STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065152	A. BUILDING _____ B. WING _____	**04/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNDANCE SKILLED NURSING AND REHABILITATION	**2612 W CUCHARRAS ST COLORADO SPRINGS, CO 80904**

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 and interviews, the facility failed to effectively follow an infection control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and possible transmission of Coronavirus disease (COVID-19) and infection. Specifically, the facility failed to: -Supply a face mask to a resident on contact and droplet isolation during cares; -Supply face masks for residents to wear when they were outside of their rooms; and -Identify the use of a mobile swamp cooler unit placed next to a resident on isolation precautions. Findings include: I. Failure to ensure face masks were consistently provided and used A. Facility policy and procedure The COVID-19 policy, revised March 2020, was provided by the nursing home administrator (NHA) on 4/16/2020 at 1:00 p.m. It read in pertinent part: The goal is to protect our residents, families, and staff from harm resulting from exposure to an emergent infectious disease while they are in our facility. If feasible, have the isolated person wear a facemask while staff is in the room. B. Observations and interviews Observations on 4/15/2020 at 9:10 a.m. showed multiple residents in the facility were not wearing face masks when out of their rooms. One resident room [ROOM NUMBER] was observed on 4/15/2020 at 9:15 a.m. to be on contact and droplet isolation precautions. The door was closed and there was a personal protective equipment (PPE) holder on the door. Gloves were in the holder. -At 9:45a.m. the plant operation manager (POM) restocked the PPE holder with masks, gowns, goggles and gloves. Registered nurse (RN) was observed on 4/15/2020 at 9:45 a.m. to put on PPE and enter room [ROOM NUMBER]. She gave the resident medications and water to drink. A mask was not given to the resident to wear during care. The RN was interviewed and she said she did not know the resident had to have a mask on when cares were given. The NHA was interviewed on 4/15/2020 at 12:00 p.m. He said he was unaware the residents had to wear masks when out of their rooms or during cares. He said he would reeducate the facility staff and give masks to the residents. II. Failure to properly place a mobile swamp cooler to prevent cross-contamination A. Observations On 4/15/2020 at 10:18 a.m., a large mobile swamp cooler approximately three feet high by three feet wide was next to the entrance of resident room [ROOM NUMBER]. The swamp cooler was running with a strong rush of air coming out of the front of the unit. The resident in room [ROOM NUMBER] was on isolation precautions for COVID-19. Several kitchen staff and residents were observed walking through the hall. The kitchen door was approximately 10-15 feet away from room [ROOM NUMBER]. Residents who lived on the second floor had to walk by the swamp cooler to access the elevator which was located at the end of the hall. B. Interviews A registered nurse (RN) was interviewed on 4/15/2020 at 9:45 a.m. She said the resident in room [ROOM NUMBER] was on isolation precautions due to recent temperature and congestion. She said the resident was tested for the Coronavirus disease (COVID-19) on 4/14/2020. The assistant director of nursing (ADON) was interviewed on 4/15/2020 at 10:39 a.m. The ADON observed the swamp cooler unit next to room [ROOM NUMBER]. She said she was familiar with the resident in room [ROOM NUMBER]. She said the resident was on isolation precautions as the resident had pneumonia and had been on antibiotics. She said the resident was recently given the COVID-19 test as of 4/14/2020 per physician order. She said the isolation was for contact and droplet precautions. The ADON said the swamp cooler should not have been placed next to the resident's room because it could spread any airborne pathogens. She said a negative outcome could be the spread of infection or illness. The ADON told the plant operation manager he needed to remove the swamp cooler immediately. The plant operation manager (POM) was interviewed on 4/15/2020 at 10:54 a.m. He said he had placed the swamp cooler next to room [ROOM NUMBER] to try and cool the hall down. He said with the fluctuation of temperatures the building heaters had been turned off as it was hot in the facility. He said he had COVID-19 training which identified [MEDICAL CONDITION] as airborne. He said after thinking about it, it was not the best practice to place the swamp cooler next to the isolation room as it could spread pathogens into the air. The PON was interviewed a second time on 4/16/2020 at 12:00 p.m. He said he had two mobile swamp coolers in the facility. He said each swamp cooler had three mesh filters inside. He said they would be replaced or changed every three months. He said he cleaned the outside of the swamp coolers when he used them. He said he used Lemon Zip, a disinfectant cleaner, to wipe the outside of the swamp cooler and he ran the same cleaner through the swamp cooler.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE