STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065327	A. BUILDING _____ B. WING _____	07/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JUNIPER VILLAGE - THE SPEARLY CENTER	2205 W 29TH AVE DENVER, CO 80211

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, record review and interviews, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary environment and to help prevent the development and transmission of communicable diseases and infections such as COVID-19 in three of three units. Specifically, the facility: -Failed to ensure residents were offered hand hygiene before meals; -Failed to ensure employees used alcohol based hand rub (ABHR) appropriately; -Failed to ensure equipment (vital sign) was disinfected and staff were knowledgeable of dwell times (time the surface must remain wet with the product to be effective); -Failed to ensure housekeeping staff performed hand hygiene when gloves were changed, changed gloves between contaminated items, and housekeeping and maintenance staff disinfected potentially contaminated surfaces, and used appropriate dwell times; and, -Failed to actively screen employees for signs and symptoms of COVID-19 prior to allowing them to work. Findings include: I. Status of COVID-19 in the facility The director of nursing (DON) was interviewed on 7/13/2020 at 1:00 p.m. She reported the resident census was 105 and there were no COVID-19 positive residents in the facility. She said there were two staff members on isolation at home, ill with COVID-19 symptoms, and four asymptomatic staff on quarantine after they tested positive for COVID-19. She said since the pandemic started nine residents passed away from COVID-19 in the facility. II. Failed to ensure residents were offered hand hygiene before meals on three of three units. A. Professional reference The CDC Interim Infection Prevention and Control (3/13/2020) Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes, retrieved from: ttps://www.cms.gov/files/document/qso-20-14-nh-revised.pdf. It read in pertinent part, Remind residents to practice social distancing and perform frequent hand hygiene. B. Facility policy and procedure The Handwashing, Hand Hygiene policy as mentioned previously, documented in pertinent part, Encourage residents and families to perform hand washing. C. Spruce unit 1. Observations On 7/13/2020 at 12:10 p.m. the steam table arrived in the common area in front of the nurse station. The dietary aide (DA) commented to another staff person that she had no plastic to cover the food for delivery to resident rooms. At 12:16 p.m., the DA plated food for a female resident sitting in the common area near the steam table. There was no silverware provided to the resident. She began eating the pasta with her fingers. No hand hygiene was offered to the resident before she was served and began eating.he was observed adjusting her table just prior to being served. At 12:18 p.m., the DA plated food for a male resident sitting in the common area near the steam table. There was no silverware provided to the resident. He began eating a slice of bread with his hands. No hand hygiene was offered to the resident before he was served and began eating. He had been seen playing the harmonica in the hall prior to lunch and walking back and forth to his room. At 12:20 p.m., a certified nurse aide (CNA) carried two uncovered disposable plates to room [ROOM NUMBER] and handed them to a resident. The plates were not covered during distribution to prevent contamination. No hand hygiene was offered or encouraged to the resident at the doorway. At 12:21 p.m., a male resident sitting in a wheelchair at a bedside table was in the hallway. He was served a plate of food. He was not offered hand hygiene. 2. Staff interviews On 7/14/2020 at 5:41 p.m. CNA #4 was interviewed. She said she offered residents a wipe to clean their hands before meals. -However, this was not observed on 7/13/2020. On 7/14/2020 at 5:44 p.m. CNA #1 was interviewed. She said she encouraged residents to wash their hands before meals. -However, this was not observed on 7/13/2020. On 7/14/2020 at 5:47p.m. CNA #2 was interviewed. She said she encouraged residents to wash their hands after going to the bathroom, before and after smoking and after going to the bathroom. -However, this CNA was on duty on 7/13/2020 and no hand hygiene was observed or encouraged. D. Pinon unit 1. Observations CNA #3 and CNA #5 were observed on 7/13/2020 at 12:00 p.m. passing lunch trays to residents in their rooms on the Pinon unit. All residents on the unit were not offered hand hygiene prior to their meal. 2. Staff Interviews CNA #3 and CNA #8 were interviewed on 7/14/2020 at 5:46 p.m. They said resident hands should be washed before and after every meal. They didn ' t know why residents were not offered hand hygiene at lunch on 7/13/2020. E. Juniper unit 1. Observations On 7/13/2020 at 11:00 a.m., six residents were observed in the dining room sitting at the tables approximately six feet apart. The lunch meal was brought on the steam table at 12:15 p.m. and the food was served to the residents. The residents in the dining room were not offered hand washing or disinfection prior to the meal. Some residents used their hands to pick up food on their plates. On 7/13/2020 at 12:22 p.m., CNA #9 was observed by the steam table assisting with residents ' menu choices. The CNA was holding a sheet of paper with food choices for each resident on the unit. She was wearing gloves. She dropped the sheet of paper, picked it up from the floor and put on the table next to the steam table. She reached out with her gloved hands and picked up a plate with food for a resident. The CNA was asked if she should change gloves before touching the resident's plate. She did change gloves without sanitizing her hands. 2. Resident interview Resident #1 was interviewed on 7/14/2020 at 6:15 p.m. sitting in her wheelchair seated at the table in the dining room. She said the staff did not offer her any hand hygiene prior to her meals. She said she did not have access to a hand sanitizer. F. Managemnet interview The DON was interviewed on 7/14/2020 at 6:48 p.m. She said her expectation was residents' hands were washed before and after meals, after bathroom use or peri-care was done, after smoking a cigarette, and as needed. She said alcohol based hand rub (ABHR) was also available for all residents in the hall. III. Failed to ensure employees used alcohol based hand rub (ABHR) appropriately A. Professional reference The Centers for Disease Control (CDC), Clean hands save lives, When and How to Wash Your Hands last updated 4/2/2020, retrieved 7/15/2020 from: https://www.cdc.gov/handwashing/when-how-handwashing.html. It read in pertinent part, How to use hand sanitizer. Apply the gel product to the palm of one hand (read the label to learn the correct amount).Rub your hands together. Rub the gel over all the surfaces of your hands and fingers until your hands are dry. This should take around 20 seconds. B. Facility policy and procedure The Handwashing, Hand Hygiene policy, dated 4/9/01 and revised 8/1/14, was received from the assistant nursing home administrator (ANHA) on 7/14/2020 at 7:25 p.m. The policy documented in pertinent part, apply product to palm of hands and rub together. Cover all surfaces of hands and fingers until dry. C. Observations and interviews On 7/13/2020 at 10:48 a.m. licensed practical nurse (LPN) #4 was observed preparing medications. Prior to pouring the medication, she placed hand sanitizer on the palms of her hands and rubbed them together. She did not cover her fingers, thumb, or nails, and then shook her hands in the air to dry. On 7/13/2020 at 10:56 a.m. LPN #1 was observed preparing medications. She placed hand sanitizer on the palms of her hands, rubbed them together, did not cover her fingers, thumb or nails. On 7/13/2020 at 11:12 a.m. LPN #1 was observed preparing medications at a medication cart. She cleaned the vital sign equipment with alcohol preparation pads and took the equipment and the medications to the resident's room. She took the resident's blood pressure and checked his pulse and oxygen level. She gave him his medication. She came back to the nurses cart and placed hand sanitizer on her palms, rubbed them together, and then wiped both hands on the front of her pants. On 7/13/2020 at 11:35 a.m. the social worker (SW) was observed walking to the hallway with a cart. She stopped for hand sanitizer on the wall. She rubbed her palms together, she did not cover her fingers, thumb or nails. On 7/13/2020 at 12:10 p.m. a dietary aide brought the steam table to the second floor. She applied hand sanitizer to the palms of her hands and rubbed them together. She did not cover her fingers, thumb or nails. She then with her bare hands began removing the foil covering the food. The director of nursing (DON) was interviewed on 7/14/2020 at 6:48 p.m. The DON said

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 -** Many	(continued... from page 1) she was the infection preventionist for the facility. She said when ABHR was used, the staff should have covered all surfaces of their hands. Hand hygiene is the primary way to prevent the spread of infection. The facility failed to perform hand hygiene appropriately. IV. Failed to ensure equipment (vital sign) was disinfected, and staff were knowledgeable of dwell times (time the surface must remain wet with the product to be effective). A. Professional reference The Centers for Disease Control (CDC) Hand Hygiene in Healthcare Settings, last up updated 6/22/2020, retrieved 7/15/2020 from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-strategies.html. It read in pertinent part, Environmental Cleaning and Disinfection: Develop a schedule for regular cleaning and disinfection of shared equipment. Ensure EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment. The environmental protection agency (EPA), List N: Disinfectants for Use Against [DIAGNOSES REDACTED]-CoV-2 (COVID-19) 5/6/2020 retrieved 7/15/2020 from: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-[DIAGNOSES REDACTED]-cov-2-covid-19. A one to five minute dwell time for product solutions with 70% [MEDICATION NAME] alcohol was documented to be effective for [DIAGNOSES REDACTED] and Covid 19. In addition, the EPA documented the Super Sani Wipes documented a two minute dwell time to be effective against COVID-19. B. Facility policy and procedure The Introduction Section partial policy, undated,, page 6 of 12 was received from the ANHA on 7/14/2020 at 7:25 p.m. It documented, non critical items (e.g., stethoscopes, blood pressure cuffs) are defined as those that come into contact with intact skin. They require a low level disinfection with an EPA disinfectant or germicide that is approved for healthcare settings. C. Observations and interviews On 7/13/2020 at 11:12 a.m. LPN #1 prepared medications for a resident including a blood pressure medication. She said she needed to check his blood pressure first. She wiped the stethoscope with an alcohol preparation pad which evaporated almost immediately, within two to three seconds. She did the same thing to an oxygen saturation machine and a blood pressure cuff. The items dried almost immediately when wiped. A purple top Super Sani Wipe container was observed on a file cabinet next to the nurse. She then went to the residents room and checked his oxygen level and blood pressure. She returned to the nurse station and began to clean the equipment with a purple top Super Sani Wipe. The equipment stayed wet with the product for approximately 20 seconds. The container documented a two minute dwell time on the outside of the container. LPN #1 was asked what the contact or dwell time was for the product. LPN #1 said we let it air dry for a minute, before we use it on someone else. She then read the container and said, we need to let it air dry for two minutes. -However, this was not what contact or dwell time means. Dwell time is the time the equipment must remain wet with the disinfectant product for it to be effective. On 7/14/2020 at 5:41 p.m. CNA #4 was interviewed. She said she used alcohol pads to clean vital sign equipment and that the alcohol dried quickly. She said she cleaned it before and after every use. On 7/14/2020 at 5:44 p.m. CNA #1 was interviewed. She said she used alcohol pads to clean vital sign equipment and that the alcohol dried fast. She did not know how long. She said she cleaned the equipment before and after every use. On 7/14/2020 at 5:47 p.m. CNA #2 was interviewed. She said she used alcohol pads or disinfectant wipes to clean the vital sign equipment before and after each use. She said she did not know what the dwell or contact time was for the alcohol pads or wipes. She said she could not find any of the wipes to check the dwell time. The DON was interviewed on 7/14/2020 at 6:48 p.m. She said the staff should have used disinfectant wipes to clean the vital sign equipment and followed the dwell time. She said the staff can also use alcohol pads, it is better than nothing. V. Failed to ensure housekeeping staff performed hand hygiene when gloves were changed, changed gloves between contaminated items, and housekeeping and maintenance staff disinfected potentially contaminated surfaces, and used appropriate dwell times. A. Professional reference The Center for Disease Control (2019) Provider Infographic Gloves Are Not Enough, retrieved 7/15/2020 from: https://www.cdc.gov/handhygiene/campaign/provider-infographic-6.html. It read in pertinent part, Wearing gloves is not a substitute for cleaning your hands. Your hands can get contaminated while wearing or removing gloves. Cleaning your hands after removing your gloves will help prevent the spread of potentially deadly germs. B. Facility policy and procedure The Using Gloves policy, dated 4/9/01 and revised 8/1/14, was received from the ANHA on 7/14/2020 at 7:25 p.m. The policy documented in pertinent part, removing gloves, discard the glove into a waste receptacle inside the room and wash and dry hands thoroughly. C. Manufacturer recommendations The EPA guidance on the use of Clorox Hydrogen Peroxide was provided by housekeeper (HSK) #2 on 7/13/2020 at 10:05 a.m. The product information documented it must dwell for one minute to be effective. D. Observations and interviews On 7/13/2020 at 9:27 a.m. HSK #2 was observed cleaning room [ROOM NUMBER]. She cleaned the bathroom toilet, rails and walls. She then mopped the bathroom floor. She removed the dirty mop head with her gloved hands and put the mop head in a bucket. She doffed her gloves and donned a new pair. She did not perform any hand hygiene. HSK #2 then cleaned the surfaces of the residents room for the bed closest to the window, including the window sill, wall around the window and outside of the bathroom door. She grabbed a mop, put on a new mop head and mopped this portion of the resident room. After mopping, she removed the dirty mop head with her gloved hands. She did not change her gloves or perform hand hygiene. She then took a bottle of chemical cleaner off the cart and began cleaning the sink. When she was done, she finished mopping the rest of the room. HSK #2 was interviewed about glove use and hand hygiene at that time. She said I don't change my gloves until I am done with the bathroom area. On 7/13/2020 at 10:00 a.m. the maintenance associate (MTN) was observed cleaning the handrails and a chair in the small hall on the second floor. He sprayed a solution and wiped the area dry as he sprayed. The MTN was interviewed regarding the product used and the dwell time. The MTN said the chemical was Clorox Hydrogen peroxide. He said he was not sure what the dwell time was but he sprayed the surface and then wiped it in a couple minutes. He said he completed this task two to three times per day of cleaning the handrails in the hallway. -However, this was not what was observed. The MTN sprayed and immediately wiped the hand rails and chair dry. On 7/13/2020 at 10:30 a.m. HSK#3 was observed cleaning room [ROOM NUMBER]. She cleaned the bathroom, sink, toilet and handrails. She then mopped the bathroom floor. She removed the dirty mop head with her gloved hands and put the mop head in a bucket. She doffed her gloves and donned a new pair. She did not wash or sanitize her hands. She said she did not have a hand sanitizer on her cart. The ANHA was interviewed on 7/14/2020 at 6:45 p.m. She said the disinfectant product should be left on the handrails for two minutes. She said a staff member cleaned the handrails every hour. -However, on 7/13/2020 the second floor was observed continuously from 9:15 a.m. through 12:20 p.m The only time handrails were cleaned, was when maintenance cleaned them without allowing the product to dwell at 10:05 a.m. The ANHA further said the housekeeping staff should have changed their gloves and performed hand hygiene when they finished cleaning the bathroom, between glove changes, and when the room was completed. VI. Failure to actively screen employees upon arrival for work A. Professional Reference The CDC, Preparing for COVID 19 in Nursing Homes retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, updated 6/22/2020, revealed in part, Screen all HCP at the beginning of their shift for fever and symptoms of COVID-19. Actively take their temperature and document absence of symptoms consistent with COVID-19. Retrieved 7/22/2020. B. Interviews The administration concierge (AC) was interviewed on 7/14/2020 at 2:55 p.m. She said employees had a separate entrance into the facility where they took their own temperature and signed off on their own screening prior to their shift. She said she only screened visitors to the facility, not other staff. The DON was interviewed on 7/14/2020 at 3:05 p.m. She said employees were all trained on how to properly take and monitor vital signs. She said they recorded their temperature on a sheet daily and the document was reviewed by department managers later that day or the next morning when they arrived at the facility. She said some employees take their screening sheets with them every day instead of leaving them at the entrance of the facility. She said she trusted her employees to go home and report to a manager if they had a fever when they arrived at work. She said there was not a process to verify the accuracy of staff self-recorded temperatures. CNA #8 was interviewed on 7/14/2020 at 5:46 p.m. She said she entered the facility through a back stairwell and then took her temperature at the nurse's station when she arrived at work. She said she left her temperature record and symptoms sheet in a binder at the nurse's station. Licensed practical nurse (LPN) #3 was interviewed on 7/14/2020 at 5:49 p.m. She said when she arrived at work she entered the third floor through a back staircase then took her temperature when she arrived at the nurse's station. She said there was a binder with sheets and each staff signed off that they did not have any symptoms and recorded their temperature. She said she left it in the book for a manager to review daily.