STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065379	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOMFIELD SKILLED NURSING AND REHABILITATION CTR	12975 SHERIDAN BLVD BROOMFIELD, CO 80020

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** - 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 ensure effective infection control practices were maintained to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of Coronavirus (COVID-19) and other communicable diseases and infections. Specifically, the facility failed to ensure: - Staff and visiting health care providers (HCP) were following proper personal protective equipment (PPE) guidelines on use and storage; - Potential cross contamination was prevented when reusing PPE from a room under isolation precautions; and - Residents were offered and assisted with hand hygiene prior to meals. Findings include: I. Facility policy The Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease (COVID-19) in Healthcare Settings policy was provided by the nursing home administrator on 6/9/2020 at 6:00 p.m. The policy read in part: Standard precautions assume that every person is potentially infected or colonized with a pathogen that could be transmitted in the healthcare setting .Attention should be paid to training and proper donning (putting on), doffing (taking off), and disposal of any PPE .HCP should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process .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 laundered after each use .Ensure that HCP are educated, trained, and have practiced the appropriate use of PPE prior to caring for a patient, including attention to correct use of PPE and prevention of contamination of clothing, skin, and environment during the process of removing such equipment. The Use of Masks, Gowns and Eye Protection to Conserve Supplies policy, read in part: Extended use of isolation gowns (disposable or cloth), such that the same gown is worn by the same HCP when interacting with more than one patient known to be infected with the same infectious disease when this patients housed in the same location. The Resident Hand Hygiene directive was provided by the director of nursing (DON) on 6/9/2020 at 6:00 p.m., read: Resident hand is just as important in infection control hence hand hygiene of resident must be encouraged and assisted with those who need assistance. Staff please ensure that residents perform hand hygiene or assist with hand hygiene after every bathroom use/pericare, before meals, residents hands are visibly dirty (wash with soap and water), when you observe resident sneezing, coughing and/or using tissues, and prn (as needed)/when in doubt. Alcohol hand sanitizer is encouraged unless the hands are visibly dirty. II. Status of COVID-19 in the facility A. Interview The nursing home administrator (NHA) was interviewed on 6/8/2020 at 10:22 a.m. He reported that one staff was out sick after testing positive for COVID-19. Total resident census was 149, 10 residents were on droplet precautions isolation and two out of those 10 residents tested positive for COVID-19. He said since the pandemic started, 13 residents passed away from COVID-19. III. Observations On 6/8/2020 at 12:07 p.m. a laboratory technician (LT) was observed entering the first floor secure unit. She was not wearing a facemask. She came to the nurses' desk and begun reviewing medical documentation. The DON was present at the nurses' desk. The LT was asked to wear a facemask. She pulled a few masks from her handbag and used a surgical mask to cover her face. She was informed by the DON to wear the facemask at all times while she was in the facility. On 6/8/2020 at 12:29 p.m. a housekeeper was observed entering the first floor secure unit. She approached a certified nurse aide, pulled the facemask down below her chin and begun asking questions about housekeeping. After she received the answers, she pulled her facemask back up and left the unit. She did not disinfect her hands. On 6/9/2020 at 5:15 p.m. an observation of supper meal service on the first floor open unit revealed the residents were not offered hand hygiene before food was served. Some residents were observed using their hands to consume the meal. On 6/9/2020 at 5:40 p.m. CNA #3 was observed donning PPE prior to entering droplet precautions, isolation room [ROOM NUMBER]. Three cloth gowns were observed hanging from the hooks at the entrance to the room. The inside of one gown touched the outside of the gown next to it. There were no markings on the gowns or hooks to identify which staff the gown belonged to so as to not reuse a gown belonging to another person since the inside of the gown would be contaminated from the prior users' clothing. The CNA pulled the first gown and put it on herself outside in, touching the outside of the gown on her personal clothes. She shortly realized the mistake, took the gown off and donned again. IV. Interviews On 6/9/2020 at 5:47 p.m., residents in rooms #138 and #139 were interviewed. They said the staff did not offer hand washing or hand sanitizing/disinfecting before the meal was served. Resident in room [ROOM NUMBER] said the staff was very inconsistent offering hand washing. She said she was unable to use the sink in her bathroom to wash her hands. She said most times staff did not offer hand washing or hand sanitizer. On 6/9/2020 at 5:53 p.m., CNA #3 and CNA #4 were interviewed. They confirmed they did not offer hand sanitizer to residents on the unit before the supper meal. CNA #4 said there was no system in place for residents' hand washing before meals. She said the staff was trying to take the trays with food to residents as soon as they arrive to the unit and then assist residents with eating. CNA #3 said the gowns in isolation rooms were not assigned to one particular staff. She said any of the nursing staff who went to the isolation room just picked up any gown to wear it. On 6/9/2020 at 6:10 p.m. the DON said the laboratory technician was screened at the entrance to the facility and was wearing a facemask. She said she didn't know why the LT took her mask off right after the screening process was completed and entered the secure unit without facemask on. She said every employee and visiting healthcare personnel must use a facemask while in the facility. The DON said the staff was educated about PPE use, donning and doffing during the COVID-19 outbreak in the facility. She said the infection control nurse will provide additional training about PPE use for all staff. She said the staff will also receive refreshing training on necessity of offering hand washing and hand sanitizing to residents before meals. V. Professional reference The Centers for Disease Control (CDC) Key Strategies to Prepare for Coronavirus COVID-19 in Long Term Care Facilities, dated April 2020, read in pertinent part: If COVID-19 was identified in the facility, have health care providers (HCP) wear all recommended PPE for care of all residents (regardless of symptoms) on the affected unit (or facility-wide depending on the situation). This includes: an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and gown. HCP should be trained on PPE use including putting it on and taking it off. This approach is recommended because of the high risk of unrecognized infection among residents. Recent experience suggests that a substantial proportion of residents could have COVID-19 without reporting symptoms or before symptoms develop. VI. Observations on the third floor secure unit and staff interviews Certified nurse aide (CNA) #1 was observed on 6/8/2020 at 12:15 p.m. to enter a COVID-19 resident room [ROOM NUMBER]. She used hand sanitizer then donned a gown and gloves. She already had on a face shield and an N95 mask. There was additional face shield that hung on the wall outside of the resident's room. When she left the room she took off her gloves and gown. She used hand sanitizer outside the room and then entered a non COVID-19 resident's room. She wore the same N95 mask and face shield providing care for both residents. CNA #2 was observed on 6/9/2020 at 4:05 p.m. to walk into a droplet precautions isolation room [ROOM NUMBER]. She wore a

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) face shield and an N95 mask. CNA #2 was interviewed on 6/9/2020 at 4:10 p.m. She said each staff member who enters an isolation room should use full PPE, a gown, gloves, face shield and an N95 mask. She said she went into room [ROOM NUMBER] to turn off the call light and forgot to put on the gown and gloves. Infection control nurse (ICN) was interviewed on 6/8/2020 at 12:25 p.m. She said a gown, gloves, face shield and an N95 mask were worn in a positive COVID-19 resident's room. She said the face shield was cleaned with a disinfectant product or soap and water when the staff left the room. The DON was interviewed on 6/9/2020 at 6:08 p.m. She said a gown, gloves, an N95 mask, face shield or goggles were worn in every isolation room. She said the face shield or goggles were cleaned after leaving the isolation room with a disinfectant or with soap and water. She said there was a risk of contamination of an infectious disease when PPE was not worn or cleaned properly.