STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065272	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIERRA REHABILITATION AND CARE COMMUNITY	1432 DEPEW 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, interviews and record review, the facility failed to implement and follow Centers for Disease Control (CDC) guidelines to prevent possible transmission of the infectious disease, COVID-19. Specifically, the facility failed to: -Ensure isolation rooms were properly set-up, with PPE (personal protective equipment) guidelines identified; and, -Ensure staff entered and exited isolation rooms appropriately. Additional identified concerns related to the facility infection control process were confirmed by the regional consultant (RC), and medical director (MD), and immediate plans were implemented during the investigation. Findings include: I. Professional references The Centers for Disease Control (2020) Coronavirus (Covid-2019), retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cleaning-disinfection.html.It read in pertinent part, Dedicate a lined trash can for the ill person. Use gloves when removing garbage bags, handling, and disposing of trash. According to the Centers for Medicare and Medicaid Services (CMS) COVID-19 Long-Term Care Facility Guidance April 2, 2020, if possible, isolate all admitted residents (including readmissions) in their room for 14 days if their COVID-19 status is unknown. According to the Centers for Disease Control (CDC) website, Preparing for COVID-19: Long-term Care Facilities, Nursing Homes https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html (Retrieved 4/29/2020) cloth face coverings are not considered personal protective equipment (PPE) because their capability to protect healthcare personnel (HCP) is unknown. HCP who enter the room of a patient with known or suspected COVID-19 should adhere to standard precautions and use of respirator, gown, gloves and eye protection. When available, respirators should be prioritized for situations where respiratory protection is most important and the care of patients with pathogens requiring airborne precautions. HCP should perform hand hygiene before and after all patient contact, contact with potentially infectious material and before putting on and after removing PPE, including gloves. The PPE recommended when caring for a patient with known or suspected COVID-19 includes: Put on an N95 respirator (or higher level of respirator) or facemask (if a respirator is not available) before entry into the patient room or care area. Cloth face coverings are NOT PPE and should not be worn for the care of patients with known or suspected COVID-19). Remove eye protection before leaving the patient room or care area. Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use. II. Isolation room observations and staff interviews On 6/29/2020 at 3:15 p.m. the director of nursing (DON) said they had no active cases of COVID-19 in the facility. She said they had one resident, a new admit, who was on isolation at this time. The resident was a new admit from home, without multiple COVID-19 tests, and required quarantine. On 6/29/2020 at 4:05 p.m., resident room [ROOM NUMBER] was observed on isolation. The isolation cart was observed outside the resident room. Two red trash bins were also observed outside the resident room. Numerous residents were observed passing the trash cans, wearing only surgical masks. On 6/30/2020 at 12:43 p.m. the social service director (SSD) was interviewed about the resident readmit and new admit process. She said that upon admission to the facility, the residents and family were informed of the isolation process. She said they let the residents know that they may be on isolation for up to 14 days. On 6/30/2020 at 11:57 a.m. the door to room [ROOM NUMBER], an isolation room, was observed open. The resident was observed coming out of the bathroom, with certified nurse aide (CNA) #1 present to assist. The staff member was observed wearing a blue disposable gown, gloves, a surgical mask, and her personal glasses. She exited the resident ' s room at 12:00 p.m. with her gloves already removed. She exited the resident ' s room with bare hands, and then doffed her disposable gown in the hallway, and rolled it up tightly. She attempted to open the lid on the red bagged trash can, knocking the lid to the floor multiple times. With bare hands, she was finally successful in placing the rolled up gown into the red trash can. She then picked up a small plastic bottle of hand sanitizer that was left on top of the isolation cart, opened it, placed product in her hands, and placed the bottle back onto the isolation cart. The bottle was not wiped down or sanitized. The staff member then left. She did not remove or clean her personal glasses, or replace the surgical mask she had been consistently wearing. Three residents were observed in the hallway, in close proximity to room [ROOM NUMBER]. On 6/30/2020 at 3:15 p.m. a surveyor and DON went down the facility hallway to ensure the isolation cart for room [ROOM NUMBER] was set up correctly. The facility identified that additional isolation was needed for facility residents while clarifying the readmit process, identified in the investigation. An isolation cart had just been placed outside room [ROOM NUMBER]. A staff member was observed inside the resident room providing care. He was wearing a surgical mask, but no other PPE. The multiple doffing trash bins were also placed outside the resident room. Residents in surgical masks were observed in close proximity to the isolation bins. On 6/30/2020 at 3:19 p.m. the DON said that the new isolation cart for room [ROOM NUMBER] was not set-up correctly. She said that the trash bins should be inside the room. She did not know who had set-up the isolation station, but said she would be educating staff on proper set-up and moving the bins inside the room. III. Improper use and disposal of personal protective equipment (PPE) Observations and interviews On 6/29/2020 the following observations were of an isolation room for a newly admitted resident: -At 4:00 p.m. two red bins labeled linen and trash sat outside the room.The pairs of protective eyewear sat in a bucket on top of a cart next to the two red bins. The assistant director of nursing (ADON) confirmed the bins were for disposal of PPE and trash from the isolation room. She said she was unsure if the protective eyewear had been sanitized. She said she was unaware of what the process was for use of PPE. -At 4:11 p.m. the resident opened the door and walked into the hallway of the unit with his cloth mask pulled down underneath his chin. He was greeted by two staff without any prompting or encouragement to return to his room or to place his mask on his face before a third staff person asked what he needed and asked him to return his room. The resident requested the use of a phone. The resident returned to his room and the door remained open. -At 4:15 p.m. the ADON was observed as she donned PPE to enter the room. She put on a gown and gloves and wore a surgical mask. She did not don a N95 mask, protective eyewear or face shield. She entered the room and spoke to the resident with the door open about his request for a phone to be able to check on an upcoming appointment. IV. Improper hand hygiene A.Professional standard The Centers for Disease and Prevention (CDC) Hand Hygiene in Healthcare Settings, last up updated 4/15/2020, retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-strategies.html included guidance the facilities should remind residents to perform frequent hand hygiene. According to the Centers for Disease Control and Prevention (2019), Hand Hygiene in Healthcare Settings, retrieved from https://www.cdc.gov/handhygiene/index.html, read in part, [MEDICATION NAME] hand hygiene is a simple yet effective way to prevent infections. Cleaning your hands can prevent the spread of germs, including those that are resistant to antibiotics. On average, healthcare providers clean their hands less than half of the times they should. Hand hygiene should be performed before eating, before and after having direct contact with a patient's intact skin, after contact with inanimate objects (including medical equipment). When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands 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

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
	065272	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIERRA REHABILITATION AND CARE COMMUNITY	1432 DEPEW 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	(continued... from page 1) 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. B.Observations and interviews On 6/30/2020 the following observations were made of the secured memory unit. -At 12:10 p.m. CNA #2 delivered a meal tray to a resident sitting in the dining room. She did not offer hand hygiene assistance to the resident. -At 12:12 p.m. LPN #3 delivered a meal tray to a resident in their room. She did not offer hand hygiene assistance to the resident. -At 12:15 p.m. CNA #2 delivered a meal tray to a resident ' s room. She placed the meal tray on a side table next to the resident ' s bed and adjusted the tray to be in front of the resident. She then adjusted the resident ' s bed position to sit him up straight in order to eat his meal. She opened condiment packages for the resident and applied the condiments for the resident. She did not offer hand hygiene assistance to the resident prior to serving his meal. LPN #3 was interviewed at 12:18 p.m. She said that the staff typically assisted the residents to perform hand hygiene throughout the day and before meals, however, it was an oversight they did not assist residents to perform hand hygiene prior to meals on the day of observations because the staff was nervous. She said that the staff was trained to assist residents with hand hygiene prior to meals. C.Administrative interviews The director of nursing (DON) and nursing home administrator (NHA) were interviewed on 6/30/2020 at 11:30 a.m. The DON said that the facility had been cleared to take new residents in the facility at the end of May 2020 and the medical director (MD) for the facility had set guidelines for admitting residents based on guidelines from the Centers for Disease Control and Prevention (CDC). She said whether or not the resident was placed on isolation precautions upon being admitted the facility was dependent upon how long they had been in the hospital for, the outcome of the Covid-19 testing and whether or not they had previously been tested positive. She said if a resident was admitted from the hospital, the facility required two negative tests for Covid-19. She said the facility used surgical masks and not N95 masks to provide care for the residents that were still on isolation precautions at the facility. She said that staff should doff their PPE in the red bins outside of the room in the hallway. The NHA said that the problem with N95 masks was having a proper fit and some staff, such as himself, had beards which made it difficult to have the right fit. The DON and NHA were interviewed again on 6/30/2020 at 1:55 p.m. along with the regional consultant (RC) and facilities MD who joined via conference call. The NHA said that one of the six newly admitted residents to the facility from the hospital had not had a second negative Covid-19 result prior to being admitted . He said that they would order a second test for the resident. The RC said that the facility was immediately placed on an admission hold and testing would be completed for all residents. The RC said that weekly training was completed with staff and bins for disposing of contaminated PPE should be in the resident ' s room and never in the hallway. She said she had initiated an immediate retraining of staff. The MD said that instructions for admissions had been misunderstood and the six newly admitted residents from the hospital should have been on isolation precautions.