STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065171	A. BUILDING _____ B. WING _____	04/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTLAKE CARE COMMUNITY	1655 EATON ST LAKEWOOD, CO 80214

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, resident interviews and staff interviews, the facility failed to maintain an infection control program designed to prevent possible spread of the Corona disease (COVID-19). Specifically, the facility failed to ensure: -Residents wore a face mask or covering when out of their rooms; -Ice coolers and linens were secure from communal use; -Community rooms where residents used computers and phones were cleaned and disinfected after each resident's use; -Beverage carts were cleaned and disinfected before going from one resident's room to another to prevent the spread of infection. Findings include: I. Facility policy and procedure The policy COVID-19 Management, revised April 2, 2020, was provided by the director of nursing (DON) on 4/15/2020 at 12:00 p.m. It read in pertinent part, COVID-19 management (policy) will help prevent the spread of [MEDICAL CONDITION] which is believed to spread through direct person-to-person contact, inhalation of an [MEDICAL CONDITION], and contact with surfaces contaminated by [MEDICAL CONDITION]. Cleaning of contaminated hands, using appropriate PPE (personal protective equipment) and cleaning and disinfecting the environment will be used to help prevent the spread of microorganisms. Our community will use COVID-19 management practices to protect our residents, visitors, and staff from infection. II. Facility failures A. Observations Observations were conducted on 4/15/2020 from 11:00 a.m. to 1:00 p.m. -At 11:00 a.m. Upon entering the facility, none of the four residents in the entry communal area were wearing masks. Upon entering the facility, there were four residents sitting at the entry communal area. There were no masks or face coverings on the residents to prevent the spread of infection. Further observations throughout the facility revealed residents had no masks or face coverings while out of their rooms. -At 11:20 a.m., the ice cooler and scoop were observed in the hallway of the south unit. -At 11:40 a.m., the ice cooler and scoop were observed in the hallway of the north unit. Both ice coolers were accessible to anyone in the facility including residents which could potentially be a risk for the spread of infection. During observations, both ice coolers were not monitored by staff to prevent the spread of infection. -At 11:30 a.m., the south hall linen closet was observed. There were towels, sheets, wash cloths and blankets in the closet. There was a curtain in front of the closet. It was located in front of a resident's door. It was accessible to anyone in the facility including the residents. During observation, it was not monitored by staff to prevent the spread of infection. -At 11:10 a.m., one resident was observed on the phone in the main hallway area between the administrative offices. The phone was available for use by all residents. After the resident was done with the phone, he hung up and left the area. The phone was not cleaned or disinfected by staff after the resident had completed his phone call. -At 11:59 a.m., the southern community room was observed. In the room was a computer, phone and a television. The room was accessible to all residents who wanted to use the computer or phone. Resident #2 was observed playing card games on the computer (communal computer). -At 11:40 a.m. three staff were observed distributing drinks to resident rooms from a cart. The drinks were on top and covered with plastic, the cups were stacked on the bottom of the cart and were not covered. They pushed both carts into one resident's room, came out and pushed both beverage carts into another resident's room. The ready to use cups were uncovered. The staff did not clean or disinfect the cart prior to pushing it into another resident's room. B. Resident interviews Resident #1 was interviewed on 4/15/2020 at 11:25 a.m. He said the facility had not offered him a face mask or covering. Resident #2 was interviewed on 4/15/2020 at 12:00 p.m. He was observed in the community room. He was playing a card game on the computer. He said the community room was not monitored by staff. He said it was used by any residents who wanted to use it. He said he had not seen staff clean and disinfect the computer or phones after each resident use. He said the housekeeper would do the regular cleaning of the room, but was not sure if they cleaned and disinfected the computer or phone after it was used by a resident. He said he was aware of COVID-19 but he was not offered or told to wear a mask or face covering. He said masks were only worn by staff. C. Staff interviews Housekeeper (HK) #1 was interviewed on 4/15/2020 at 12:00 p.m. She said each HK was responsible for a hall, including communal areas. She said all areas of the facility were cleaned twice a day. She said all communal areas and electronics should be wiped down and disinfected after resident use (during observations the phone and computer were not cleaned and disinfected after they were used by the residents). Dietary aide (DA) #1 was interviewed on 4/15/2020 at 12:55 p.m. He said he brought the carts into the residents' rooms because there were no lids for the beverages. He said the carts were brought into the rooms so that nothing could get into the drinks. He said all drinks and ice were delivered to the residents' rooms before mealtimes and should be covered with plastic. He said drink carts would sometimes be left in the hallway if the residents liked to touch the carts or the things on the cart. He said he did not know how COVID-19 was transmitted. The social services director (SSD) was interviewed on 4/15/20 at 12:55 p.m. She said she assisted with serving beverages to the residents. She said to take the entire cart into the resident's room was not the usual practice at the facility and she was not sure why it was done this way. The ADON, who was also the infection preventionist, was interviewed on 4/15/2020 at 1:26 p.m. She said masks were not provided to the residents due to a shortage of masks. She said masks were only given to residents who were potentially symptomatic. She said she was not aware that all residents were to be wearing face masks or coverings. She said masks were given to residents who had symptoms. She said the ice coolers and linen closets were monitored by staff. She said if the residents needed ice or linen, they would ask the staff. (However, during observation the ice coolers and the linen closets were not monitored by staff and were accessible to anybody. She said she had not put a plan in place regarding the community room. She acknowledged that if the computer or phone was used by a resident in the community room and was not clean or disinfected after use, it could potentially spread infection. She said she would put a plan in place for staff to monitor the room and clean/disinfect after each resident's use to prevent the spread of infection. She also said DA #1 should not have taken the entire cart into the resident's room. She said the cart should have remained in the hall in front of the resident's door. She said taking the cart from one resident's room to the other could spread infection. She said she would provide education to the staff.

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.