STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065165	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIERRA VISTA HEALTHCARE CENTER	821 DUFFIELD CT LOVELAND, CO 80537

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 maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection such as coronavirus (COVID-19) in two of three halls and one of one therapy room observed for infection control practices. Specifically, the facility failed to: -Ensure proper personal protective equipment (PPE) techniques were followed for new admission isolation rooms 119, 120, 122, and contact precaution isolation rooms [ROOM NUMBERS]; -Ensure staff and residents were wearing masks appropriately, and; -Ensure proper hand hygiene and cleaning of face shields/goggles was performed during donning and doffing of PPE, and cleaning of equipment after use. Findings include I. Isolation/PPE usage and hand hygiene A. The Centers for Disease Control (CDC) references According to the CDC guidance, Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19, dated 3/20/2020, retrieved online from https://www.cdc.gov/coronavirus/2019-ncov/downloads/A_FS_HCP_COVID19_PPE.pdf: -PPE must be donned correctly before entering the patient area. - PPE must remain in place and be worn correctly for the duration of work in potentially contaminated areas. PPE should not be adjusted. - Face masks should be extended under the chin. - Both your mouth and nose should be protected . Accessed on 8/27/2020. The CDC (2020) Coronavirus Infection Control Recommendations, retrieved from :https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html, revealed in part, Healthcare professionals (HCP) should continue to adhere to Standard and Transmission-Based Precautions, including use of eye protection and/or an N95 or equivalent or higher-level respirator based on anticipated exposures and suspected or confirmed diagnoses. Universal use of a facemask for source control is recommended for HCP. Accessed on 8/27/2020. The CDC (2020) Hand Hygiene, retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/hand-hygiene.html, revealed in part, Hand hygiene is an important part of the U.S. response to the international emergence of COVID-19. [MEDICATION NAME] hand hygiene, which includes the use of alcohol-based hand rub (ABHR) or handwashing, is a simple yet effective way to prevent the spread of pathogens and infections in healthcare settings. CDC recommendations reflect this important role. The exact contribution of hand hygiene to the reduction of direct and indirect spread of coronaviruses between people is currently unknown. However, hand washing mechanically removes pathogens, and laboratory data demonstrate that ABHR formulations in the range of alcohol concentrations recommended by CDC, inactivate [DIAGNOSES REDACTED]-CoV-2. ABHR effectively reduces the number of pathogens that may be present on the hands of healthcare providers after brief interactions with patients or the care environment. The CDC recommends using ABHR with greater than 60% [MEDICATION NAME] or 70% [MEDICATION NAME] in healthcare settings. Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and are effective in the absence of a sink. Accessed on 8/27/2020. B. Facility policy and procedure The Infection Prevention Strategies and Guidance for COVID-19 policy and procedure, dated 8/5/2020, provided by the nursing home administrator (NHA) on 8/24/2020 at 12:59 p.m., read in pertinent part: The center should ensure that all staff is using appropriate PPE when they are interacting with residents to the extent PPE is available. Staff should perform hand hygiene, which includes washing hands with soap and water or using an alcohol-based hand sanitizer that contains 60 to 95% alcohol for at least 20 seconds, as appropriate. Conservation strategies should be followed by the center, as necessary, to provide care to the residents and protection for staff. As of May 14 (2020), full PPE is recommended in the following areas: admission units, observation units, and dedicated areas where residents with suspected or confirmed COVID-19 are located. Resident Use of Face Masks When possible, whether COVID-19 symptoms are present or not, residents should cover their nose and mouth whenever staff is in their room. Remind and/or assist residents with frequent hand hygiene and social distancing. How to Re-Use Eye Protection (Goggles and Face Shields) -Perform hand hygiene. -Apply a clean pair of gloves. -Carefully wipe the inside of the face shield or goggles, followed by the outside of the face shield or goggles using a clean cloth saturated with neutral detergent solution or cleaner wipe. -Carefully wipe the outside of the face shield or goggles using a wipe or clean cloth saturated with environmental protection agency (EPA)-registered hospital disinfectant solution. -Utilize cleaning solutions and ensure dwell time is met. -Fully dry (place eye protection on clean paper towel on a clean surface). -Once the face shield or goggles are dry, wipe the outside of face shield or goggles with clean water or alcohol to remove residue. -Remove gloves and perform hand hygiene. C. Manufacturer ' s instructions Review of the manufacturer ' s instructions for the Clorox Bleach Germicidal Wipe and the Micro-Kill Bleach Germicidal Wipe read in pertinent part: For surfaces and medical equipment, disinfect after each patient use by following this protocol to help ensure effective disinfection and reduce the risk of cross-contamination. -Always use personal protective equipment -Perform hand hygiene first, then put on gloves. To clean, disinfect, and deodorize hard, nonporous surfaces: Wipe hard, nonporous surface to be disinfected. Use enough wipes for treated surface to remain visibly wet for the contact time listed on label. Let air dry. Dispose of wipe in trash after use. Perform hand hygiene when finished. The wipe has a surface contact time of one minute to be effective against human coronavirus. D. Staff education Review of the staff education provided by the nursing home administrator (NHA) on 8/25/2020 at 10:20 a.m., revealed in-services were conducted in the facility by the staff development coordinator on a monthly basis that included updates on COVID-19, proper PPE usage (donning and doffing, hand hygiene, and isolation procedures). All staff were required to attend. Even though the housekeeping staff were a contracted company that provided their own COVID-19 education, the facility included them in their staff education. The 8/2020 education was conducted on 8/5/2020. II. Observations and staff interviews On 8/24/2020 at 10:40 a.m., restorative aide (RA) #1 was seen in the therapy room with his mask below his nose. There were six residents receiving therapy. He touched a resident, on the back and arms. He was not wearing gloves and did not perform hand hygiene after walking away from the resident. He then sat at a desk, picked up a pen and proceeded to document on paperwork. -At 10:42 a.m., a female therapist was seen in the therapy room touching a resident seated in a wheelchair then touching the handles of the wheelchair. She was not wearing gloves and walked away from the resident. She did not perform hand hygiene then touched her face mask, her forehead, and her glasses before walking to another resident and touching them on the arms. -At 11:20 a.m. in room [ROOM NUMBER] the resident was seen lying in bed with the head of the bed elevated and the bed parallel to and up against the open window. The resident did not have a roommate. A female was seen outside the screened open window wearing a mask and conversing with the resident, who was not wearing a mask. They were approximately two feet apart. The NHA was notified immediately and the window was shut. The NHA said the female outside the window was the resident ' s wife and she had gained access to that side of the facility through an unlocked gate. She said the facility did not allow open window visits and she provided education to the resident ' s wife regarding that rule. She said they had now locked the gate to prevent further access to that side of the building. -At 1:40 p.m., two staff members were observed preparing to enter contact isolation rooms [ROOM NUMBERS]. They donned PPE but did not perform hand hygiene prior to donning gloves and entering the rooms. -At 2:00 p.m., the speech therapist (ST) was seen seated at a table in the therapy room working with a resident who was also seated at the table. The ST had her mask below her nose and the resident ' s mask

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) was hanging from her left ear. -At 2:10 p.m., the maintenance technician (MT) was seen kneeling at the foot of the bed by the door in room [ROOM NUMBER] working on the air mattress pump. His mask was below his nose. The resident in the bed by the window was lying in bed. The MT exited the room and walked down the hall to the front office where other staff members were working, with the mask still below his nose. -At 2:15 p.m. resident care advisor (RCA) #2 was seen preparing to enter admission isolation room [ROOM NUMBER]. She removed her goggles and placed them on top of a table in the hall with no barrier underneath. She removed her surgical mask and donned an N95 mask. She did not perform hand hygiene prior to donning gloves and entering the room. When she exited the room, she again placed the goggles on top of the table. She donned gloves without performing hand hygiene. She cleaned the goggles with a bleach wipe and placed them back on the table without a clean barrier underneath. She did not allow the disinfectant solution to remain wet on the surface of the goggles for the required one minute contact time per the manufacturer ' s instructions. She then used tissues to dry the goggles before she placed them back on her face. -At 2:30 p.m., the resident in room [ROOM NUMBER] was seen outside the door to the room into the hall approximately three feet. He was not wearing a mask. Several staff members walked past him, acknowledged him, but did not have him apply a mask. At this time, on the same hall, an unknown nurse was seen at a medication cart near the nurse ' s station. A resident approached him and he bent down to hug the resident, patting them on the back with his face next to the residents ' . He did not perform hand hygiene and continued to touch multiple medication cards, dispensing medications, touching keys, drawers, and the computer keyboard and mouse. -At 2:40 p.m., an unknown staff member was seen exiting new admission isolation room [ROOM NUMBER] wearing a face shield and an N95 mask. She walked to a table down the hall, removed the face shield and placed it on the table with no barrier underneath. She obtained a bleach wipe with her bare hands and cleaned the outside then the inside of the face shield. She did not allow the solution to remain wet for the required one minute surface contact time per manufacturer ' s instructions before placing it back on her head. She did not perform hand hygiene then walked down the hall still wearing the N95 mask. On 8/25/2020 at 9:00 a.m., the resident in new admission isolation room [ROOM NUMBER] was seen seated in a wheelchair outside of the room approximately two feet, asking for help. She was not wearing a mask. The resident care specialist (RCS) approached the resident wearing a surgical mask. She donned PPE but did not apply an N95 mask or perform hand hygiene prior to donning gloves and entering the room. She did not have the resident apply a mask. When she exited the room at 9:15 a.m., she did not clean her goggles and exited the hall. -At 9:25 a.m., the licensed practical nurse (LPN) was seen at a medication cart with a blood pressure cuff draped around her neck. She entered room [ROOM NUMBER] to administer medications and to obtain the resident ' s blood pressure. After obtaining the blood pressure reading she again draped the blood pressure cuff around her neck with the cuff lying between her bare arm and her side. She exited the room and returned to the medication cart to prepare another resident ' s medications. She did not clean the blood pressure cuff and continued to another resident ' s room with the cuff still around her neck. -At 9:30 a.m. the ST and RCA #1 were seen in the dining room assisting residents with their breakfast. Both had their masks below their noses and the ST repeatedly touched her mask with her bare hands and did not perform hand hygiene. -At 9:42 a.m., RA #2 was seen in the therapy room with a resident and several other staff members. Her mask was below her nose. The ST and three other staff members were seen in the documentation area of the therapy room. None of them were wearing goggles or face shields and all had their masks below their noses and mouths. They were all in close proximity to one another, approximately three feet apart. The LPN was interviewed on 8/25/2020 at 9:28 a.m. She said the facility had vital sign equipment that was used for all residents. She said none of the residents had designated equipment and when the equipment was used it had to be cleaned with the bleach wipes prior to being used on another resident. The NHA and the director of nurses (DON) were interviewed on 8/25/2020 at 10:00 a.m. The NHA acknowledged staff were not wearing their masks properly to cover the nose. She said she had to remind several staff members to follow correct protocol and all staff should remind and encourage residents to apply a mask when out of their rooms and the resident should wear a mask when staff was performing care. The DON said as part of proper procedure when donning and doffing PPE to enter an isolation room, they were to perform hand hygiene prior to applying gloves and when removing them. She said staff should perform hand hygiene before and after resident care, after touching a resident or resident equipment, and after touching their own face, mask, glasses, or hair. She said an N95 mask was to be worn in the new admission isolation rooms and staff were to clean their goggles when exiting the rooms with a bleach wipe, allow the solution to dwell on the surface for the manufacturer ' s recommended dwell time, and allow them to air dry. She said if the goggles or face shield were to be placed on a surface after they were cleaned, a clean barrier had to be underneath them. They were to wear gloves when using the bleach wipes and were not to dry the goggles with tissues. She said the facility did not have designated vital sign equipment for residents and the nurses were to clean the equipment with bleach wipes after each resident use. III. COVID-19 status The NHA and the infection prevention registered nurse (IPRN) were interviewed on 8/25/2020 at 10:00 a.m. The NHA said they had zero COVID-19 positive residents and zero COVID-19 positive staff. She said there were no presumptive COVID-19 positive residents or staff. The results of the mass testing of staff and residents, done on 8/21/2020, all came back negative. The IPRN said rooms [ROOM NUMBER] were quarantined residents as they were new admissions from the hospital. She said residents admitted from the hospital were only accepted if they had a negative COVID-19 test at the hospital. She said she then retests them on day 12 after admission.