STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065175	A. BUILDING _____ B. WING _____	04/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CEDARWOOD HEALTH CARE CENTER	924 W KIOWA ST COLORADO SPRINGS, CO 80905

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** - 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 effectively follow an infection control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection. Specifically, the facility failed to ensure: -Outside agencies were screened and educated on the Coronavirus disease (COVID-19); -Staff performed proper hand hygiene prior to exiting Hall 100, which was a identified as a quarantined unit; and, -Failed to ensure infection control protocol was followed during room meal tray preparation. Findings include: I. Outside agency A. Observation and interview from outside agency Steri cycle technician (SCT) was observed on 4/5/2020 at 10:45 a.m. to come into the facility without being screened for infection control. He said he walked in from the open door in the basement. He had a mask and gloves on and said he was there to collect the red biohazard containers. He opened the biohazard storage room and set eight biohazard containers in the hallway. -At 11:00 the facility consultant (FC) assisted him to get screened for infection control at the front door. After he was screened he transported three containers through the hall downstairs to where the truck was. Three biohazard containers were left in the hallway unattended. He said he was not trained by the facility on COVID-19. B. Observations On 4/6/2020 at 10:35 a.m. five room tray carts were left in the corridor of the hallway near the dining room. Residents had potential to touch the room trays and take items off the cart. -At 11:10 a.m. the room tray carts were filled with food and delivered to the residents. Certified nurse aide (CNA) was observed on 4/6/2020 at 11:45 a.m. going in and out of resident rooms down the 100 isolation hallway then out to the 400 room hallway without washing his hands. C. Staff interviews Maintenance supervisor (MS) was interviewed on 4/6/2020 at 11:15 a.m. He said all the doors in the facility were locked except the front door. He said everyone had to enter from the front door to get screened for COVID-19. He said he was trained from the toolkit book for COVID-19. The director of nurses (DON) was interviewed on 4/6/2020 at 12:15 p.m. She said all visitors including outside agencies had to be screened for COVID-19 at the front door. She said a staff member opened the downstairs door to an outside agency and let them in without being screened. She said the negative outcome of someone not being screened was a break in infection control and the danger for the biohazard containers left in the hallway was cross contamination. She trained the entire facility staff to wash their hands before and after resident care, going in and out of residents' rooms and before and after glove use. II. Quarantined hall A. Observations On 4/6/2020 at 10:33 a.m. certified nurse aide (CNA) #1 was observed checking the vitals of resident in room [ROOM NUMBER]. He entered the residents room with a clipboard, took the residents vitals and exited the room. He exited hall 100 through the closed doors, which had been identified as a quarantined unit. He walked into the nursing station to drop off the clipboard. He then assisted a male resident who was sitting next to the bird Avery. He touched the residents ' hand and asked the resident what he needed. CNA #1 did not wash or sanitize his hands during this process of checking the resident's vitals on the quarantined unit, before leaving the unit and before touching the resident sitting by the bird avery -At 10:51 a.m., the maintenance supervisor (MS) was observed entering room [ROOM NUMBER]. He exited the room with tools in hand and placed them onto his work cart. The MS was observed replacing electrical outlet covers in resident ' s rooms. He then proceeded to enter room [ROOM NUMBER] and talk with the resident. The MS then exited room [ROOM NUMBER] and pushed his cart out of hall 100 through the closed doors. The MS was observed talking to a male resident who was next to the bird Avery. The MS requested a towel from staff as a resident had spilled his drink underneath his wheelchair. The MS wiped the spill with a towel moving the residents ' wheelchair and continued down the hall pushing his cart. The MS did not wash or sanitize his hands during this process of cleaning up after the resident ' s spill outside of the quarantined unit. -At 11:21 p.m., CNA #1 was observed pushing a black cart from 100 hundred hall through the closed doors to hall 600. CNA #1 pushed the cart to the corner across from the nursing station. CNA #1 assisted a resident who was requesting help to the bathroom. CNA #1 asked the resident to lift his feet onto the foot pedals. CNA #1 lifted the resident's feet onto the foot pedals and escorted the resident to his room. The CNA did not wash or sanitize his hands during this process. B.Interviews Registered nurse (RN) #1 was interviewed on 4/6/2020 at 10:55 a.m. She said all the residents who were living in the 100 hundred hall were new admits to the facility. She said they would be under quarantine for 14 days to ensure they did not have COVID 19. She said after the 14 days if they did not show signs or symptoms of [MEDICAL CONDITION] they would be placed on various halls throughout the facility. CNA #1 was interviewed on 4/6/2020 at 11:23 a.m. CNA #1 said the residents who resided in 100 halls were under quarantine. He said all of the residents on the 100 hundred hall were new admits and were to be quarantined for 14 days to ensure they did not have the coronavirus. He said all staff are supposed to wash or sanitize our hands when we enter a resident ' s room and after we exit the room. He said a negative outcome would be the spread of infection or disease. The director of nursing was interviewed on 4/6/2020 at 12:15 p.m. She said the residents who lived on hall 100 were new admits who were under quarantine to ensure they did not have the coronavirus. She said they are being quarantined for 14 days. She said the resident in room [ROOM NUMBER] was on isolation precautions due to [MEDICAL CONDITIONS] ([MEDICAL CONDITION]). The DON was informed of the observation above. She said it would be her expectations that staff would wash their hands before and after entering or exiting a residents rooms. She said staff should wash their hands before and after providing care to all residents. She said a negative outcome would be spreading infections or disease. III. Room meal trays A. Observation On 4/6/2020 at 11:09 a.m., dietary staff were observed to be preparing to serve room trays. There were approximately four food carts. Each cart had 13 serving trays with utensils and napkins and other condiments on them. Dietary staff were filling the meal orders as the orders were being filled. Multiple unidentified CNA ' s were filling cups with milk, coffee and other beverages. Several residents were observed self-propelling themselves next to the food carts. One male resident was observed trying to grab a cup of milk. Several other residents ' were observed walking by the carts to see what was on the carts. Dietary staff would place the meals on to the carts and the CNA ' s would deliver the meals to the resident rooms. One food cart had 13 meals on the cart and was pushed to the corner behind the residents door. A male resident was observed trying to get a meal on the bottom shelf of the cart. A CNA came by and redirected the resident. B. Staff interview Dietary aide (DA) #1 was interviewed on 4/6/2020 at 11:48 a.m. She said now that the dining room was closed the area gets real cluttered during meal time. She said the main problem was residents ' start grabbing things off the meal carts. She said they grab a glass of juice or milk and then we have to try and redirect them. She said if the residents would touch a meal we would have to throw it away and have staff make another plate which would delay the meal process. She said a negative outcome would be cross contamination as well as other infection control issues. Dietary manager was interviewed on 4/6/2020 at 12:35 p.m. She said staff would line up the carts next to the satellite kitchen and they would take orders and as they filled them they would place them onto the meal carts. The DM was informed of the observations above. She said, Yes I do see this as a problem because the area does get cluttered. She said residents do try to take food items off the meals carts while staff was trying to fill the meal orders. She said they have had residents ' grab food and when this happens we have to throw the food away and make

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 -** Some	(continued... from page 1) another meal tray. She said, This was a big cross contamination problem. She said we have to find an alternative method of serving the meals to ensure we are not having any cross contaminations concerns.