STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065373	A. BUILDING _____ B. WING _____	04/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEAR CREEK SENIOR LIVING	1685 S 21ST ST COLORADO SPRINGS, CO 80904

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, interviews and record review, the facility failed to ensure infection control procedures were followed to prevent the possible cross-contamination of Coronavirus disease (COVID-19). Specifically, the facility failed to: -Follow isolation precautions with hand washing and sharps disposal; -Train all facility staff on infection control COVID-19; -Follow proper housekeeping protocols to prevent cross-contamination; and -Maintain proper cleaning standards and procedures. Findings include: I. Failure to prevent cross-contamination with isolation precautions, hand washing and sharps disposal A. Facility policy and procedure The Coronavirus Disease (COVID-19) interim policy, not dated, provided by the nursing home administrator (NHA) on 4/13/2020 at 10:00 a.m., read in pertinent part: The procedure for employees was to educate and re-educate and reinforce strong hand hygiene practices. The Isolation and Categories of Transmission-Based Precautions policy, revised date of October 2018, provided by the NHA on 4/13/2020 at 10:00 a.m., read in pertinent part: While caring for a resident, staff will change gloves after having contact with infective material. Gloves will be removed and hand hygiene performed before leaving the room. B. Observations and interviews Two resident rooms, #167 and #172, were observed on 4/13/2020 at 9:15 a.m. to be on contact and droplet isolation precautions. The doors were open to both rooms and a three drawer cart sat outside each room with personal protective equipment (PPE). Certified nurse aide (CNA) #1 was observed on 4/13/2020 at 10:33 a.m. to take a bag of linen and trash out of room [ROOM NUMBER] (isolation room). She had no gloves on and put the bags in the main trash bin in the supply room (not a biohazard container). She entered another resident's room (not an isolation room) and did not wash her hands after leaving the supply room. She was interviewed and said she put items from an isolation room into a biohazard container. She said the biohazard containers were on the next hallway over from room [ROOM NUMBER]. In the biohazard room there was one biohazard container and it was empty of any contents. She said she would put a biohazard container in room [ROOM NUMBER]. CNA #2 was observed on 4/13/2020 at 12:25 p.m. to deliver a meal tray to room [ROOM NUMBER]. She donned the gown that hung outside the door, put on gloves and goggles. When finished with her task she took off her gloves first, goggles second and gown last, and hung the gown back up on the door. The gown fell on the floor and she rehung the gown on the door. She left the room and did not wash her hands. A registered nurse (RN) was observed on 4/13/2020 at 12:35 p.m. to carry out a used needle (biohazard material) from room [ROOM NUMBER] (isolation room). She walked down the hallway to put the biohazard needle into the sharps container on the medication cart. She was interviewed and said she was in the isolation room and realized there was no sharps container to discard the used needle into. She said she was not trained on how to dispose of the sharps material in an isolation room. The director of nurses (DON) was interviewed on 4/13/2020 at 9:35 a.m. She said when a resident was in isolation the facility staff had to wear full personal protective equipment (PPE). She said she expected them to wash their hands before and after all cares and after glove use. She said all equipment should be in the isolation room and not taken out of the room without being put in a proper container first. She said there was a spread of infection when infection control measures were not followed. II. Failure to ensure coronavirus training was provided to all facility staff in a timely manner. A. Professional reference and staff training documentation According to the Center for Clinical Standards and Quality/Quality, Safety & Oversight Group Memorandum Ref: QSO-20-09-ALL (2/6/2020) Information for Healthcare Facilities Concerning 2019 Novel Coronavirus Illness (2019-nCoV): Train and Educate Healthcare Personnel: Provide HCP with job- or task-specific education and training on preventing transmission of infectious agents, including refresher training. 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. On 4/13/2020 at 1:39 p.m., the staff development coordinator (SDC) provided a copy of the [MEDICAL CONDITION] in service, which was provided by the facility for staff on 3/3/2020, 3/17/2020, and 3/19/2020. The in-service revealed mandatory meetings for all nurses and CNAs for Coronavirus education. It contained: -[MEDICAL CONDITION]/evacuation; -Isolation precautions; -Admission precautions, contact and droplet precautions; and -Covid 19 spread. The sign-up sheets identified 37 staff members who attended the 2020-nCoV in-service. However, the facility had 67 current staff members according to the facility-provided staff list. B. Staff interview The SDC was interviewed on 4/14/2020 at 3:14 p.m. She said, I gave all of the department supervisors a hand out and they trained their own staff. She said all staff needed to be trained on Covid-19. She said she created educational sheets to train the staff and she would do that this week. She said the nursing home administrator would receive daily updates from the Center for Disease Control (CDC), Department of Health, and Center for Medicaid and Medicare Services (CMS). She said she talked to everyone often but did not document what was discussed or trained on. The SDC said the facility utilized agency nursing. She said they received their training from their agency. She said, We did inform them of our facility policies but I do not have any documentation showing this. She added, I will get an updated sign in sheet identifying all staff have been trained on Covid-19 immediately. She said a negative outcome would be a potential outbreak. She said the facility would get the training done this week. III. Failure to prevent cross-contamination during resident room cleaning A. Observations On 4/13/2020 at 12:10 p.m., housekeeper (HSK) #1 was observed cleaning room [ROOM NUMBER]. HSK #1 was cleaning four pillows on the bed. HSK #1 was spraying the disinfectant on each one of the pillows and immediately wiping the pillow without allowing time for the disinfectant to take effect. HSK #1 stated, Oh, I forgot to put my gloves on. She exited the resident room immediately and grabbed a pair of gloves from the top of her cart. She returned into the resident's room and proceeded to finish cleaning the pillows. HSK #1 moved to the mattress, which she sprayed with the disinfectant spray and wiped the mattress immediately. She continued to wipe the remainder of the room, spraying the area and wiping immediately, not following the disinfectant dwell time. She exited the resident's room. She did not wash or sanitize her hands during this process. HSK #1 left the room and grabbed her caddy of cleaners and returned into the resident room. She proceeded to wipe the resident's wheelchair following the same process as before of spraying and immediately wiping with the same rag. HSK #1 wiped the wheelchair wheels and foot pedals. She pushed the wheelchair to the corner of the room. She grabbed her caddy of cleaners and entered the resident's restroom. She sprayed the sink, the commode and other areas in the restroom and immediately wiped all areas. She exited the restroom and placed her caddy onto her cart. She removed her gloves and put on a new pair of gloves. She did not wash or sanitize her hand during this process. HSK #1 grabbed a mop pad from her cart. She rang the excess water from the mop pad. She reentered the resident room and dropped one mop pad on the floor by the window. She returned to the cart and grabbed a mop handle. She proceeded to wash the floor with the mop. She then entered the restroom and proceeded to wash the restroom floor. She finished mopping the floor with the mop working herself out to the doorway. She exited the room and pulled the mop pad off with her same contaminated gloved hands and placed the mop pad in the plastic bag. She removed her gloves and threw them into the trash on her cart. Throughout this entire process HSK #1 did not change her gloves or perform hand hygiene in between tasks while leaving the resident's room to take items from her cart. HSK #1 then walked over the linen closet in

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) the hall and retrieved linens to make the bed. She returned to the room and proceeded to make the bed. She did not have any gloves on as she made the bed. She completed making the bed and completed the room. She did not wash or sanitize her hands before or after making the resident's bed and finishing the room-cleaning process. B. Staff interviews HSK #1 was interviewed on 4/13/2020 at 12:28 p.m. She said she would start cleaning the room from the large area to the restroom. She said she left the spray on for three minutes then wiped working her way out of the room. She said she would then mop the floor and then finish mopping the restroom. She said she used the same mop for both the room and the bathroom. The housekeeping supervisor (HS) was interviewed on 1/30/2020 at 1:16 p.m. The HS was told of the observation above. She stated housekeepers should start cleaning from the window out and the restroom should be the last thing to clean. She said they should use different rags for every task or area they were cleaning. She said the disinfectant dwell time should be three to four minutes and then wipe off the area. She said staff needed to change gloves between cleaning areas. She said after they came out of the bathroom they should either wash their hands or use hand sanitizer and then change to a new pair of gloves. She said they should change gloves after every new task especially after cleaning the restroom. She said the housekeeper should use two different mop heads when washing the large room floor and they needed to use another mop for the restroom. She said a negative outcome would be the spread of infections and potential for cross contamination.