STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065150	A. BUILDING _____ B. WING _____	10/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DEVONSHIRE ACRES	1330 SIDNEY AVE STERLING, CO 80751

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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, interviews and record review the facility failed to implement an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the possible development and transmission of Coronavirus (COVID-19) communicable diseases and infections for two out of five units. Specifically, the facility failed to: -Actively screen for COVID-19 and document results for staff on the isolation unit; -Properly perform hand hygiene between resident cares on the isolation unit; -Ensure staff changed gloves appropriately after providing direct residents care on the isolation unit; -Ensure staff offered residents hand hygiene prior to meals on the isolation unit and hall 100; -Ensure staff practice appropriate hand hygiene after peri care; -Ensure staff removed biohazard bags from the isolation unit in a timely manner; -Ensure staff changed gowns between housekeeping services and resident care on the isolation unit; -Ensure staff adhere to the manufacturers recommended disinfectant dwell times when cleaning resident rooms on the isolation unit; and, -Ensure staff to receive additional training on infection control prior to working on the isolation unit. Findings include: I. Screening concerns A. Professional reference According to the Centers for Disease Control and Prevention (CDC) updated 6/25/2020, retrieved on 10/12/2020 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, included the following recommendations: Actively screen everyone for fever and symptoms of COVID-19 before they enter the healthcare facility. B. Record review The COVID-19 screening Checklist for visitors and staff was provided by the nursing home administrator. The document date 7/24/2020 read Completion of the screen is mandatory per COVID-19 prevention protocols. If you mark Yes, you must notify the lead employee on the shift before starting work. If you begin to experience any respiratory symptoms while at work, you must immediately STOP WORK, put on a mask inform the lead employee of your symptoms and provide information on the individuals, equipment and location you came in contact with; then notify your health care provider of symptoms and that you are an essential healthcare worker; inform executive director (ED) of your health care provider's directive so ED can report to Department of Public Health as needed. Close Contact means being within approximately 6 feet of COVID-19 case for a prolonged period of time; Close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case, or having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on). The assessment portion of the form revealed each staff should answer yes or no to the questions; do you have any of the following respiratory symptoms: new or worsening cough, shortness of breath, fever, repeated shaking chills, headache, new loss of taste or smell, diarrhea, chills, muscle pain, sore throat or vomiting ? -The checklist had a designated portion for recording the temperatures of the individual who completed the form.The checklist directed that Lead/Designated employee each shift is to review Employee screening form after the start of each shift to ensure all Yes answers are screened further). If an individual recorded a temperature over 100.0 degrees fahrenheit, answered Yes to respiratory symptom, or 2 plus (+) other symptoms the individual must be sent home immediately. -A review of the checklists completed from 9/28/2020 through 10/7/2020 revealed the two certified nurse aides (CNA #1 and CNA #2) who had worked on the unit for 10 days since the unit opened and did not complete the screening form for each day they worked. C. Interview Registered nurse (RN) #1 who worked on the COVID-19 unit was interviewed on 10/7/2020 at 9:25 a.m. She said staff came into the isolation unit using a separate rear entrance that led them straight into the isolation unit. She said she screened herself into the facility. She said she took her own temperature and documented the reading and other responses to the questions asked in the checklist which sat on the desk in her office. She said she was not provided any education on COVID-19 or informed about the need to be actively screened prior to working the floor. She said it was important to ensure staff complied with the screening requirement because of the risk of reinfection and /or cross contamination it posed when a symptomatic or positive staff member came in contact with other staff members or residents. CNA #2 was interviewed on 10/7//2020 at 12:30 p.m. She said she was a temporary CNA and had been for a couple of weeks. She said she was not aware there was a screening process into the facility. She said when staff came into the COVID-19 unit, they first went into the storage room which was the room to the immediate right upon entrance into the COVID-19 unit from the back door. She said when in the storage room, nursing staff accessed their personal protective equipment (PPE) and work shoes which were used for the entire shift. She said staff then proceeded to room #A4 which was where they took shower and had their scrubs waiting in the closets which staff changed into. She said staff gave themselves 15 minutes gap when they came in. She acknowledged she had never completed a screening checklist for COVID-19 before she worked the floor. She said she was not educated on COVID-19 and necessary isolation precaution practices before she was assigned to work the floor. CNA #1 was interviewed on 10/7/2020 at 12:37 p.m. She said the COVID-19 unit was activated abruptly. She said it affected an educational forum on how they (staff working the COVID-19 unit) had not been trained on what was expected of them. She said We were just thrown here II. Hand hygiene, disinfectant and gown issues A. Professional references The Centers for Disease Control and Prevention (CDC) Hand Hygiene Guidance, retrieved from: https://www.cdc.gov/handhygiene/providers/guidelin.html (updated 1/30/2020, retrieved on 10/12/2020), read in part, Healthcare personnel should use an alcohol-based hand rub or wash their hands with soap and water for the following clinical indications: Before moving from work on a soiled body site to a clean body site on the same patient, After touching a patient or the patient's immediate environment. After contact with blood, body fluids, or contaminated surfaces and immediately after glove removal. The CDC, Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html#infection_control (updated 4/1/2020, retrieved on 10/12/2020) read in part, Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for [DIAGNOSES REDACTED]-CoV-2 in healthcare settings, including those patient-care areas in which aerosol generating procedures are performed. B. Observations 1. COVID-19 unit Observations were conducted on 10/6/2020 between 12:05 p.m. and 1:15 p.m. during in room tray delivery of noon meal on the COVID-19 unit. CNA #1 and CNA #2 served meals to residents in the unit. Both CNAs did not offer or encourage hand hygiene when they delivered the noon meal to the residents. 13 residents in the COVID-19 unit did not receive hand hygiene before they ate their meal. They served residents in rooms #A1, #A2, #A2.5, #A3 (double occupancy) #A3.5 (double occupancy), #A5 (quadruple occupancy) #A6 (quadruple occupancy but only had 2 residents at the time of survey) in no particular order. 2. Hall 100 On 10/6/2020 at 12:02 p.m., observations revealed certified nurse aide (CNA) #6 provided a meal tray to one resident in room [ROOM NUMBER]. She did not encourage or offer to assist the resident with hand hygiene. -At 12:06 p.m., CNA #5 provided meal trays to two residents in room [ROOM NUMBER]. She did not encourage or offer to assist either resident with hand hygiene. -At 12:09 p.m., CNA #6 provided meal trays to two residents in room [ROOM NUMBER]. She did not encourage or offer to assist either resident with hand hygiene. -At 12:10 p.m., registered nurse (RN)

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) #3 provided a meal tray to a resident in room [ROOM NUMBER]. She did not encourage or offer to assist the resident with hand hygiene. -At 12:13 p.m., CNA #6 assisted a second resident with her meal at the entrance threshold to room [ROOM NUMBER]. She did not encourage or offer to assist the resident with hand hygiene. -At 12:15 p.m., RN #2 provided a meal tray to a resident in room [ROOM NUMBER]. She did not encourage or offer to assist the resident with hand hygiene. 3. Additional observations On 9/7/2020 at approximately 8:35 a.m. CNA #1 and CNA #2 were observed on the COVID unit when they both performed housekeeping duties in the rooms identified above. The CNAs independently cleaned rooms. When the CNAs arrived at the doorway of the rooms to be cleaned, they knocked on the door to announce their presence and the procedure they were to carry out to the resident who occupied the rooms. Prior to entering the rooms, the CNAs wore a pair of gloves, N95 masks, goggles and gown. The CNAs applied alcohol based hand rubs (ABHR) over their gloves and then donned a new pair of gloves (double gloved). The CNAs utilized PH7q disinfectant and swiffer dry sweeping cloths to clean the rooms. They sprayed the disinfectant on the room floors, toilet floors and toilet seats and then wiped off the disinfectant immediately. They did not change their gloves nor use a new wipe/s when moving from one side of the resident ' s room to another (observation of the shared rooms). They pulled the soiled sweeping clothes described above with their gloved hands and without performing hand hygiene and/or replacing the gloves, they touched residents personal items which included remote controls, bible, reading glasses etc . At the time of the observation, the residents had their morning meals as room trays and the trays were sitting on the side tables when the CNAs sprayed disinfectants and touched the contents of the room trays (disposable plates which had the resident ' s food, spoons and cups) with their potentially contaminated gloves. Some of the residents were still eating at this time. When the CNAs sprayed disinfectant on the walls in the toilet and the toilet bowl, they bent forward to spray chemical disinfectant into the toilet bowl, their gowns made contact with the toilet bowl. The process of cleaning and wiping surfaces in the rooms left the gown soiled with brownish, blackish and dustlike particles which were consistent with dirt. The CNAs failed to change out their gloves in-between tasks such as when they wiped the door knobs, when they wiped table tops and when went from dirty to clean surface. They also failed to perform hand hygiene in between the described tasks stated above. At the completion of the cleaning, the CNAs retained their gowns and continued to provide direct care to the residents using the same gowns. At 9:45 a.m., immediately after the procedure described above, CNA #2 started assisting a resident in room #A1 with eating. She failed to completely replace her gloves (she doubled gloved and removed just the second layer gloves and then applied ABHR over the first layer of gloves she had on) and gowns that were worn when she cleaned the rooms as described above. On 10/7/2020 at 11:43 a.m. this moment immediately preceded noon meal service. CNA #1 and CNA #2 jointly performed peri care on a resident in room #A3. After the completion of the peri care, both CNAs only removed the second layer of their gloves (they double gloved prior to the procedure). Neither of the CNAs performed handwashing after performing peri care on the resident. They removed the second layer of their gloves, applied ABHR and immediately proceeded to serve noon meal to the residents. On 10/7/2020 between 11:55 a.m. and 12:50 a.m. during in room tray delivery of noon meals on the COVID-19 unit. The CNAs identified above were the same ones who worked the floor at the time of the observation. They did not offer or encourage hand hygiene when they delivered the noon meal to the residents. 13 residents in the COVID-19 unit did not receive hand hygiene before they ate their meal. On 10/7/2020 at 12:17 p.m. this moment was in-between noon meal service. CNA #1 and CNA #2 jointly performed peri care on a resident in room #A6. After the completion of the peri care, both CNAs only removed the second layer of their gloves. Neither of the CNAs performed handwashing after performing peri care on the resident. They removed the second layer of their gloves, applied ABHR and immediately proceeded to serve noon meal to the residents. The identified failures and breaches in infection control practices identified above failed to ensure residents ate their meal under sanitary condition and direct care staff did not cross-contaminate the resident by using the same gowns they wore when they performed housekeeping duties then performed direct care. In addition, the staff's failure to follow the manufacturer ' s recommended kill time for chemical disinfectant also failed to ensure contact surfaces were properly disinfected. C. Record review The NHA provided a copy of the material safety data sheet for the chemical disinfectant (PH7q) on 10/7/2020 at 5:10 p.m. The document revealed the manufacturer ' s recommended kill time for the disinfectant PH7q was 10 minutes (meaning it needed to remain wet for 10 minutes). D. Staff interviews CNA #2 was interviewed on 10/7/2020 at 1:20 p.m. She said she was trained to perform hand hygiene after she performed peri care with a resident and to offer hand hygiene to residents when she delivered their meal trays. She acknowledged she did not wash her hands after she performed peri care with two residents as described in the observations above. She acknowledged she did not offer and/or provide hand hygiene to the residents as observed above. She said she had no housekeeping training prior to having to multitask (perform nursing and housekeeping duties). She said she did not know not to wear the same gown she had worn when she cleaned the toilet when she provided direct care to residents. She acknowledged she did not follow through with the manufacturer's recommended kill time (10 minutes) for the disinfectant (PH7q). She said she would offer hand hygiene and get more clarification from the management staff going forward. CNA #1 was interviewed on 10/7/2020 at 1:22 p.m. She acknowledged that they performed peri care with the two residents as described in the observation above. She said she knew to perform hand wash after peri care but did not just do it. RN #1 was interviewed on 10/7/2020 at 1:03 p.m. She said staff must knock on doors, announce themselves, encourage the resident to wear a face mask when staff was present, and ensure the meal card matched the meal and name of the resident who received the meals. She said hand hygiene should be offered and/or provided at the time of meal delivery. She said residents should have been offered hand hygiene at meal delivery to ensure that their hands were clean and free of contaminants when they ate their meal. She said it was important for nursing staff to wash their hands after peri care and before meal service to prevent fecal material from getting in residents' meals. The RN said the manufacturer's recommended kill time for disinfectants were to be followed strictly to ensure they performed their disinfecting function. She said she never gave the idea of the CNAs using their gowns for dual functions (housekeeping and direct care) a thought. She clarified that the practice could lead to infecting, reinfecting and or cross-contaminating residents and staff with existing or secondary infection. She cited an example of the potential to spread [MEDICAL CONDITION]-resistant Staphylococcus aureus (MRSA) and or [MEDICAL CONDITION] (C.diff) with the current practice as explained above she would provide increased training to the CNAs and inform the interdisciplinary team of the observed concern. III. Biohazard material A. Observation On 10/7/2020 at 10:45 a.m. Seven biohazards labelled plastic bags which had contents in them sat in piles directly in front and across from resident ' s rooms (#A6 and #A1) B. Interview CNA #2 was interviewed on 10/7/2020 at 10:48 a.m. She said she had not received education on the proper handling of biohazard materials. She said they left the piles of biohazard bags because housekeeping staff from the non-isolated portion of the facility who had designated responsibility of picking them up had not shown up. She said the process communicated to her was to simply call the designated housekeeping staff when the biohazard from a resident room was filled. She said the designated housekeeping staff were never timely at responding to the calls and that led to the piles of biohazard bags being observed. RN #1 was interviewed on 10/7/2020 at 11:03 a.m. She acknowledged the seven piles of hazard labelled bags which sat on the hallway in front and across residents rooms as stated above. She said the standard was to take out the hazard containers when it was full and dispose of the content immediately. She said since the onset of COVID-19 they have had to wait for the hazard collection personnel instead of the hazard collecting personnel waiting on them. She said the lag in the collection time resulted in piles of the hazard bags sitting by residents room as observed. She said the practice of piling up hazard bags in the proximity where residents had potential of running into them posed a risk of secondary infection/reinfecting the residents. She said she would bring the concern to the attention of the facility's administration. C. Administrative interviews The DON and NHA were interviewed on 10/7/2020 at approximately 2:13 p.m. The DON said she was also the infection preventionist. She said the facility had a group of nursing staff who signed up to work in the COVID-19 unit back in March of 2020 if the unit was activated (if anyone tested positive for COVID-19). She said the group changed because some of those individuals who signed up to work on the COVID-19 unit once activated were no longer staff at the facility. She said the management team went through a check off list of expectations of how the unit was going to work. She said the plan that was put in place in March, 2020 and the ongoing logistics were not inline with the initial plan. She cited an example of having designed the COVID-19 unit for only eight residents, however it had 13 residents at the time of survey. She said the dynamics of the plan had to change with each day as they reported new cases. She said nursing staff were not wanting to work in the COVID-19 unit once it was activated. She said one of the staff (CNA #2) had to acquire the nurse aide waiver so that she was able to work as a temporary CNA on the unit. She said work shifts were scheduled to start at 6:00 a.m. and staff who worked on the COVID-19 unit were instructed to check-in, get screened and be issued a time card. She said staff showered on the unit before they worked the floor. She said the COVID-19 screening checklist was to be completed before nursing staff worked the floor. She said the lag in the system (identified

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) breach in infection control practices) was that the situation was quite overwhelming for anybody. She said staff did not have the support of the management team to help reassure and guide them and to make sure everything was going correctly. She said when staff were out in the general area, they were screened by the facility's designated screener and it was easy to ensure compliance with the screening process. She said for staff who worked on the COVID-19 unit, they were secured away from the rest of the facility staff and they were with no support system. She said the work conditions were overwhelming and were what was responsible for why the staff who worked on the COVID-19 unit fell short of some of their procedures. She said when the COVID-19 unit was opened in March, 2020, we probably didn't know what we were doing, we were instructed to open up a COVID unit on a separate hallway without guidance on how the unit was to look, how it was to flow . She said they have never worked in a pandemic. She said when the COVID-19 unit was activated, nursing staff who volunteered to work on the unit knew they were going to be universal workers (perform the duties of nursing as well as housekeeping). She said she however failed to train them on the need to change out their gowns between tasks. She said nursing staff on the COVID-19 unit should have changed their gowns after they cleaned the toilets before they proceeded to perform direct care. She added that the facility did not identify nursing staff use of the same gown to perform housekeeping and direct care tasks had potential risk of cross-contamination until the survey team brought it to their attention. She said staff were expected to perform hand hygiene after peri care and before serving food and in between any contact with residents. She said if staff were helping or assisting two residents at the same time, the staff should have performed hand hygiene after having physical contact with one resident before moving to help another resident. She said the importance of adherence to the manufacturer ' s recommended kill time for disinfectants can not be over emphasized. She said it was important to follow the recommended guidelines for disinfectants to ensure they function as what they were designed to do. She said going forward, nursing staff on the COVID-19 unit would utilize separate disposable gowns when they performed housekeeping and direct care tasks. She added that other identified breaches in infection control practices will be equally addressed through continued education. The nursing home administrator was interviewed on 10/7/2020 at 4:10 p.m. She said the screening checklist for visitors and staff was one of the guidance put out by CDC and Center for Medicare and Medicaid Services (CMS) to ensure anyone visiting the facility was screened by asking the questions contained within the checklist. She acknowledged the identified staff had not completed the checklist since the facility activated its COVID-19 unit (10 days from the day of this interview). She said no member of the management team reviewed the checklists from the COVID-19 unit to identify staff were not completing the forms. She said they (management team) were not auditing the checklists completed by staff on the COVID unit because they thought the staff knew to complete the screening checklist. She said the oversight resulted from not having a member of the management team go into the COVID-19 unit. She said she had not personally visited the COVID-19 unit because she does not want to be out due to being sick from COVID-19. She emphasized that she was the only management team on site due to the director of nursing (DON) being out from being symptomatic from COVID-19. She acknowledged that not documenting the temperatures and other parameters consistent with COVID-19 of the individuals who had access to residents at the facility could potentially result in exposing and cross-contaminating residents if those individuals whose profile were missed were positive for COVID-19. She said the process for screening nursing staff into the isolation unit was that the outgoing nurse screened the incoming nurse. She said she did not realize that the information was not communicated to the nurses who worked on the isolation unit. She acknowledged there was no document which recorded the screening of the identified staff on the isolation unit. The NHA said Without having a record of the screening, I was unable to tell if a nurse reported on the job with symptoms that would have warranted they'd be sent back home. She said hazard labelled bags would be timely disposed of going forward. She said she would provide more education to the identified nursing staff going forward.