STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065269	A. BUILDING _____ B. WING _____	03/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF PUEBLO	2118 CHATALET LN PUEBLO, CO 81005

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 failed to ensure infection control practices were followed to prevent possible spread of the Coronavirus disease (COVID-19) for three (#1, #2, #3, and #4) of five residents out of 12 sample residents. Specifically the facility failed to: -Follow proper isolation precautions with mask, hand hygiene and glove use for Resident #1, #2, #3, and #4; and, -Follow proper isolation precautions during meal times. Findings include: I. Improper isolation precautions for Resident 1, #2, #3 and #4. A. Resident #1 1. Resident status Resident #1, age 94, was admitted on [DATE]. According to the March 2020 current physician orders [REDACTED]. According to the 3/9/2020 minimum data set (MDS) assessment, the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of eight out of 15. The resident received oxygen therapy. 2. Record review The care plan, initiated 11/21/18 and revised 3/9/2020, identified the resident had oxygen therapy related to (R/T) ineffective gas exchange. The resident frequently removes her oxygen cannula and forgets to replace it. She will also change the liter flow. Interventions include observing for signs and symptoms of respiratory distress and reporting to a medical doctor (MD) as needed (PRN). Check respirations, pulse oximetry, increased heart rate ([MEDICAL CONDITION], restlessness, diaphoresis, headaches, lethargy, confusion, atelectasis, hemoptysis, cough, pleuritic pain, accessory muscle usage, and skin color. Resident #1 did not have a CPO for the isolation precautions related to a roommate with symptoms of respiratory infection. Resident #1 did not have a care plan identifying isolation precautions. Nurse log note dated 3/24/2020 at 6:27 p.m., revealed this nurse notified Resident #1's family of the [MEDICAL CONDITION] respiratory panel to include coronavirus (COVID) 19 testing. Would notify once results are received. Education on isolations precautions, monitoring residents, and close contact with the public health department. No other question or concerns at this time. 3. Observations On 3/30/2020 at 10:25 a.m., Resident #1 was observed self-propelling herself out of her room and down the hall next to the medication cart. Several staff members walked by Resident #1 with no interaction or redirection to return to her room. A female resident self-propelled herself next to Resident #1 on the way to her room. -At 10:41 a.m., licensed practical nurse (LPN) # 2 observed Resident #1 in the hall. LPN #2 leaned over Resident touched her on the shoulder and said, You should not be in the hall, you need to stay in your room. LPN #2 grabbed the handles on Resident #1's wheel chair turned her around and escorted Resident #1 back into her room. LPN #2 returned to the medication cart and did not wash or sanitize her hands. -At 10:56 a.m., Resident #1 was observed exiting her room. Resident #1 was approximately six feet outside of her doorway. Several staff were observed to walk by her without redirecting Resident #1 back into her room. -At 11:06 a.m., the assistant director of nursing (ADON) was observed to redirect Resident #1 back into her room. Resident #1 complied with redirection and reentered her room. 4. Interviews LPN #3 was interviewed on 3/30/2020 at 10:43 a.m. She said Resident #1 was placed in isolation precautions on 3/25/2020 related to a roommate with symptoms of respiratory infection, and chronic cough. She said the resident was on droplet precautions and when providing care, all staff should wear a mask, gown, gloves and goggles while providing care. She said Resident #1 liked to come out of her room but she was easily redirected but would come right back out of her room. LPN #2 said, I should wash my hands when coming into close contact with Resident #1. Certified nurse aide (CNA) #3 was interviewed on 3/30/2020 at 11:13 a.m. She said the resident was on isolation precautions due to her cough. She said staff should wear all personal protective equipment while providing care to Resident #1. She said all staff should wash their hands if they come into contact with any resident on isolations precautions. B. Resident #2 1. Observations of Resident #2 On 3/30/2020 at 10:38 a.m., registered nurse (RN) #2 was observed administering morning medications to Resident #2 and #3. RN #2 put on a pair of gloves and put on her mask. She did not put on a gown or goggles. RN #2 entered the resident rooms with two plastic cups with the Resident #2 medications. She was observed to lifting Resident #2 by the hand to sit-up while she was in bed. She administered Resident #2's medication. She exited the room and returned and washed her hands in the sink in the residents' room. She dried her hands with a paper towel and lifted the red medical container with her ungloved hands and exited the resident room. She returned to the medication cart and retrieved the medication of Resident #3. She reentered the residents' room and did not put on gloves. She placed the medication on the bedside table. She proceeded to wake Resident #3 who was in bed sleeping. RN #2 lifted Resident #3 up by her hand into a sitting position so she could take her medication. RN #2 grabbed the medications and administered Resident #3's medication. RN #2 finished administering the resident's medication and proceeded to wash her hands. She dried her hands with a paper towel and lifted the lid of the red medical waste container with her ungloved hand. She exited the residents ' room and proceeded to prepare the next resident medications. 2. Resident status Resident #2, age 77, was admitted on [DATE] and readmitted on [DATE]. According to the March 2020 CPO, [DIAGNOSES REDACTED]. According to the 12/30/19 minimum data set (MDS) assessment, the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 13 out of 15. TThe resident received oxygen therapy. 3. Record review The care plan, initiated 10/11/18 and revised 12/30/19, identified the resident received oxygen therapy r/t ineffective gas exchange. Interventions include observing for signs and symptoms of respiratory distress and reporting to a medical doctor (MD) as needed (PRN). Check respirations, pulse oximetry, increased heart rate ([MEDICAL CONDITION], restlessness, diaphoresis, headaches, lethargy, confusion, atelectasis, hemoptysis, cough, pleuritic pain, accessory muscle usage, and skin color. Prevent abdomen compression and respiratory embarrassment by routinely checking the resident's position so he or she does not slide down in bed. Resident #2 did not have a CPO for the isolation precautions related to respiratory distress. Resident #2 did not have a care plan identifying isolation precautions. Nurse log note dated 3/25/2020 at 5:04 p.m., revealed this nurse notified Resident #2 [MEDICAL CONDITION] respiratory panel testing to include COVID 19 testing. Will notify once results are received. Education on isolation precautions, monitoring residents, and close contact with the public health department. Resident verbalized understanding. No other question or concerns at this time. C. Resident #3 1. Resident status Resident #3, age 63, was admitted on [DATE]. According to the March 2020 CPO, [DIAGNOSES REDACTED]. According to the 3/10/2020 minimum data set (MDS) assessment, the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of five out of 15. The resident received oxygen therapy. 2. Record review The care plan, initiated 2/6/2020 and revised 3/10/2020, identified the resident received oxygen therapy r/t respiratory illness. Interventions include giving medications as ordered by a physician. Oxygen setting at 2/liters per minute continuous. Resident #3 did not have a CPO for the isolation precautions related to respiratory distress. Resident #3 did not have a care plan identifying isolation precautions. Nurse log note dated 3/25/2020 at 6:29 p.m., revealed this nurse notified the family of the [MEDICAL CONDITION] panel to include coronavirus (COVID) 19. Would notify once results are received. Education on isolations precautions, monitoring residents, and close contact with the public health department. No other question or concerns at this time. 3. Interviews RN #2 was interviewed on 3/30/2020 at 1:15 p.m. She said Resident #2 and #3 were in isolation since 3/25/2020 due to respiratory issues. She said the process upon entering the residents' rooms was that all staff are required to wear gloves, mask, goggles and gown. She said all staff were supposed to wash their hands with soap after completing care of residents ' and between providing care between other residents. She said she wore all PPE during medication administration. She said she did not put on an apron. She said she should have had her gown

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) on and she should have washed her hands between both residents ' care. RN #2 stated she should have followed the isolation precaution process when entering the residents room. RN #2 said she was not aware if the residents ' care plan identified isolation precautions. The facility consultant (FC) and director of nursing (DON) were interviewed on 3/30/2020 at 1:30 p.m. They were told of the observations listed above. The FC said the facility had been completing audits to ensure adequate infection control protocol was being followed. She said they would update training and provide further services to reiterate the importance of following infection control protocol to include physician order [REDACTED]. The DON said a negative outcome of not following infection control protocol would be spread of infections to other residents and staff. D. Resident #4 1. Resident status Resident #4, age 92 was admitted to the facility on [DATE]. According to the March 2020 computerized physician orders [REDACTED]. The 1/20/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 6 out of 15. The resident required extensive assistance of one person for transfers, toileting, dressing, and meals. There was a risk for skin breakdown. Resident was on oxygen. 2. Observations and interviews for Resident #4 Resident #4 was observed on 3/30/2020 at 11:15 a.m. to leave her isolation room and go to the common area where three other residents sat. Certified nurse aide (CNA) #4 assisted the resident back to her room. The CNA did not wear gloves and did not wash her hands after she left the residents room. The resident nor the CNA wore a mask. -At 11:20 a.m. resident left the isolation room and licensed practical nurse (LPN) #1 assisted her back into the room. She did not wear gloves, nor mask and did not wash her hands after she left the room. -At 11:40 a.m the resident tried to leave her the isolation room, LPN #3 stood at the doorway to redirect the resident to stay in her room. She did not have a mask on and she touched the resident with her bare hands. She walked away later without washing her hands. CNA #4 was interviewed on 3/30/20 at 11:20 a.m., she said Resident #4 left her room often. She said the resident was not supposed to be out of her room as she was on isolation precautions. She said the resident had a cough. She said she had a mask to wear and to use the cloth mask that was in the residents drawer to cover her own mask when she was in the room. She said her mask was in the brown bag the facility gave her and she wore that when a resident or herself had symptoms. She said the resident did not wear a mask. 3. Record review for Resident #4 Nurse progress note reviewed on 3/30/2020 at 2:00 p.m. dated 3/23/2020 at 15:12p.m. read in pertinent part; Resident #4 was on droplet precautions for respiratory symptoms per facility protocol. Resident continues to leave the room and be redirected. and another note on 3/24/2020 at 8:03 a.m. Read in pertinent part: Monitoring residents while on isolation droplet precaution for respiratory symptoms. Resident leaves the room occasionally and is redirected back to the room. II. Observations and interview at meal time Three resident rooms #314, #315, and #324 were observed on 3/30/2020 at 10:00 a.m to have isolation bins inside the room. There was a hospital gown that hung on each bin area and red bags in the trash can next to that. One of the rooms had two isolation bin areas set up as that was a double occupancy room. All three room doors were open and the sign on the doors said droplet precautions. CNA #4 was observed on 3/30/2020 at 11:45 a.m. to enter isolation room [ROOM NUMBER]. She walked into the room without any protective equipment on, no gloves, no mask and washed her hands in the sink three feet from the resident. She walked out of the room and donned the hospital gown, shoe covers, gloves and mask. She took the food tray from the container in the hallway into the room for the resident. CNA #1 was interviewed on 3/30/2020 at 11:50 a.m. She said she goofed up on the process when to put the isolation gown, gloves and mask on. She said she had training for that but forgot. She said when the residents on isolation finished the meal the tray was put in a bag and then placed on a red cart that was separate from the rest of the food trays. Dietary manager (DM) was interviewed on 3/30/2020 at 1:30 p.m. She said the trays from the isolation room were placed in sugar bags and ran through the dishwasher. She said there was no specific cart used for the isolation trays. III. Interviews LPN #1 was interviewed on 3/30/2020 at 10:15 a m., she said the residents that were in isolation had a higher risk for respiratory illness. She said the facility focused on safety for the community. She said the residents had no fever and nor symptoms of cough or shortness of breath. She said the residents were tested for the Covid-19 virus but the tests were pending from the lab. She said the lab results took over five to seven days to get back. She said Resident #4 was confused and the facility staff had a hard time to keep her isolated in her room. She said the resident had a mask on at times but would take that off. CNA #1 was interviewed on 3/30/2020 at 10:30 a.m., she said the resident that resided in room [ROOM NUMBER] had been in isolation for a week. She said she was trained to wear a mask and gloves in the isolation rooms. She said the mask was optional when to wear that. She said there was a personal protective gown shortage so she was taught to rewear a hospital gown for each room. Central supply director (CSD) was observed and interviewed on 3/30/2020 at 10:45 a.m. to stock the supply closet with gloves and gowns. She said there was a shortage of gowns and she ordered all supplies on Wednesdays and they were delivered on Thursdays from their supplier. Every employee had one mask and the facility used cloth masks for the isolation residents. She said the employees had to reuse their mask with a cloth mask over that when they were in the isolation rooms. The Director of nurses (DON) was interviewed on 3/30/2020 at 1:30 p.m. She said they tested residents who had symptoms of shortness of breath and cough. She said she had trained the facility staff about hand hygiene and how to use the personal protective equipment (PPE). She would expect the staff to use the PPE with the isolation residents. IV. Follow-up Observations after interviews on 3/30/2020 at 2:00 p.m. showed isolation rooms #314, #315 and #324 doors were now closed.