STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065176	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUMMIT REHABILITATION AND CARE COMMUNITY	500 GENEVA ST AURORA, CO 80010

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection such as coronavirus (COVID-19) in four of five halls observed for infection control practices. Specifically, the facility failed to: -Ensure proper personal protective equipment (PPE) isolation techniques were followed for new admission Residents (#1, #2 ,#3, #5); and -Ensure staff performed proper hand hygiene. Findings include I. Isolation/PPE usage and hand hygiene A. Centers for Disease Control (CDC) references and facility policies Review of the CDC website: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html, updated 5/22/2020 (retrieved 7/1/2020), revealed in part, Healthcare professionals (HCP) should continue to adhere to Standard and Transmission-Based Precautions, including use of eye protection and/or an N95 or equivalent or higher-level respirator based on anticipated exposures and suspected or confirmed diagnoses. Universal use of a facemask for source control is recommended for HCP. Review of the CDC website: https://www.cdc.gov/coronavirus/2019-ncov/hcp/hand-hygiene.html, updated 5/17/2020 (retrieved 7/1/2020), revealed in part, Hand hygiene is an important part of the U.S. response to the international emergence of COVID-19. [MEDICATION NAME] hand hygiene, which includes the use of alcohol-based hand rub (ABHR) or handwashing, is a simple yet effective way to prevent the spread of pathogens and infections in healthcare settings. CDC recommendations reflect this important role. The exact contribution of hand hygiene to the reduction of direct and indirect spread of coronaviruses between people is currently unknown. However, hand washing mechanically removes pathogens, and laboratory data demonstrate that ABHR formulations in the range of alcohol concentrations recommended by CDC, inactivate [DIAGNOSES REDACTED]-CoV-2. (1,2) ABHR effectively reduces the number of pathogens that may be present on the hands of healthcare providers after brief interactions with patients or the care environment. CDC recommends using ABHR with greater than 60% [MEDICATION NAME] or 70% [MEDICATION NAME] 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. (3) Hands should be washed with soap and water for at least 20 seconds when visibly soiled, before eating, and after using the restroom. Review of the COVID-19 policy, dated 3/10/2020, provided by the nursing home administrator (NHA) on 6/29/2020 at 3:45 p.m., read in pertinent part: Although COVID-19 appears to be transmitted from person-to-person only by aerosolized transmission, it is theoretically possible that hand-to-mouth transmission may occur. Effective immediately, all facility staff will be re-educated in regard to: -Hand-washing, to include when, how, how often, and with what agents (e.g., soap and water, alcohol-based solutions); -Standard infection prevention policies; -Appropriate use of PPE (which items and when to use them) with an emphasis on masks. Review of the undated Use of PPE When Caring for Patients with Confirmed or Suspected COVID-19 policy, provided by the director of nursing (DON) on 6/30/2020 at 10:30 a.m., read in pertinent part: Care partners are to follow standard, contact and droplet precautions (i.e. facemask, gloves, isolation gown) eye protection when caring for a resident. PPE must be donned correctly before entering the patient area: Donning -Perform hand hygiene using hand sanitizer; -Put on isolation gown; -Put on national institute for occupational safety and health (NIOSH) approved N95 filtering facepiece respirator or higher (use facemask if a respirator is not available); -Put on face shield or goggles; -Perform hand hygiene before putting on gloves. Doffing -Remove gloves; -Remove gown; -Exit patient room; -Perform hand hygiene; -Remove face shield or goggles; -Remove and discard respirator (or facemask if used instead of respirator); -Perform hand hygiene. Review of the Handwashing/Hand Hygiene policy and procedure, dated 2001, revised 8/2019, provided by the DON on 6/30/2020 at 11:03 a.m., read in pertinent part: Use an alcohol-based hand rub containing at least 60% alcohol; or, alternatively, soap and water for the following situations: -After contact with objects in the immediate vicinity of the resident; -After removing gloves; -Before and after entering isolation precaution settings; -Before and after assisting a resident with meals; -Hand hygiene is the final step after removing and disposing of PPE. Procedure: A. Washing Hands -Wet hands first with water, apply an amount of product recommended by the manufacturer; -Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers; -Rinse hands with water and dry thoroughly with a disposable towel. B. Using Alcohol-Based Hand Rubs -Apply generous amount of product to palm of hand and rub hands together; -Cover all surfaces of hands and fingers until hands are dry. Review of the Cleaning Non Critical Care Equipment policy, dated 1/8/14, provided by the DON on 6/30/2020 at 11:03 a.m., read in pertinent part: All non critical care equipment (touches intact skin) such as stethoscopes etc. will be cleaned with a low level disinfectant on a daily basis or immediately if the equipment becomes visibly soiled with secretions or debris. II. COVID-19 status in the building The director of nursing (DON) was interviewed on 6/30/2020 at 9:23 a.m. She said they currently had no positive COVID-19 residents in the building. She said they recently had a positive COVID-19 staff member as of 6/22/2020. She said they had eight deaths confirmed from COVID-19. III. Resident #1 A. Resident status Resident #1, age 83, was admitted on [DATE]. According to the June 2020 computerized physician orders [REDACTED]. The minimum data set (MDS) assessment was not completed. Review of the June 2020 medication administration administration (MAR) revealed: Droplet precautions: in progress notes document every shift areas such as: vital signs (VS), respiratory status, signs and symptoms (s/s) of infection, encouragement of fluids, activities of daily living (ADL) support and assistance with repositioning every shift for new admit protocol for 14 days. Order date: 6/26/2020. (3 days after admission) B. Observations: Resident #1 was observed to be in isolation with an isolation cart outside of his room on 6/29/2020 at 1:43 p.m. There was no sign on his door regarding isolation. The cart did not have any gowns or masks available for staff. IV Resident #2 A. Resident status Resident #2, age 82, was admitted on [DATE]. According to the June 2020 computerized physician orders [REDACTED]. The minimum data set (MDS) assessment was not completed. Review of the June 2020 CPO revealed: Droplet isolation for COVID-19 x 14 days, then move to the dementia unit. Order start: 6/22/2020. Review of the June 2020 medication administration administration (MAR) revealed: Droplet precautions: in progress notes document every shift areas such as: VS, respiratory status, signs and s/s of infection, encouragement of fluids, ADL support and assistance with repositioning every shift for new admit protocol for 14 days. Order date: 6/22/2020. B. Observations Resident #2 was observed to be in isolation with an isolation cart outside of his room on 6/29/2020 at 1:43 p.m. The cart did not have any gowns or masks. There was no sign on the door regarding isolation. The resident was observed walking in the hallway, outside of his room. -At 2:45 p.m., the resident was observed walking around the hallway and his door was open. Certified nurse assistant (CNA) #5 was observed going into the residents isolation room on 6/29/2020 at 2:48 p.m. She was wearing a mask. She put on a plastic blue gown and gloves. She did not have any goggles on and proceeded to enter the room. The cart contained goggles. She assisted the resident in changing the TV channel. The resident did not have on a mask and none were offered. She took off her gown and gloves and placed them in the trash. She proceeded to wash her hands in the residents sink. Hand washing took approximately five seconds. She left the residents room with the same mask. Resident #2 was observed on 6/29/2020 at 2:55 p.m. walking around the hallway. He did not have a mask on. He went back to his room. At 2:56 p.m., he walked outside

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** - Some	(continued... from page 1) of his room and went into the dining room area and looked outside. No staff observed in the hallway. He proceeded to go into another resident ' s room and then back to his room. At 3:00 p.m., he walked outside of his room and went into another resident's room and talked to the resident and then went back to his room. He was not wearing a mask. V. Resident #3 A. Resident status Resident #3, age 77, was admitted on [DATE] with initial admission on 1/17/2020. According to the June 2020 computerized physician orders [REDACTED]. The 6/10/2020 minimum data set (MDS) assessment revealed the resident had a severe cognitive deficit with a brief interview for mental status (BIMS) score of five out of 15. Review of the June 2020 CPO revealed: Droplet precautions: in progress notes document every shift areas such as: VS, respiratory status, signs and s/s of infection, encouragement of fluids, ADL support and assistance with repositioning every shift for the new admit protocol for 14 days. Order date: 6/26/2020. (3 days after readmission) B. Observations Resident #3 was observed to be in isolation with an isolation cart outside of his room on 6/29/2020 at 1:43 p.m. There was no sign on the door regarding isolation. The cart did not have any gowns or masks available for staff. CNA #5 was observed going into the residents isolation room on 6/29/2020 at 2:52 p.m. She was wearing a mask. She put on a gown and gloves to enter the resident ' s room. She did not put on any goggles. She knocked on the resident's door and entered. The call light was on. The cart did not contain any goggles for staff use. At 3:02 p.m., CNA #5 came out of the resident ' s room with her surgical mask on and did not close the door. VI. Resident #5 A. Resident status Resident #5, age 89, was admitted on [DATE]. According to the June 2020 computerized physician orders [REDACTED]. The minimum data set (MDS) assessment was not completed. Review of the June 2020 medication administration administration (MAR) revealed the following: Droplet precautions: in progress notes document every shift areas such as: VS, respiratory status, signs and s/s of infection, encouragement of fluids, ADL support and assistance with repositioning every shift for new admit protocol for 14 days. Order date: 6/26/2020. (4 days after admission) B.Observations Resident #5 was observed to be in isolation with an isolation cart outside of his room on 6/29/2020 at 1:43 p.m. The door was open and the cart did not have any masks available. -At 2:45 p.m., there was a sign on the residents door that read Please see the nurse before entering the room. Thank You! CNA #5 was observed going into the residents isolation room on 6/29/2020 at 3:04 p.m. She was wearing a mask. She put on a gown and gloves. She did not put on any goggles. She went into the resident ' s room for assistance. The resident was sitting in a chair next to the doorway, not wearing a mask or covering. She took off the gown and gloves and placed them into the trash. The trash bins were located across the room, away from the exit. She washed her hands in the resident ' s sink. Hand washing took less than 10 seconds. VII. Additional observations and staff interviews On 6/29/2020 at 1:30 p.m. the following rooms had isolation carts outside their doors: 201, 207, 604, 606, 607, 608. There were signs posted on each door that read Please see nurse before entering but no signage that indicated any type of isolation. None of the isolation carts contained designated vital signs equipment, masks, goggles/face shields, or alcohol based hand rub (ABHR). The assistant director of nursing (ADON) said those residents were in observation for 14 days after being admitted from the hospital. It was noted there were few ABHR dispensers throughout the facility. The 100 hall had one dispenser outside the conference room, the 200 hall had two dispensers, the 300 hall had three dispensers, the 400 hall had one dispenser, the 500 hall had one dispenser in the hall and one on a medication cart, the 600 hall had one dispenser outside room [ROOM NUMBER]. CNA #5 was interviewed on 6/29/2020 at 2:47 p.m. She was observed sitting in a chair in the 600 hallway. She said they had to watch the residents in order to help prevent them from wandering in the hallway. -At 3:08 p.m., she was interviewed again. She said the residents were being monitored from being admitted from the hospital. She said they had to monitor them for 14 days. She said they were on standard precautions because they had tested negative. She said the building was COVID negative. She said they had to monitor for fever and any change in condition. She said the only PPE that was needed were masks and gowns. She said goggles or face shields were not needed because they were only in standard precautions. She said hand washing was supposed to take about 20 seconds. She said she usually had a small sanitizer container in her pocket, but she did not have any currently. -At 2:58 p.m., certified nurse aide (CNA) #3 was seen preparing to enter isolation room [ROOM NUMBER]. She was wearing a surgical mask and donned a disposable gown and gloves. She did not don a face shield, goggles or an N95 mask. She did not sanitize her hands prior to donning the gloves. There was no ABHR on the isolation cart or within easy access of the CNA. She then entered the room with a vital signs machine. She did not clean the machine prior to entering the room. -At 3:13 p.m., CNA #3 exited isolation room [ROOM NUMBER] wearing the same surgical mask, she did not change it. She did not perform hand hygiene. She did not clean the vital signs machine after exiting the room and touched buttons on the machine with her bare fingers. She took the machine across the hall to a nurse ' s station. The assistant director of nurses (ADON) was interviewed on 6/29/2020 at 3:17 p.m. He said he was in charge of the infection control in the building. He said the isolation was droplet and required a gown, mask, gloves and goggles. He said they would use the N95 mask if the resident was a positive COVID. He said they monitored for signs and symptoms and vitals every shift. He said hang hygiene should occur before and after glove use; before and after care; restroom use and with feeding residents. He said the last COVID positive resident was on 5/27/2020. -At 3:18 p.m., CNA #3 then took the vital signs machine across another hall, plugged it in, and walked away. She did not clean the machine after plugging it in then entered non-isolation room [ROOM NUMBER], wearing the same surgical mask and not performing hand hygiene prior to entering the resident room. -CNA #3 was interviewed at 3:21 p.m. She said the residents on the 200 hall were in isolation because they came from the hospital. She said they did not have to wear N95 masks or use goggles or face shields because the residents were not COVID-19 positive. -At 5:00 p.m. There was a new isolation cart seen outside room [ROOM NUMBER]. Resident #6 had just been readmitted from the hospital. The isolation cart did not contain ABHR, masks, goggles, face shields, or designated vital signs equipment. CNA #3 entered the room. She was wearing a surgical mask, a gown, and gloves. She did not sanitize her hands prior to donning gloves and she did not don an N95 mask or goggles/face shield. -At 5:10 p.m. CNA #3 exited room [ROOM NUMBER] with the surgical mask in place. She did not change the mask and walked to the 200 hall. -At 5:12 p.m. dinner trays were being served in the 300 hall. An unknown staff member entered room [ROOM NUMBER] to deliver the meal tray and did not offer the resident a way to sanitize their hands prior to eating. -At 5:14 p.m. an unknown staff member delivered a dinner tray to a resident on the 300 hall. He used ABHR afterwards, rubbed his hands together for 5 seconds and with his hands still wet, obtained a dinner tray for another resident, delivered it to their room and did not offer the resident a way to sanitize her hands CNA #4 was interviewed on 6/30/2020 at 8:48 a.m. He was sitting in the 600 hallway. He said he was watching two of the isolation rooms. He said the residents came from the hospital and they were monitored for fall risk. He said the PPE was not full PPE. He said they only needed to use gowns and gloves. He said he did not remember the last time he was trained on COVID-19 information. The transport coordinator (TC) was interviewed on 6/30/2020 at 8:53 a.m. He was sitting in the 600 hallway. He said he was watching a couple of the isolation rooms. He said they were monitored for fall risk. He said they were not monitoring for anything else. He said he was not sure what kind of the isolation the residents were in. He said he did not know if the residents had returned from the hospital. He said he did have to go into the residents rooms. He said they only used the gowns and gloves. -At 9:00 a.m., an unknown CNA entered isolation room [ROOM NUMBER]. She was wearing a gown, gloves, and a surgical mask. She did not don an N95 mask, goggles or a face shield. She did not sanitize her hands prior to donning gloves. The director of nurses (DON) was interviewed on 6/30/2020 at 9:23 a.m. She said for readmission isolation, they used a gown, gloves and a mask for PPE. She said the isolation was contact, not droplet isolation. She said they were considered as possible positive COVID upon admission. A few minutes later, said the 14-day isolation should have been droplet. She said they were using symptoms based measures for the isolation. The DON was interviewed at 9:39 a.m. She said when a new resident was admitted or a current resident was readmitted , they were placed in isolation for 14 days for COVID-19 monitoring. She said those residents were considered to have been possibly exposed to COVID-19 while out of the facility, so the staff would monitor for signs and symptoms of the disease. The staff were to wear gowns, a surgical mask, and gloves to care for those residents. They were considered to be in contact isolation, not droplet isolation. She said staff were to change their surgical masks daily. She said as far as she was concerned if a resident did not have a fever, a cough, a runny nose, or any symptoms of a respiratory illness, staff did not need to wear goggles, a face shield, or an N95 mask when caring for those residents in isolation. She said she had an adequate supply of N95 masks, goggles and face shields in her office. -The registered nurse (RN), and CNAs #1, and #2 were interviewed at 10:05 a.m. They said hand sanitizer should remain wet on your hands for 20 seconds while rubbing your hands together the entire time. The housekeeping supervisor (HKS) was interviewed at 10:20 a.m. She said when her housekeeping staff cleaned isolation rooms they were to don full PPE which included gowns, gloves, a mask, and a face shield. The medical director (MD) was interviewed at 10:28 a.m. He said when a resident went out of the facility and was admitted to the hospital, upon their return to the facility, they were to be placed in droplet isolation for 14 days to monitor for symptoms of COVID-19, because they did not know who they came in contact with while away from the facility. Staff were to

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) wear full PPE when caring for those residents. PPE should include a gown, gloves, goggles, an N95 mask or a surgical mask is adequate if a face shield is used. -At 11:15 a.m. CNA #4 was seen preparing to enter isolation room [ROOM NUMBER]. After donning appropriate PPE he entered the room and exited at 11:20 a.m. with the face shield on. He walked down the hall, placed the face shield face down, on an overbed table in the hall. He obtained two tissues from a box and applied hand sanitizer to the tissues. With his bare hands he wiped the face shield front and back with the tissues, touching all surfaces of the shield with his hands. He said he was not provided disinfecting wipes to clean the face shield after use. -At 11:23 a.m. staff were observed passing lunch trays on the 500 hall. An unknown staff member delivered a lunch tray to the resident in room [ROOM NUMBER]. She did not offer the resident hand sanitization prior to eating. Resident #8 was interviewed at 11:28 a.m. She said all residents ate meals in their rooms now and staff did not offer her a way to sanitize her hands prior to eating. Resident #7 was interviewed at 11:35 a.m. He said he was not offered a way to sanitize his hands prior to eating meals. -At 11:37 a.m. an unknown CNA, on the 300 hall, was seen entering room [ROOM NUMBER] to deliver a lunch tray. She wore goggles at all times and the surgical mask she had on was below her nose.