and encourage her to wear a mask or face covering when she was out of her room. AA #1 was interviewed on 5/5//2020 at 10:42 a.m. She said she was provided training on Covid-19. She said she was not aware the residents had to wear a mask or face covering when out of their rooms. She said she was not provided education on that. ADON #1 was interviewed on 5/5/2020 at 10:45 a.m. She said all staff were provided education on Covid-19. She said staff should be encouraging residents to wear a mask or face covering when out of their rooms. She said LPN #1 and AA #1 should have offered the residents masks or face covering and encouraged them to wear it. She said she would provide education to all staff to continue offering and encouraging residents to wear their masks when out of their rooms. HA #1 was interviewed on 5/5/2020 at 11:25 a.m. He said he was responsible to screen staff and visitors. He said the nurses were responsible to screen the residents twice daily. He said he was not instructed to screen residents or offer hand hygiene when they left the facility and returned. The nursing home administrator (NHA) and the clinical nurse consultant (CNC) were interviewed on 5/5/2020 at 1:35 p.m. The NHA said it had been an ongoing concern with residents going out to smoke when it was not the smoking times and also leaving the facility grounds. She said she was not sure what process was in place to screen residents who left the facility grounds. She said residents should be discouraged to leave facility grounds and education should be provided to residents. The NHA said she had provided education to Resident #2 regarding his son visiting him in the parking lot. She said it had been an ongoing issue and the resident continued to meet his son in the parking lot. (However she was unable to provide education that was provided to the resident regarding his son's visits.) The NHA and the CNC said all staff were trained on Covid-19 and should be encouraging residents to wear masks when out of their rooms. The NHA said she would change her screening process to include questions to screen residents who left the facility grounds and offer hand hygiene to all residents upon return to the facility. She said she would continue to discourage visitors and provide education to Resident #2 on why it was important for his son not to visit him during this time. She said education would be provided to the screener to screen residents and offer hand hygiene when they returned to the facility. C. Facility follow-up An updated screening form was provided by NHA via email on 5/6/2020. The form was reviewed. It documented screening questions for residents who left the facility grounds. The questions included: Did you leave the facility? Did you meet with someone who is not an employee or resident at the facility? Do you want a new mask? Did you receive an education handout on hand hygiene, face mask use and social distancing today or previously? III. Resident screening process A. Resident observations and interviews Three residents were observed to exit the facility on 5/5/20 at 10:26 a.m. Two of the residents left the facility grounds. One resident parked himself in the middle of the parking lot in front of the building. -At 10:31 a.m., the resident was observed smoking in the parking lot. The resident was not supervised. According to the resident, he could come outside to smoke at any time and did not require supervision or smoke at a designated time. He said staff had not encouraged hand hygiene when entering the facility, or asked if he

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) left the grounds, or spoke to anyone or had visitors off grounds. -At 11:30 a.m., a resident walked from the backside of the parking lot with a lit cigarette. She said she liked to go for a walk to get fresh air and sun. She said she does not often stay in the designated smoking area because it was shaded and no one was over there to talk to. She said if she smokes at the designated time, sometimes the smoking area was supervised by a staff member. The resident entered the designated smoking area and put out her cigarette. -At 11:38 a.m. the resident walked to the facility door and was greeted by a staff member who told her he was running about 10 minutes late to supervise the smokers. The resident entered the facility and passed the hospitality assistant (HA) #1. She was not encouraged to perform hand hygiene when entering the facility, or asked if she left the grounds, or spoke to anyone or had visitors off grounds. Resident #3 was observed entering the facility on 5/5/20 at 1:50 p.m. He was greeted by HA #1 and propelled himself down the hall towards the elevator. The resident touched the elevator button and entered the elevator. The HA #1 did not offer or encourage hand hygiene. The screener did not ask the resident if he left the facility grounds. HA #1 did not encourage a new mask. The HA did not ask the resident if he spoke to any outside visitors. The resident passed ABHR at the front entryway and he did not use the ABHR located in front of the elevator. Resident #3 was interviewed on 5/5/20 at 1:53 p.m. He said he was outside smoking off grounds on the sidewalk away from the facility. He said he spoke to people outside. He did not indicate who he spoke with. B. Staff interviews HA #1 was interviewed on 5/5/20 at 10:25 a.m. He said he screened all staff, as well as outside visitors such as medical professionals from the community. He said he must make sure they do not pose a risk to residents. He said he takes their temperature and reviews a screening questionnaire with them. The HA#1 said residents can come and go from the outside as they desire, if they were an independent smoker and not on a floor designated on isolation for COVID. He said he does not ask the residents questions when they enter the facility or offer hand hygiene. HA #1 said he tried not to disturb the residents as they enter and exit by asking them questions or offering hand hygiene. He said he just made sure to disinfect the entryway high touch points that were handled, such as the push button to open the door. The assistant director of nursing (ADON) #1 was interviewed on 5/5/20 at 11:10 a.m. She said residents should be encouraged to use hand hygiene when returning from the outside. The ADON said all residents who smoke are encouraged to smoke at their designated time. She said staff should supervise even independent smokers to ensure appropriate smoker safety, mask use when interacting with other residents, and safe social distancing. A certified nurse aide (CNA) was interviewed at 11:15 am. She said only dependent smokers needed supervision and to smoke at a designed time. She said independent smokers could go outside at any time and without supervision. The NHA was interviewed on 5/5/20 at 11:53 a.m. She said residents should smoke at their scheduled designated times and in the designated smoking area to ensure staff supervision for resident safety. The NHA said residents should sign out of the facility if they were planning on leaving the facility grounds. She said some residents like to go outside for fresh air and can go wherever they would like to go. They should maintain social distancing, wear a mask and perform hand hygiene when they enter the facility. The NHA said residents were not screened when they enter the facility but the HA encourages resident hand hygiene when they enter the facility. She said she assumed that her staff would be asking the residents if they had contact with visitors and people from the community. She said residents outside smoking should be supervised. The NHA said each floor had a designated time to smoke. Assigned staff are responsible for supervising the smokers during that time. She said a camera, monitored by human resources was positioned to cover half of the parking lot. A view from the camera did not include sidewalks, the alley or other areas around the building. She said it was concerning to her that residents could have contact with unknown people from the community but she said she could not prevent them from going outside. The NHA said the facility needed to come up with a new screening process for residents entering the facility to include hand hygiene and questions to ask the resident if they have had contact with people from the community. IV. Cross-contamination A. Contamination of a resident mask 1. Observations On 5/5/2020 at 10:58 a.m., a resident sat in his wheelchair in the 5th floor dining room. He wore a plastic glove on his right hand and a mask under his chin. The mask did not cover his nose or mouth. At 11:00 a.m., assistant director of nursing (ADON) #1 encouraged the resident to pull up his mask to cover his nose and mouth. The resident pulled the mask back under his chin. He bent over and touched his gloved right hand on to the surface of the floor. The ADON instructed the resident not to touch the floor and to pull his mask up. The resident placed his gloved hand contaminated by the floor on the inside and outside of the mask as he positioned his mask to only cover the bottom portion of his mouth. The ADON walked over to the resident and removed his gloves. She securely fastened his face mask to cover the resident's nose and mouth. She did not provide him with a clean face mask that was not contaminated by his gloved hand after touching the floor. 2. Staff interviews The registered nurse (RN) #1 was interviewed on 5/5/2020 at 10:59 p.m. She said residents were encouraged to wear masks when they were outside of their room. The infection prevention specialist (IPS) was interviewed on 5/5/2020 at 2:44 p.m. He said residents and staff should be provided clean masks if they become damaged or soiled. B. Housekeeping 1. Observations On 5/5/20 at 12:43 p.m., HK #2 was observed cleaning isolation rooms on the 6rd floor for suspected or confirmed COVID-19. The housekeeper wore a PPE of gloves, gown, a N-95 mask and a face shield. The gown did not fully cover the backside of her torso. At 12:45 p.m., HK #1 entered room [ROOM NUMBER] designated for isolation precautions. She sprayed the sink and toilet with disinfectant, wiped down the sink, and re-entered the bathroom. She scrubbed the bathroom toilet, exited the bathroom and placed the toilet brush on the cart without changing her gloves. She reentered the bathroom, washed the mirror and placed the cleaning products in her cart with her gloved hands. HK #1 collected the trash and mopped and vacuumed the floors. Her gloved hands used to clean the bathroom touched the handles of the vacuum and the mop. She doffed her gloves. With her bare hands she moved the cart and the vacuum in front of room [ROOM NUMBER]. Signage on the door indicated to use isolation precautions. According to the signage, hand hygiene should be performed before donning PPE and after doffing PPE. At 11:59 a.m., HK #1 donned a new pair of gloves and entered room [ROOM NUMBER]. She did not perform hand hygiene before donning new gloves or after touching the contaminated surfaces of the cart and vacuum. She sprayed the toilet and sink, scrubbed the toilet with her gloved hands. She did not remove her gloves or perform hand hygiene after cleaning the toilet. The HK #1 proceeded to wipe the surface of the sink and mirror with gloved hands. She walked to her cart, touched keys with her gloved hands and placed the cleaning products inside the cart. HK #1 collected the trash, swept and mopped the bathroom floor and vacuumed the carpet. She used the same gloved hands to clean the toilet as she used to handle to mop, the broom and the vacuum. At 11:10 a.m., HK #1 doffed her gloves. She did not perform hand hygiene. She said she did not have alcohol based hand rub (ABHR) on her cart. She said ABHR was located on the wall and pointed to the ABHR attached to the wall about 5 feet from her. She did not use the ABHR she pointed to. At 11:11 a.m., HK #1 donned a new pair of gloves without hand hygiene. She entered an isolation room [ROOM NUMBER] and used the same cleaning procedural steps such as cleaning the toilet without changing gloves. At 11:24 a.m., HK #1 exited the room without removing her gloves, retrieved her keys out of her pocket, opened the door to the utility room, touching the door handle. She removed a small step ladder from the utility room with her gloved hands and re-entered room [ROOM NUMBER]. At 11:30 a.m. HK #1 removed the ladder from the room, doffed all PPE including the N-95 mask and the face shield. She disinfected the face shield and placed it in a sealed plastic bag. She placed the N-95 in a sealed plastic. She did not perform hand hygiene. She retrieved her keys from her pocket, opened the door again to the utility closet and placed the bagged the PPE in the closet and returned the ladder. She donned a new pair of gloves. She did not wipe down the ladder, nor the keys or door knob to the utility room that she touched with the same gloves she used to clean the isolation room. She did not perform hand hygiene after doffing the PPE including the gloves. At 11:35 a.m., HK #1 donned a new pair of gloves without hand hygiene and unlocked and entered the housekeeping closet. She emptied the mop water from the bucket and placed the mop into the closet. She did not wipe down the handle of the mop. HK #1 removed her gloves. She did not perform hand hygiene. She rolled her cart down the hall and parked the housekeeping cart outside of the resident shower room. She did not wipe down her cleaning cart. At 11:40 a.m., HK #1 washed her hands in the shower room. 2. Staff interviews HK #1 was interviewed on 5/5/20 at 11:41 a.m. She said at the beginning of her shift she wipes down her cart and equipment but not at the end of the day or after use. She said she leaves the isolation rooms for the end of each day to prevent cross-contamination. She said she was not trained to perform hand hygiene before donning and after doffing her gloves. HK #1 said she did not think about how she could potentially cross-contaminate high touch surfaces with her contaminated gloves or un-sanitized hands. She said she wipes down the door handle twice a day, but did not think about wiping down the doors when she touched them after working in isolation rooms. The ADON #2 was interviewed on 5/5/20, at 2:44 p.m. with the clinical nurse consultant (CNC). The ADON #2 identified himself as the infection prevention specialist (IPS). He said the PPE gowns should fit all staff if properly worn and should fully cover the front and back of the torso. The IPS said hand hygiene should always be performed before donning and after doffing gloves, especially when working with residents on COVID isolation precautions. The IPS said N-95 and the face shield should be placed in paper bags not sealed plastic bags. He agreed that plastic bags would not

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 2) allow air flow and could potentially allow growth of bacteria. The IPS said the housekeepers were trained by the director of maintenance. The director of maintenance (DM) was interviewed on 5/6/20 at 4:25 p.m. The DM said the housekeepers have been trained to appropriately don and doff PPE when cleaning rooms. He said it was important to follow appropriate infection control practices when cleaning residents' rooms including full coverage of the PPE gown and appropriate glove use. The DM said hygiene should be performed before donning gloves and after doffing gloves. He said the bathrooms should be the last area to clean in a resident room. The DM said gloves used to clean a room should not be worn in the hallway or to touch high contact surface areas such as the utility room. He said all equipment and the housekeeping cart should be cleaned at the end of the day. The DM said HK #1 was a newer staff member to the facility, has had limited training but should be aware of hand hygiene, proper use of and storage of PPE and the proper procedural steps when cleaning resident rooms. He said he would provide additional education to her.