STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065239	A. BUILDING _____ B. WING _____	**05/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SAN LUIS CARE CENTER	**240 CRAFT DR ALAMOSA, CO 81101**

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 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based on observation and interview, the facility failed to secure medications and limit access to authorized personnel consistent with professional standards of practice for one of two med storage rooms in the facility. Specifically, the facility failed to store all the over-counter-medications for its residents in a secure location accessible only to nursing staff. Findings include: A. Observations An observation on 4/28/2020 at 3:26 p.m. revealed several shelves of over-the-counter medications were stored in a room where one could see them from a door which led to a main hallway. One could see the laundry room through a door in the room in which they were stored. There was no nursing staff in the room. B. Staff interviews The central supply (CS) staff was interviewed on 4/28/2020 at 3:28 p.m. She said she ordered and stored all of the over-the-counter medications for the facility in that room, and had done so for at least a year. She, the laundry staff, and the maintenance director all had keys to both doors to that storage room, and they all had unrestricted, unsupervised access to it as well. The assistant director of nursing (ADON) was interviewed on 4/28/2020 at 3:48 p.m. She said the over-the-counter medications should not be stored in an unattended room and be accessible to staff who are not nurses. The nursing home administrator (NHA) was interviewed on 4/28/2020 at 3:55 p.m. He said residents ' over-the-counter medications should not be accessible to staff who were not nurses. He said he would have the over-the-counter medications moved to a more secure room, have the door to the room rekeyed, and ensure only nurses had access to the room.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on observations and interviews, the facility failed to maintain an infection and prevention control program to provide a safe environment to help prevent the development and transmission of COVID-19. Specifically, the facility failed to: -follow proper protocol for use of personal protection to ensure adequate supplies for respiratory hygiene and cough etiquette were provided to residents. -Ensure hand hygeine was completed appropriatly; and -Vital machine was cleaned after use. Findings include: I. Face masks for residents A. Professional reference The Center for Disease Control (CDC), Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings (4/30/2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#minimize, (Update April 13, 2020) Patients may remove their cloth face covering when in their rooms but should put them back on when leaving their room or when others (e.g., HCP, visitors) enter the room. Screening for symptoms and appropriate triage, evaluation, and isolation of individuals who report symptoms should still occur. B. Facility policy According to the Infection and Prevention Control Plan (IPCP), provided by the nursing home administrator (NHA) on 4/30/2020 at 7:20 p.m., it was to address the detection, prevention, and control of infection among residents. According to the Group Programming During Public Health Emergency, provided by the nursing home administrator (NHA) on 4/30/2020 at 7:20 p.m., the facility was to implement social distancing and limit social gatherings to less than 10 people. C. Observations On 4/28/2020 at 2:30 p.m., Resident #1 was observed without a mask on at the entrance of the facility; the receptionist was at the entrance and did not offer her a mask. On 4/28/2020 at 2:40 p.m., Resident #5 was observed without a mask as she sat in her wheelchair in the common area of the facility, staff passed by her and did not make attempts to assist or encourage her to place a mask over their nose and mouth On 4/28/2020 at 2:50 p.m., Resident #3 was observed without a mask, he was in his wheelchair next to the medication cart. Registered nurse (RN) #1 stood at the medication cart and did not offer him a mask. On 4/28/2020 at 2:57 p.m. There were 13 residents in the dining room playing bingo and none wore masks which covered their mouth and nose. One male resident wore a mask under his chin and a female resident wore a mask which hung on her ear. There were staff in the dining room and they made no attempt to assist or encourage residents to wear masks, or attempt to assist the male or female resident to place the mask over their nose and mouth. On 4/28/2020 at 3:11 p.m. There were 13 residents in the dining room playing bingo and seven wore masks which covered their mouth and nose. There were staff in the dining room and they made no attempt to assist or encourage the remaining residents to wear masks. On 4/28/2020 at 3:15 p.m. Resident #5 wore a mask under her chin as she self-propelled along the hallway of the facility and stopped in the common area of the facility; she passed by staff who made no attempt to assist or encourage her to place the mask over their nose and mouth. On 4/28/2020 at 3:30 p.m., Resident #5 was observed without a mask as she sat in her wheelchair in the common area of the facility; staff passed by her and did not make attempts to assist or encourage her to place a mask over their nose and mouth. On 4/28/2020 at 3:35 p.m. There were 13 residents in the dining room playing bingo and five wore masks which covered their mouth and nose. One male resident wore a mask under his nose. There were staff in the dining room and they made no attempt to assist or encourage the other residents to wear masks, or attempt to assist the male resident to place the mask over his nose and mouth. On 4/28/2020 at 4:03 p.m. Three residents were observed in the same common area of the facility without a mask on; staff passed by them and did not make attempts to assist or encourage them to place the mask over their nose and mouth. On 4/28/2020 at 4:11 p.m. Two residents (#1 and #2) were observed in the same common area of the facility without a mask on, were next to each other, and Resident #1 placed her hand on Resident #2 ' s arm; staff passed by them and did not make attempts to assist or encourage them to place the mask over their nose and mouth, nor move them apart six feet. Down the hall from this common area Resident #3 was observed without a mask, he was in his wheelchair next to the medication cart. RN #1 stood at the medication cart and did not offer him a mask. B. Resident interview Resident #3 was interviewed on 4/28/2020 at p.m. He said the masks the facility provided residents were too small (as he displayed his attempts to put the mask on the elastic appeared too tight and the surface of the mask did not thoroughly cover his mouth and nose, and it did not reach his chin). He said he could not wear the mask (he held the mask in his hand after he took it off to show how tight it was on his head). C. Staff interviews Certified nurse aide (CNA) #2 was interviewed on 4/28/2020 at 3:04 p.m. He said residents were to wear masks when they were out of their rooms. RN #1 was interviewed on 4/28/2020 at 3:21 p.m. She said residents were to wear masks when not in their rooms. If they take the mask off, or do not wear the mask, staff were supposed to remind them or encourage them to wear a mask to protect them. The infection control preventionist (ICP) was interviewed on 4/28/2020 at 4:18 p.m. The ICP said the residents should be wearing masks when out of their rooms. She said that staff and residents had both been educated on the importance of wearing the masks when out of their rooms. II. Hand washing According to the Centers for Disease and Prevention (CDC) Hand Hygiene in Healthcare Settings, last up updated 1/31/2020, retrieved from https://www.cdc.gov/handhygiene/providers/index.html, included the following

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065239	A. BUILDING _____ B. WING _____	**05/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SAN LUIS CARE CENTER	**240 CRAFT DR ALAMOSA, CO 81101**

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	(continued... from page 1) recommendations: Multiple opportunities for hand hygiene may occur during a single care episode. Following are the clinical indications for hand hygiene: Use an alcohol-based hand sanitizer immediately before touching a patient, before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids or contaminated surfaces, and immediately after glove removal. Wash with soap and water when hands are visibly soiled, after caring for a person with known or suspected infectious diarrhea, and after known or suspected exposure to spores. When using alcohol-based hand sanitizer, put the product on hands and rub hands together. Cover all surfaces until hands feel dry. This should take around 20 seconds. When cleaning hands with soap and water, wet hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Avoid using hot water, to prevent drying of skin. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times. Observations On 4/28/2020 at 4:36 p.m., CNA #7 was observed to enter a resident ' s room. She assisted the resident in bed B, and then assisted the resident in bed A. She did not wash her hands in between residents. The CNA #7 was interviewed on 4/28/2020 at approximately 4:45 p.m. The CNA #7 confirmed she did not wash her hands in between the two residents. She said she should of washed her hands. Interviews The infection control preventionist was interviewed on 4/28/2020 at approximetly 5:00 p.m. The ICP said the staff had been trained on hand washing. She said the staff were to wash for 20 seconds. III. Equipment cleaning A. Observation On 4/28/2020 at approximately 5:00 p.m., CNA # 1 was observed to push the vital machine into a room and proceeded to take the vitals on a resident. The CNA then proceeded to push the vital machine into the hallway. She left the vital machine in the hallway and did not clean it. Interview The ICP was interviewed at approximately 5:00 p.m. The ICP was informed of the above observation. She said that the vital machine should be cleaned with appropriate cleaning wipe prior to it being left in the hallway. She said she would provide training.