STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065235	A. BUILDING _____ B. WING _____	07/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PIONEER HEALTH CARE CENTER	900 S 12TH ST ROCKY FORD, CO 81067

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 -** Immediate jeopardy **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 prevent the spread of the novel Coronavirus (COVID-19) in three of three neighborhoods. Specifically: Observations, record review and interviews revealed the facility failed to conduct active screening of staff in a manner to prevent the spread of COVID-19. Staff reported self-screening. Further review of screening logs and staff interviews revealed no follow up of one staff member after staff reported symptoms and no system to ensure all staff were screened, that screening logs were completed, and finally, that these logs were reviewed timely. Observations and interviews revealed additional infection control failures, including staff's failure to follow appropriate donning and doffing procedures when caring for residents on isolation precautions for COVID-19, and lack of hand hygiene practices for residents on secure/memory units. The above failures in infection control practices created an immediate jeopardy situation with the likelihood of serious harm to residents in three of three neighborhoods, staff, and others, if not corrected immediately. Findings include: I. Immediate jeopardy A. Findings of immediate jeopardy Observations, record review, and interviews revealed the facility failed to conduct active screening of staff in a manner to prevent the spread of COVID-19. Staff reported self-screening. Further review of screening logs and staff interviews revealed no follow up of one staff member after staff reported symptoms, and no system to ensure all staff were screened, that screening logs were completed, and finally, that these logs were reviewed timely. Observations and interviews further revealed the facility failed to follow appropriate donning and doffing procedures when caring for residents on isolation precautions. In addition, the facility failed to offer residents on the behavior and memory care units the opportunity to wash or sanitize their hands prior to meals. The above failures in infection control practices created an immediate jeopardy situation with the likelihood of serious harm to residents in three of three neighborhoods, staff, and others, if not corrected immediately. On 7/28/2020 at 6:28 p.m. the nursing home administrator (NHA) was notified that the failures above created an immediate jeopardy situation that placed all residents in the facility at risk for serious harm (COVID-19). B. Facility plan to remove immediate jeopardy On 7/28/2020 at 8:43 p.m., the facility submitted an action plan to abate the immediate jeopardy. The abatement plan read: Identified current, positive and/or presumptive COVID-19 residents in the facility and 6 residents with pending test results placed on transmission-based precautions Post droplet precautions signs to identify transmission-based precautions for current, positive and/or presumptive COVID-19 residents In-services for staff initiated at 7/28/2020 at 6:50 pm and will be provided for all staff prior to start of shift or caring for resident (nursing, rehab, CNAs, housekeepers, social services, activities) on: -Current residents who are identified as COVID-19 positive and/or presumptive -Transmission-based Precautions: Droplet (posting of proper signs and keeping doors closed) -When to utilize PPE (i.e. passing medications, meal trays) -How to don/doff PPE -Cleaning/disinfecting of resident equipment (i.e. vital sign equipment-dispose of disinfectant wipe after one use). -Offer/remind residents on hand hygiene, masking, and social distancing Complete competencies for 100% staff by Friday, July 31, 2020 (nursing, rehab, CNAs, housekeepers, social services, activities): -Hand Hygiene -Don/Doff PPE -Cleaning/disinfecting of resident equipment The Corporate Chief Clinical Officer and Regional Director of Clinical Services will begin to monitor staff daily for 30 days beginning on 7/29/20, for hand hygiene, posting of signs for transmission-based precautions, use of PPE (donning/doffing), and cleaning/disinfecting of resident equipment. The facility nursing administrative staff will assume monitoring when back to work. Plan will be addressed at the next scheduled QAPI Committee Meeting August 2020. C. Removal of immediate jeopardy On 7/28/2020 at 9:10 p.m. the NHA, and corporate chief clinical officer (CCCO) were informed the immediate jeopardy had been abated, based on the facility's implementation of the above plan. However, deficient practice remained at F level (widespread with the potential for more than minimal harm). II. The facility failed to conduct active screening of staff in a manner to prevent the spread of COVID-19. A. Professional references 1. The Centers for Disease Control and Prevention (CDC) updated 6/25/2020, retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, reads: Actively screen everyone for fever and symptoms of COVID-19 before they enter the healthcare facility. Screen all healthcare personnel at the beginning of their shift. Actively take their temperature and document the absence of symptoms consistent with COVID-19. 2. The Centers for Medicare and Medicaid Services (CMS) (4/2/2020) COVID-19 Long-Term Care Facility Guidance. Retrieved from: https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf read in pertinent part, Long-term care facilities should immediately implement symptom screening for all. Facilities should limit access points and ensure that all accessible entrances have a screening station. B. Screening process On 7/29/2020, observations of the facility's screening area for all healthcare, dietary, activities, and housekeeping personnel who entered the facility revealed the screening area was located at the time clock at the facility's south entrance and secured with a keypad code. The staff could access the building using the code and, thereafter, enter the facility for screening. The facility policy, Coronavirus/COVID-19, March 2020, was received from the nursing home administrator (NHA) on 7/29/2020. It read in pertinent part: Screening and self-monitoring: Staff will be educated on the facility's plan to control exposure to the residents. This plan will be developed with the guidance of the CDC and public health authorities. Staff will be reminded to stay home when ill. Screening of staff will be conducted prior to their shift and logged. If staff develop fever or symptoms while at work, they should put on a facemask (if not wearing one already), inform their supervisor, and leave the workplace. For COVID-19 naive facilities, staff who work at multiple locations may pose higher risk and should be asked about exposure to facilities with recognized COVID-19 cases. 1. Observations and interviews revealed deficiencies in the facility's screening process; specifically, self-screening by staff. a. Time clock observations were conducted on 7/20/2020 at 10:50 a.m. At the clock-in station, there was a thermometer, hand sanitizer, alcohol wipes, two folders containing the questionnaire logs (one folder for dietary and one for nursing staff), directions on the wall above the time clock, and a box of surgical masks. Three dietary staff members were observed screening themselves in before their shift. None called for nursing staff assistance on their personal phone and no walkie-talkie or facility phone was observed at the screening station. b. Observation of staff self-screening prior to starting their shifts. Dietary aid (DA) #1 clocked in at 10:58 a.m. He proceeded to take his own temperature, fill in the screening log, fill out his own sticker with the date and temperature of screening, doff the face mask worn into the building, use hand sanitizer, and don a surgical mask. DA #1 then proceeded to the kitchen to start his shift. DA #2 clocked in at 11:00 a.m. She proceeded to take her temperature, fill in the screening log, fill out her own sticker with the date and temperature of screening, doff the face mask worn into the building, use hand sanitizer, and don a surgical mask. She then proceeded to the kitchen to start her shift. At 11:00 a.m., two nursing staff members walked by the time clock area on their way out the south door. They did not stop to assist with screening the dietary staff members. Cook #1 clocked in at 11:05 a.m. He proceeded to take his own temperature, fill in the screening log, fill out his own sticker with the date and temperature of screening, doff the face mask worn into the building, use hand sanitizer, and don a surgical mask. He then proceeded to the kitchen to start his shift. c. Staff interviews confirmed staff self-screening by staff before starting their shifts. Cook #1 was interviewed on 7/29/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065235	A. BUILDING _____ B. WING _____	07/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PIONEER HEALTH CARE CENTER	900 S 12TH ST ROCKY FORD, CO 81067

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 -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) at 11:05 a.m. He said staff received training on the screening process in March. He said staff were supposed to call a certified nurse aide (CNA) or registered nurse (RN) to come and assist them with the screening but sometimes they did not come. He said they were to call the nursing staff with a walkie-talkie that was supposed to be at the screening station. He said he had been self-screening since June when the screening station was moved to the south entrance from the west entrance. He said there was always someone at the west entrance to screen staff in before a shift but there was no one to screen staff at the south entrance. He said he felt that self-screening was not safe and could enable someone to work who was sick. Dietary aid (DA) #1 was interviewed on 7/29/2020 at 11:15 a.m. He said he was supposed to call a CNA or RN to assist with the screening process. However, he said he had been self-screening in the two weeks he had been working at the facility. He said he had not been trained on the screening process, except on how to take his temperature. DA #2 was interviewed on 7/29/2020 at 11:15 a.m. She, too, said she was supposed to call a CNA or RN to assist with the screening process but said they did not respond timely when called. She said she would wait ten minutes before a nursing staff member would come to the time clock to assist with her screening. She said she had been self-screening for a couple of weeks. She said she had not been trained on the screening process. Activities assistant (AA) #1 was interviewed on 7/29/2020 at 11:30 a.m. She said a CNA or RN was supposed to screen them in before a shift. She said if a coworker was clocking in at the same time, they would screen each other. She said at times, she had self-screened before starting a shift because a walkie-talkie was not available to get in touch with the nursing staff or they took too long to respond to her call for assistance. AA #2 was interviewed on 7/29/2020 at 11:55 a.m. She said if she and a coworker arrived together, they would screen each other in. She said if no one else was at the screening station she screened herself in. She said she took her temperature, filled out the screening log, and gave herself a sticker. She said when the screening station was at the west entrance there always was someone to screen in staff. She said since staff screening moved to the south entrance in June, there had not been a designated person at the screening station. CNA #2 was interviewed on 7/29/2020 at 12:02 p.m. She said there was usually someone at the screening station to do staff screening. She said if employees arrived together, they would screen each other in. She said she has had to self-screen before starting her shift. She said there used to be a dedicated staff member screening employees at the west entrance. She said since the screening station was moved to the south entrance, there had not been a dedicated staff member to screen staff in. She said she received screening training a few months ago and she knew active screening was important to catch signs and symptoms of illness before staff started their shift on the floor. d. Administration interviews confirmed staff members were not to self-screen prior to starting their shifts. The dietary supervisor (DS), interviewed on 7/28/2020 at 4:00 p.m., said the dietary staff was to call a CNA or RN to complete their screening before they started their shift. He said dietary staff were not to screen themselves in. The director of nursing (DON) was interviewed on 7/29/2020 at 2:20 p.m. She said they assigned a CNA to screen staff in at shift change. She said the CNA was to ask the screening questions, take temperatures, and then fill out and give the stickers to the staff they screened. She said if the screening was clear (without signs or symptoms of illness) staff could go to work and if not, the CNA would call the nurse to conduct an assessment. -She said the infection preventionist coordinator (IPC) conducted training on screening in April and the training had been incorporated into new employee orientation. She said all departments participated. She said staff should always be screened by someone else; they should not self-screen. She said dietary, activities, and housekeeping staff were to call the CNA or RN on the walkie-talkie to screen them before a shift. -She said screening was important; it provided an objective eye to assess the staff member and get more details about symptoms. She said the screener was to inform a RN if a staff member presented with symptoms so he or she could be assessed. The IPC was interviewed on 7/29/2020 at 2:46 p.m. She confirmed the facility had changed the screening station recently, moving it from the west entrance to the south entrance. She also confirmed dietary staff was to be screened by a CNA or above from any department. -She explained staff were to be screened before they started their shift by a CNA or RN. She said a CNA or RN was to take temperatures, go through the screening log , and provide the screening stickers. She said if the staff did not present with symptoms, they then began their shift. -She said there was supposed to be a walkie-talkie at the screening station so staff could call for assistance with screening. She said on weekends and nights, a staff member was designated on the schedule to actively screen in employees. She said almost all staff had been trained in the screening process. She said an outcome of self-screening was [MEDICAL CONDITION]/illness could enter the facility. 2. Record review revealed additional deficiencies in the facility's screening process; specifically, missing, inadequate and/or incomplete staff screening logs. a. The Prevent COVID-19 Start of Shift Screening Log, updated March 2020, was provided by the NHA on 7/29/2020. A review of the screening logs revealed staff had their temperatures taken, were screened for a cough, sore throat, new shortness of breath or difficulty breathing, vomiting or diarrhea, chills or repeated shaking with chills, muscle pain, headache, a new loss of taste or smell, and if these symptoms were present, staff was asked to go home. The form did not include a space to document who provided the screening, the time the screening was completed, or if the person had washed their hands or used hand sanitizer. Moreover, the form did not include a space to document any follow up if the person reported symptoms. b. Staff daily screening logs from 7/10/2020 to 7/28/2020 were reviewed. All were found incomplete. No screening data was provided for July 12, 2020, and when there were multiple dates on a screening log, the log did not show where a new date started. Of the 42 staff screening logs reviewed, all of them were incomplete. Some of the logs had responses that should have triggered additional screening questions. Others had complete work units of staff missing. Forty-two (42) screening logs had no additional signature to indicate the temperature had been witnessed by another staff member. C. Potential adverse outcome related to the facility's screening deficiencies Review of screening logs and staff schedules revealed three CNAs, were not screened consistently and/or prevented from working with residents when symptomatic or when his/her COVID-19 status was unknown. 1. CNA #4, CNA #5, and CNA #6 a. CNA #4 was positive for COVID-19 on 7/29/2020. He had been providing direct resident care in the days leading up to the positive diagnosis. According to the screening logs, his last screening was completed on 7/22/2020, and revealed he was experiencing a cough, vomiting/diarrhea, a new loss of taste or smell, and no fever. No symptom follow up was documented on the screening log. CNA #4 worked on 7/12, 7/13, 7/17, 7/23, 7/24, 7/25, and 7/28/2020, without being screened before starting his shift. b. CNA #5 was rapid-tested for COVID-19 on 7/17/2020 and no confirmed positive date was provided by the facility. She provided direct resident care while awaiting test results. According to the screening logs, her last screening was completed on 7/20/2020, and it revealed she was experiencing no symptoms or temperature. CNA #5 worked on 7/12, 7/13, 7/14, 7/19, and 7/21/2020 without being screened before starting her shift. c. CNA #6 provided direct care to residents in the east unit. She was scheduled for COVID 19 testing on 7/31/2020. The screening logs revealed screening documentation for 7/16, 7/20, and 7/22/2020, three of 13 shifts the CNA worked between 7/10/2020 and 7/28/2020. The other ten shifts documented no screening data before starting her shifts. 2. On 7/29/2020, the IPC and health information manager (HIM) were interviewed regarding the screening failures identified involving CNA #4, #5, and #6. The IPC, interviewed at 2:46 p.m., said she was responsible for auditing the screening logs. She said she reviews the temperatures, symptom checks and whether all staff had screened in before their shift. She said she audited the screening logs daily. She said if she identified a staff member had not screened in, she would immediately go screen the staff. She said she has had to do some one-on-one training with some staff about the importance of screening. She said in her absence, since 7/22/2020, the HIM was responsible for auditing the screening logs. The HIM, interviewed at 3:10 p.m., said she was auditing the screening logs while the DON was out. She said the DON trained her to verify with the daily schedule that all staff had been actively screened before their shift, check the temperatures, and if any signs and symptoms were circled yes, have the staff assessed by a nurse. She said she had been able to collect the screening logs but had not been able to audit them thoroughly. She said when she picked up the logs, she checked the staff temperatures and to see if any symptoms had been checked off as yes. She said she had not had enough time to verify that all staff had been screened in because of her other job duties. III. Additional infection control failures - Failure to follow appropriate donning and doffing procedures for residents on isolation precautions, failure to properly clean vital signs equipment between the use, and offer hand hygiene to residents. A. Failure to follow appropriate donning and doffing procedures for residents on isolation precautions 1. Reference and facility policy The Centers for Disease Control and Prevention, Preparing for COVID-19 in Nursing Homes, retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html (updated 6/25/2020) reads, in pertinent part: Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown. Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP (health care providers) should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065235	A. BUILDING _____ B. WING _____	07/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PIONEER HEALTH CARE CENTER	900 S 12TH ST ROCKY FORD, CO 81067

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 -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission . Residents with known or suspected COVID-19 should be cared for using all recommended PPE (personal protective equipment), which includes use of N95 or higher level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front sides of the face), gloves, and gown. A copy of the facility's COVID-19 admissions policy, dated May 2020, was provided by the NHA on 7/29/2020, read in part, A resident diagnosed with [REDACTED]. 2. Observations of isolation rooms and interviews on the east unit a. Isolation rooms #24, #25, #26, and #27 on 7/28/2020 Isolation rooms # 24, #25, #26 and #27 had isolation carts next to them. Every room held two residents and doors to these rooms were completely open. One of the residents from room [ROOM NUMBER] was standing right outside room [ROOM NUMBER]. She said she was waiting for her dinner which was running late today. At 5:34 p.m., licensed practical nurse (LPN) #2 was observed passing medications to the residents in rooms #24, #25, #26, and #27. He parked a medication cart at the entrance of every room in a way that medication drawer would open towards the resident room. The LPN stayed inside the room while he was dispensing medications. He was wearing a N95 mask and glasses. Upon entering the resident rooms, he did not don gloves and gown. Around 5:40 p.m., CNA #6 observed passing Styrofoam meal boxes to residents on the east unit. She entered rooms #24, #26 and #27 without a donning gown or gloves. CNA #6 was interviewed around 5:50 p.m. She said isolation carts next to rooms meant that residents were on isolation precautions. She said she did not don gown and gloves when she entered the residents' rooms because she believed it was almost time to take them off the isolation precautions. She said only two residents on the unit require full personal protective equipment (PPE), identifying a newly readmitted resident in room [ROOM NUMBER] and resident in room [ROOM NUMBER] who tested positive for COVID-19. LPN #2 was interviewed around 5:55 p.m. He said it was his third day working on the unit. He said the isolation carts were parked next to the rooms of residents that were on droplet isolation precautions for testing positive for COVID-19. He said he had a total of seven residents who currently tested positive for COVID-19 and were on droplet isolation precautions on the east unit. He said droplet precautions meant [MEDICAL CONDITION] can be transmitted through air droplets. -He said all nurses and CNAs were expected to wear N95 masks, eye protection, gown and gloves when entering isolation rooms. He said N95 masks and eye protection were worn by everyone on the unit, and gown and gloves should be used when entering isolation rooms. He said he did not don gown and gloves when he was entering rooms on isolation precautions because he tried to keep a distance of several feet from the residents. Then he corrected himself and stated that he should have worn a gown and gloves when he was entering every room. He said he did not know why he did not don appropriate PPE for isolation rooms. -He said he passed medications to all residents on the east unit and he did not wear appropriate PPE when he was entered the rooms of all seven of the residents' on isolation precautions. He said some residents on the unit were still waiting for their test results, some refused to be tested , and few tested negative. The NHA was interviewed on 7/28/2020 around 4:00 p.m. She said prior to COVID outbreak in the building, all residents that were admitted or readmitted from hospital, other facilities or homes were housed in different units based on their needs. For example, if a resident required a memory care unit, he or she were placed in a memory care unit, and if residents were admitted for rehabilitation, they went to the west unit, and all readmissions went to their original rooms. -She said since the outbreak of COVID-19 on 7/15/2020, all admissions were placed on hold and the facility did not accept new residents. She said the DON and IPC were working from home as they were quarantined for exposure for COVID-19. The DON was interviewed over the phone on 7/29/2020 at 2:20 p.m. She said the IPC was in charge of providing education to the nurses and CNAs on proper PPE donning and doffing technique. She said the latest training was in March 2020. -She said after the outbreak beginning on 7/15/2020, the facility tested all staff members and all residents in the building every Friday for COVID-19. She said some results from the latest test on 7/24/2020 were still pending. From the results that were available on 7/29/2020, the facility has identified six staff members who tested positive for COVID-19 and eight residents. She said seven of these residents resided on the east unit and one resident was in the west unit. -She said the entire east unit could not be treated as COVID-19 unit because it still had residents who tested negative for COVID-19 or refused the test. She said individual rooms were placed in isolation and staff members were expected to don full PPE (facemask, eye protection, gown and gloves) prior to entering the isolation rooms The IPC was interviewed over the phone on 7/29/2020 at 2:46 p.m. She said she had been the IPC for three months and shared some responsibilities with DON. -She said she could not recall the date of the most recent training for nurses and CNAs on proper PPE use. She said she usually received her information from DON on results of COVID-19 testing and would enter it in her own log that she had separately from DON's log for infection tracking. -She said nurses and CNAs were expected to wear full PPE upon entering rooms with COVID-19 positive residents. B. Failure to properly clean vital signs equipment between resident use 1. References and facility policy A copy of the Cleaning and Disinfection of Resident-Care Items and Equipment, dated 10/2018, was provided by the NHA on 7/29/2020. It read in part, Reusable resident care equipment will be cleaned and disinfected between residents; using disinfectant wipes and the wipes discarded after one use. The Centers for Disease Control and Prevention, Responding to Coronavirus (COVID-19) in Nursing Homes, retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html (updated 4/30/2020) read, in pertinent part: Assign dedicated resident care equipment (e.g., vitals machine) to the cohort unit. Cleaning and disinfection of shared equipment should be performed between residents and the equipment should not leave the cohort unit. 2. Observations and interview CNA #7 was observed on 7/28/20 at 2:38 p.m., on the west unit taking the vital signs of the resident in room [ROOM NUMBER]. After she completed vital signs, she cleaned the thermometer, blood pressure cuff and pulse sock with one sani cloth super germicidal wipe. Then she placed used wipe on top of her clipboard and moved to room [ROOM NUMBER], across from the room [ROOM NUMBER]. She checked vital signs for resident who was residing in room [ROOM NUMBER], picked up the used wipe from the clipboard and used it to clean the thermometer, blood pressure cuff and pulse sock device. After she was done cleaning the equipment, she discarded the wipe into the trash bin. CNA #7 was interviewed on 7/28/2020 around 2:48 p.m. after she exited room [ROOM NUMBER]. She confirmed she used the same wipe to clean the resident equipment she used to take the vital signs of two different residents. She said management had instructed her to use one wipe between several residents until it became dry. She said she disagreed with such practice and was reusing the wipe only between two residents. The DON was interviewed over the phone on 7/29/2020 at 2:20 p.m. She said resident care equipment was not designated to specific rooms and CNAs were expected to clean the equipment after every use. She said an individual wipe should be used to clean the equipment and it should not be reused. The IPC was interviewed over the phone on 7/29/2020 at 2:46 p.m. She said wipes for resident care equipment should not be reused. C. Failure to provide hand hygiene prior to meals 1. Reference and facility policy According to the CDC, Hands should be washed with soap and water for at least 20 seconds when visibly soiled, before eating, and after using the restroom. CDC recommends using ABHR (alcohol-based hand rub) with 60-95% alcohol in healthcare settings. Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and are effective in the absence of a sink. (Hand hygiene recommendations (May 17, 2020). Accessed 8/4/2020 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/hand-hygiene.html The facility policy Handwashing/Hand Hygiene, May 2020, was provided by the NHA on 7/29/2020. It read in pertinent part, This facility considers hand hygiene the primary means to prevent the spread of infections . Residents, family members, and visitors will be encouraged to practice hand hygiene. 2. Observation and interviews related to the dinner meal on the behavior and memory care units. Room tray delivery was observed on the behavior and memory care units on 7/28/2020 at 5:00 p.m. CNA #1 delivered eight room trays to residents in their rooms. No hand hygiene was offered to any of the eight residents before CNA #1 left the room. 2. Staff interviews CNA #1 was interviewed on 7/28/2020 at 5:30 p.m. She said she knew which residents washed their hands independently and which needed assistance. She said she also knew who would refuse hand hygiene, and did not offer it to those residents, although she acknowledged hand hygiene was important and she should offer to help with hand hygiene and encourage hand hygiene before the residents eat their meal. She said residents could become angry when hand hygiene was offered so sometimes she took a hand sanitizing wipe and wiped off their hands without offering to help them with hand hygiene. RN #1 was interviewed on 7/28/2020 at 6:23 p.m. She said hand hygiene was supposed to be offered to all residents. She said it should be offered even if staff know the resident will refuse. She said hand hygiene was important for the safety of the residents and staff. The DON was interviewed on 7/29/2020 at 2:20 p.m. She said CNAs should always offer and encourage hand hygiene to all residents before meals. She said hand hygiene was important to prevent the spread of illness among residents and staff. The IPC was interviewed on 7/29/2020 at 2:46 p.m. She said hand hygiene should be offered to all residents before meals, after using the restroom, after smoking, after coughing or sneezing, and when visibly soiled. She said if the residents refuse to use soap and water, staff should offer hand

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065235	A. BUILDING _____ B. WING _____	**07/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PIONEER HEALTH CARE CENTER	**900 S 12TH ST ROCKY FORD, CO 81067**

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 -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 3) sanitizer. IV. Actions taken on and after the facility was notified of immediate jeopardy A. On 7/28/2020 at 5:52 p.m., the NHA, was interviewed about PPE use and care. She said they had been using the Center for Disease Control guidelines for everybody in the facility. The DON said all staff had been educated on the use of gowns, and she said the gowns were to be worn at all times in isolation rooms. She said they had N95 masks, gowns, gloves, and face protection for any staff member going into the isolation rooms. B. On 7/29/2020 at 2:37 p.m., NHA provided education logs for all staff members that received education on proper PPE use prior to starting their shift in the morning. C. On 7/30/2020, DON provided a completed list of residents infected with COVID-19 that she submitted to the state health department.