STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065193	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALPINE LIVING CENTER	501 THORNTON PKWY THORNTON, CO 80229

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.** Based on observations, record review and interviews, the facility failed to properly maintain an infection control program designed to prevent the spread of COVID-19 in two of two neighborhoods. Specifically, the facility: -Failed to ensure staff wore surgical masks in the resident care areas; -Failed to ensure nursing staff did not walk down the hall with a contaminated face shield and N95 mask that were used in a presumptive Covid-19 positive room; and -Failed to ensure kitchen staff changed contaminated gloves and performed hand hygiene before touching ready to eat food. Findings include: I. Failure to wear surgical masks in resident care areas A. Facility policy and procedure An infection control tool kit, dated 6/10/2020, was provided by the infection control preventionist (ICP) on 6/24/2020 at approximately 3:30 p.m. It read in pertinent part, The center will help ensure the appropriate use of PPE (personal protective equipment) with regard to universal masking guidance by implanting the following steps: -Provide every direct care staff member a surgical face mask to wear at the start of the shift. -Cloth masks (example, homemade cloth masks, bandana, scarf, etc.) are not considered PPE, since their capability to protect is unknown, but are instead worn as a form of source control. B. Professional reference According to the Centers for Disease Control and Prevention (CDC) Strategies for Optimizing the Supply of Face Masks, last updated 4/3/2020, retrieved 7/8/2020 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html#contingency-capacity: In settings where facemasks are not available, HCP (healthcare personnel) might use homemade masks (e.g., bandana, scarf) for care of patients with COVID-19 as a last resort. However, homemade masks are not considered PPE, since their capability to protect HCP is unknown. Caution should be exercised when considering this option. Homemade masks should ideally be used in combination with a face shield that covers the entire front (that extends to the chin or below) and sides of the face. C. Observations On 6/24/20 at 2:35 p.m., licensed practical nurse (LPN) #1 was observed wearing a cloth mask in the facility. She was standing at the nurse station in front of the medication cart. There were three residents sitting in the area. On 6/24/20 at 2:40 p.m., the director of nursing (DON) was observed wearing a cloth mask. She was observed multiple times in the hallway talking to residents. On 6/24/20 at 4:20 p.m., the activity staff was observed wearing a cloth mask. She was observed pushing a resident down the hall in his wheelchair. At 4:28 p.m., she was observed in a resident's room doing a one-on-one activity with the resident. D. Interview LPN #1 was interviewed on 6/24/20 at 4:16 p.m. She said she was an agency staff member and it was her first day in the facility. She said she wore a cloth mask to work because that was what she had. She said she was screened at the door before she entered the facility and no one said that she could not wear a cloth mask. II. Failure to ensure nursing staff did not walk down the hall with a contaminated face shield and N95 mask that were used in a presumptive Covid-19 positive room A. Professional reference The Centers for Disease Control and Prevention (CDC) Recommended Guidance for extended use and limited reuse of N95 filtering face-piece respirators in healthcare settings, last updated 3/27/2020, retrieved 7/8/2020 from https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html, included the following recommendation of extended and reuse of N95: Extended use refers to the practice of wearing the same N95 respirator for repeated close contact encounters with several patients, without removing the respirator between patient encounters. Extended use may be implemented when multiple patients are infected with the same respiratory pathogen and patients are placed together in dedicated waiting rooms or hospital wards. Extended use has been recommended as an option for conserving respirators during previous respiratory pathogen outbreaks and pandemics. Reuse refers to the practice of using the same N95 respirator for multiple encounters with patients but removing it ('doffing') after each encounter. The respirator is stored in between encounters to be put on again ('donned') prior to the next encounter with a patient. B. Observations On 6/25/20 at 9:39 a.m., registered nurse (RN) #1 was observed standing by her medication cart. She had an N95 mask and a face shield on. She prepared the resident's medication and walked to his room door. She placed the medication cup on the isolation cart and she donned a gown and a pair of gloves. She entered the resident's room (presumptive Covid-19 positive for new admission). At 9:45 a.m., she was observed to exit the resident's room. She doffed her gown and gloves before exiting the room. She had her N95 mask and her face shield on. She walked down the hallway with the face shield and N95 mask on that were used in a presumptive Covid-19 room. She was observed to stop and talk to a resident in the hallway. After she had spoken to the resident, she walked down to the chart room located behind the nurses' station (potentially spreading germs in the hallway) to clean and disinfect the face shield and to remove the N95 mask. C. Interview RN #1 was interviewed on 6/25/20 at 10:00 a.m. She said she was an agency staff member. She said she received training on Covid-19. She said the training included isolation precautions and how to don and doff PPE correctly. She said she was not provided education on where to remove her N95 mask and face shield after use. She said she saw other nursing staff walk to the chart room with their face shields and N95 masks on before doffing them. She said she did what she saw other staff doing. III. Failure to ensure kitchen staff performed hand hygiene and changed contaminated gloves before touching ready to eat food A. Professional reference According to Centers for Disease Control (CDC) Control and Prevention, Hand Hygiene Basics (2019), retrieved 7/8/2020 from http://www.cdc.gov/handhygiene/Basics.html, in pertinent part, Healthcare providers should practice hand hygiene at key points in time to disrupt the transmission of microorganisms to patients including: before patient contact; after contact with blood, body fluids, or contaminated surfaces (even if gloves are worn); before invasive procedures; and after removing gloves (wearing gloves is not enough to prevent the transmission of pathogens in healthcare settings). B. Observations On 6/25/20 at 11:16 a.m. the server was observed serving food in the kitchen. He had a pair of gloves on. He was serving the residents' meals. There was a plastic bag on the table which had tortillas in it. He used his gloved hands and touched the outside of the plastic bag to open it. He touched the tortillas with his gloved hands. He did not change his gloves and wash his hands before touching the tortillas. He was also observed to touch the outside of the plate, the handle of the utensils and he touched the tortillas. The dietary manager (DM) was present in the kitchen and was made aware. She observed the server serving the meals. the food. He touched the outside of the plastic bag to open it and touched the handle of the utensils, possibly cross-contaminating the utensils from the outside of the plastic bag and touched the tortillas with his same gloved hand he used to touch the outside of the bag. He put the tortillas on the plate touching the outside of the plate. He put the meat in the bread and used his gloved hands to turn the bread over on the plate after touching the outside of the plate. The DM asked the server to change his gloves and wash his hands before touching the tortillas. C. Record review An in-service hand washing procedure for dining services, dated 3/10/2020, was provided by the ICP on 6/24/2020. It read in purpose, To provide healthcare services group (HCSG) personnel with a simple, practical, and easy-to-implement procedure for hand washing on the units, in the kitchen, or in the dining room. Procedures included: Gloves are not meant to be used as a replacement for handwashing. They are only effective if proper handwashing is completed. Hand hygiene continues to be the primary means of preventing the transmission of infection. Some situations that require hand hygiene: Before and after eating and handling food, in between gloves changes (for example, when changing tasks) and in-between tasks (for example, when switching between cutting chicken and cutting onions). D. Interviews The

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) server was interviewed on 6/25/2020 at 11:30 a.m. He said he was trained to wear gloves when serving meals. He said he was not aware that he should have changed his gloves after touching the outside of the plastic bag that had the tortillas to prevent the spread of any germs that were on the outside of the bag. He said he should have changed his gloves and washed his hands before touching the tortillas and the utensils to prevent the spread of infection. The DM was interviewed on 6/25/2020 at 11:35 a.m. She said it was her second day in her position. She said her expectation was for the server to change his gloves, and wash his hands before touching the ready to eat food to prevent the spread of infection. She said she would provide education to him. IV. Management interviews The ICP was interviewed on 6/25/2020 at 11:45 a.m. She said the process was for all direct care staff (nurses, certified nurse aides, therapists and activity staff) to wear surgical masks in the facility to prevent the spread of Covid-19. She said if a staff member came into the facility with a cloth mask, the screener at the door would give the staff a surgical mask before entering the facility. She said she was not aware that LPN #1 entered the facility with a cloth mask. She said the screener should have identified the nurse with the cloth mask and should have given her a surgical mask. She said the face shields and N95 masks were being reused in the isolation rooms. She said the guidance she received from her corporate office was that anything that was worn on the head in an isolation room can be worn outside of the room. She said the cleaning and disinfecting station was located in the chart room behind the nurses' station.She said the staff would have to walk with the face shield and N95 mask on, to the cleaning area. She acknowledged that the process could potentially spread infection in the facility, but that was the area that was designated for cleaning and disinfecting PPE for reuse. The DON was interviewed on 6/25/20 at 11:55 a.m. She said all direct care staff in the facility should wear surgical masks. She said she was not aware that she needed to wear a surgical mask since she was not providing direct care to the residents. She agreed that she should have worn a surgical mask because she was in the facility and encountered a lot of residents daily. She said there was a cleaning and disinfecting station set up in the chart room. She said when the staff exited the isolation room, they would walk to the chart room with the PPE on (face shield and N95 mask) to be cleaned and removed. She agreed that walking down the hall with the face shield and N95 mask on after being used in the isolation room would potentially spread infections. She said she would discuss with the ICP to implement other ways the face shield and N95 masks could be cleaned and removed without the staff walking in the halls wearing used PPE. V. Facility follow-up LPN #1 and the DON were observed on 6/24/2020 at 4:15 p.m. with surgical masks on. On 6/24/2020 at 4:30 p.m., the ICP said she noticed the LPN and the DON were wearing cloth masks and she gave them surgical masks to wear.