STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065345	A. BUILDING _____ B. WING _____	**04/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUITES AT SOMEREN GLEN CARE CENTER, THE	**5000 E ARAPAHOE RD CENTENNIAL, CO 80122**

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 ensure infection control practices were established and maintained to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of Coronavirus (COVID-19) and other communicable diseases, and infections. Specifically, the facility failed to: -Ensure staff were following proper personal protective equipment (PPE) guidelines; and -Provide hand hygiene opportunities for residents; Findings include: I. Failure to provide hand hygiene opportunities for residents A. Observations On 4/7/2020 at approximately 12:10 p.m., an unidentified certified nurse aide (CNA) was observed to pass a noon meal to room [ROOM NUMBER]. The CNA failed to offer handwashing to the resident. At 12:13 p.m., CNA #1 was observed to pass a noon meal to Resident #3. The CNA failed to offer handwashing to the resident. At 12:15 p.m., an unidentified CNA and unidentified registered nurse both served a noon meal to residents in room [ROOM NUMBER] which was a shared room. Both failed to offer handwashing to the residents. At 12:25 p.m., CNA #2 was observed to to pass a tray to a resident a male resident. While he carried the food to the resident, he held the plate and dessert against his uniform. After he set the resident up with his meal, he did not offer handwashing to the resident. The CNA was informed to not hold the food next to his uniform, he replied good tip. At 12:33 p.m., the social worker (SW) was observed to pass a tray to a resident. She held the food up against her clothes in order to carry the multiple plates and drink. The SW then went into the room and served the meal. B. Interview The DON was interviewed on 4/7/2020 at approximately 1:00 p.m. The DON said the residents should be offered and assisted to wash their hands prior to eating. She said that the staff had been trained to assist the residents to wash their hands with either soap and water at the sink, or to use the alcohol based hand rub (ABHR). The food service director (FSD) was interviewed on 4/7/2020 at approximately 1:00 p.m. The FSD said the facility did not have enough trays to pass the meals. She said some had been ordered. She said she would provide training as to not hold the food against their bodies. II. Failure to ensure staff were following proper PPE guidelines A. Record review Training provided March 2020 titled personal protective equipment was provided by the nursing home administer (NHA) on 4/7/2020. The training documented in pertinent part, masks are often misused, as everytime you touch the front of the mask - put it up ull it down- you are actually risking more exposure to germs to your facial mucus membranes. Masks should only be touched by the loops. B. Observations and interviews On 4/7/2020 at p.m., a unidentified CNA was in room [ROOM NUMBER]. The sign outside of the door documented the resident was on droplet/contact isolation. The CNA opened the door and stood at the door and requested a clean night gown. She did not have her mask on properly. She had her N95 mask below her nose. The surveyor told the CNA she needed to keep the mask on properly while she was in the isolation room. She then proceeded to move it up with her gloved hands. The DON was interviewed on 4/7/2020 at approximately 1:00 p.m. The DON said when staff were in the isolation rooms, the correct PPE needed to be worn and worn properly. She said the mask should always be over both the mouth and the nose. She said she would provide training to all staff. Although, the staff had been trained on correct usage of PPE.

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.