STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065212	A. BUILDING _____ B. WING _____	04/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CENTENNIAL HEALTH CARE CENTER	1637 29TH AVENUE PL GREELEY, CO 80634

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 ensure infection control practices were established and maintained to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of Coronavirus (COVID-19) and other communicable diseases, and infections. Specifically, the facility failed to: -Ensure staff were following proper hand hygiene procedures; -Provide hand hygiene opportunities for residents; -Ensure staff were following proper cleaning techniques for room cleaning. Findings include: I. Facility policies The Infection Prevention Overview policy, not dated, was provided via email by the nursing home administrator (NHA) on 4/1/2020. It read in part, prevention of spread of infection is accomplished by the use of hand hygiene standards of precautions. Staff and resident education focus risk of infection and practices to decrease risk. II. Failure to provide hand hygiene opportunities for residents A. Observations On 4/1/2020 at 8:13 a.m., certified nurse aide (CNA) #2 was observed to pass a tray to a resident on the North side. She failed to offer handwashing to the resident. On 4/1/2020 at 8:24 a.m., CNA #1 was observed serve the breakfast tray to Resident #1. The CNA set the resident's meal up, however, she failed to offer handwashing to the resident. On 4/1/2020 at 8:30 a.m., the physical therapist (PT) was observed to serve the breakfast tray to Resident #2. The PT failed to offer handwashing to the resident. On 4/1/2020 at approximately 8:45 a.m., the PT served the breakfast tray to Resident #3. The PT failed to offer hand washing to the resident. B. Interview The interim director of nurses (IDON) was interviewed on 4/1/2020 at approximately 4:30 p.m. The IDON said residents should be assisted with handwashing before and after meals. She said their were a variety of ways the residents hands could be washed. III. Clinical visit observation and interview On 4/1/2020 at 10:53 a.m. the nurse practitioner (NP) was observed visiting with residents and providing clinical assessments. She approached room [ROOM NUMBER] and placed on the floor outside of the room a bottle of germicidal disinfectant and a notebook with a pen. She entered the non-COVID-19 room with a stethoscope around her neck and the finger pulse oximeter. She washed her hands at the sink prior to donning gloves. Spoke to the resident in the room, asked the resident to stick out her tongue, asked the resident if she wanted water to drink. She auscultated the resident's lung sounds and abdomen with the stethoscope and placed the finger pulse oximeter on the resident's finger. When the assessment was completed the NP reached outside of the room and grabbed the pen and the notebook and wrote a note that she gave to the resident. She reached outside the room and from the floor sprayed the germicidal disinfectant on the finger pulse oximeter and the stethoscope. She grabbed a few towels to dry the finger pulse oximeter and the stethoscope at the sink inside the resident's room. The NP said there was not enough disinfectant wipes so she was using the germicidal spray and wiping the items off with towels. She said she wanted to keep the residents safe so she was not bringing her notebook or pen inside the rooms. She said she was going to enter a few of the rooms that were COVID-19 positive in a short while. Hallway 300 contained eight rooms and four of them were on COVID-19 precautions/isolation. The interim director of nurses (IDON) was interviewed on 4/1/2020 at 4:30 p.m. She said she would provide a clean surface for the NP to place the notebook, pen and bottle of germicidal disinfectant on to prevent from setting items on the floor causing a potential for cross contamination. IV. Observation of the cleaning of a resident's room and interview On 4/1/2020 at 12:35 p.m. observed housekeeper (HSK) #1 cleaning room [ROOM NUMBER]. CNA #3 translated during the discussion. HSK said she received COVID-19 training. The training included wearing a mask, frequent hand washing and keeping distance. She said she was told to use the germicidal disinfectant on the sink and frequently touched surfaces. She said she was assigned the rooms that did not have COVID-19 precautions/isolation. The housekeeping supervisor said that she provided the training to the housekeeping staff and devoted staff to COVID-19 positive rooms. The HSK was wearing a surgical mask and said she changed it at the end of the week or if it was difficult to breathe. HSK used alcohol based hand rub (ABHR) on the cleaning cart then donned gloves before entering the room. She emptied the trash and changed the trash bags in the double occupancy room. She sprayed the sink and the soap and towel dispensers with the germicidal disinfectant. She sprayed a rag with the germicidal disinfectant then wiped the handle on the entrance door front and back. She used the rag without reapplication of the germicidal disinfectant and wiped off the resident's bedside table, which was in front of the resident at the moment. The HSK wiped off the resident's water container, the television remote, then down the sides of the bedside table to the foot. She wiped off the handles on the dresser and across the top of the television. She then went back to the sink, soap and towel dispensers and wiped them off with the same rag as she used to dust the room. She rinsed the sink with water. She continued to use the rag and wiped off the handrails in the bathroom and the top of the toilet without reapplication of the germicidal disinfectant. She wiped off the mirror and then left the room to grab the toilet bowl cleaner and brush from the cleaning cart outside of the room. She then put the liquid toilet bowl cleaner in the bowl of the toilet. She used the toilet bowl brush to scrub the inside of the bowl, underside of the lid and then on the top of the seat. She used the same rag without reapplication of the disinfectant, wiped off the top of the toilet seat, down the sides of the toilet along the floor, then on the handrails and back to the top of the tank. She finished by putting the rag in a bag for dirty rags, swept and mopped the floor. The interim director of nurses (IDON) was interviewed on 4/1/2020 at approximately 4:30 p.m. She said the housekeeping staff were trained on what chemical should be used on the different types of surfaces. She said the housekeeper should have sprayed the surfaces that required disinfecting with the germicidal disinfectant spray then wait for three minutes before wiping the surface clean. She said the rag should not be used to wipe off surfaces without the surface being saturated with the germicidal disinfectant. She said the toilet brush should be used inside the toilet bowl and never on the 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.