STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065282	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF LONGMONT	2451 PRATT ST LONGMONT, CO 80501

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.** **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 and visitors completed the screening process prior to entering the facility; -Staff discarded personal protective equipment (PPE) before they exited the facility; -Staff wore PPE appropriately; and, -The staff and residents completed hand hygiene when appropriate. Findings include: I. Status of COVID-19 in the facility The nursing home administrator (NHA) and director of nursing (DON) were interviewed on 6/29/2020 at 3:20 p.m. The NHA stated there were no current positive COVID-19 and/or suspected residents and/or staff in the facility. The facility had a full site testing for COVID-19 by the National Guard on 4/2/2020, with one person positive without symptoms. The NHA stated the facility was using contingency strategies to extend the use of the PPE with cloth gowns and N95 masks. She said that staff were educated on how to reuse N95 masks and how to store the masks in a brown bag and discard mask when soiled or damaged. Cloth gowns were used for one resident by one staff member per shift and stored in the residents room. At the end of the shift the gown was sent to laundry. Cloth masks are suitable for residents, however not for staff. The NHA stated the screening process began with all staff and visitors who entered the building through the front entrance on the second floor. She said the staff and visitors were to report to the front entrance for screening and not the other doors. She said she educated the vendors to be screened at the front entrance before delivering goods and supplies to the south side entrance on the first floor. The NHA said that the receptionist and nurses were trained by the infection prevention and control nurse (IPCN) with an inservice about how to screen everyone entering the building. The receptionist screened from 8:00 a.m. to 8:00 p.m., and notified the IPCN about symptoms and out of range temperatures. The second floor nurses screen staff entering at 8:00 p.m. to 10:00 p.m. Staff were screened again when leaving the facility after their shift was completed. The day shift staff arrived by 6:00 a.m., and were screened by the nurses on the second floor prior to starting their shift. The NHA said the facility developed a system to control the flow of traffic throughout the facility, to prevent staff from unnecessarily coming in contact with each other. The facility had a designated wing for COVID-19 positive and/or suspected residents. She said the wing had designated staff. She said they tried to designate staff as much as possible to the floors, however, due to staff shortages at times this could not be done. The NHA stated that residents have cloth masks to use when out of their room in other areas of the facility or leaving the building. Staff were to use surgical masks issued by the facility by guidance of the Centers for Disease Control (CDC). II. Screening process for staff and visitors A. Facility policy and procedure The Response to State Survey Related to COVID-19 policy, last revised on 4/29/2020, was provided by the NHA via email on 7/6/2020. It read in pertinent part, Screening before and after (staff) shift. To take temperature (temp) before and after shift, and document at the front desk. If you have a low temp take your temp again and if it still reads low ask a nurse for assistance. If your temp is greater than 99.2 degrees Fahrenheit (F) notify your supervisor and IP (infection preventionist) for further guidance. A temperature of 99.2 degrees F is okay to work with as long as no other symptoms are present. If your temperature is greater than 100.4 degrees F you will be dismissed from work right away. B. Professional reference The CDC Interim Infection Prevention and Control (4/12/2020) Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings. Retrieved online from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html (7/9/2020). It read in pertinent part, Screen all healthcare personnel (HCP) at the beginning of their shift for fever and symptoms consistent with COVID-19. Actively take their temperature and document absence of symptoms consistent with COVID-19. If they are ill, have them keep their cloth face covering or facemask on and leave the workplace. The Colorado Department of Public Health and Environment (5/7/2020) Preparation and Rapid Response Checklist for Long Term Care Facilities (LTCF's), Retrieved from: https://covid19.colorado.gov/ltcf (7/9/2020). It read in pertinent part, Screen each employee for symptoms before they start their shift. Circle an answer (y=yes, n=no) for each symptom for each employee for fever 100.4 or above, cough, shortness of breath or difficulty breathing, fever, chills, rigors, myalgia, headache, sore throat, new olfactory (smell) and taste disorder(s); consider also rhinorrhea, diarrhea, nausea or vomiting). Centers for Medicare and Medicaid Services (CMS) (4/2/2020) COVID-19 Long-Term Care Facility Guidance. Retrieved from: https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf (7/9/2020). It read in pertinent part, Long-term care facilities should immediately implement symptom screening for all. Facilities should limit access points and ensure that all accessible entrances have a screening station. All long-term care facility personnel should wear a facemask while they are in the facility. C. Training Both the 3/26/2020 More Coronavirus Education staff in-service and the 4/29/2020 Response to State Survey Related COVID Training Notes staff in-service read, in pertinent part, Continue to temp (temperature) in before the start of your shift and prior to leaving for the day. Both temperatures should be documented on your page at the front desk. -The training failed to include instructions for the screening process: entering through a single entrance prior to entering resident care areas, social distancing while waiting for screening at the beginning and end of shifts, and discarding masks at the door and performing hand hygiene prior to leaving. D. Observations and interviews of the screening process Upon entering the facility on 6/29/2020 at 2:15 p.m. signs posted on the main entrance doors read to enter the facility the visitor/vendor was required to wear a mask, restrict visitation, and receive a health screening. Through the double sets of doors, three surveyors were greeted by the receptionist for the screening process. There were no indications about the flow of traffic at the screening table to maintain social distancing and the receptionist did not provide instructions. The three surveyors were asked to stand around the desk next to each other so the receptionist could ask exposure and symptom questions. There were two staff members leaning against the wall across from the screening desk that were standing next to each other, wearing masks, and within four feet of the surveyors being screened. The receptionist asked the surveyors if they had any COVID-19 symptoms but did not ask specific symptom questions of the three surveyors, until requested. She documented the answers on the log. Once the questions were completed, the receptionist waved to the staff standing along the wall to come forward to the reception desk. Both staff members approached the desk standing side by side and within two feet of each other while the receptionist took their temperatures and asked questions then completed the responses on the log. Both staff members exited the facility from the front entrance doors but failed to remove the mask and perform hand hygiene. The receptionist failed to provide guidance on flow to ensure social distancing was maintained, did not instruct staff/visitors/vendors to perform hand hygiene prior to entering resident areas and after doffing ppe before exiting the facility, and she did not ask specific questions about symptoms of COVID-19. The receptionist was interviewed at 2:25 p.m. She said that the bottom of the log contained a list of symptoms that she could read from if the staff/visitor did not remember the symptoms. She said she did not usually ask the staff/visitor each symptom but instead would ask if the staff/visitor had any new onset of symptoms. She said the responses were documented on the log with a 'yes or no' response. She said that if there were 'yes' responses then she would contact

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** - Many	(continued... from page 1) the infection prevention and control nurse (IPCN) and the director of nursing (DON). She said that the staff were screened upon entering and exiting the facility. She said she received training from the IPCN prior to performing the screening function and it included taking the temperature, asking the questions on the log, documenting the results on the log, and notifying abnormal responses to the DON and IPCN. She said the training included staff performing hand hygiene before entering resident areas after the screening process. She said there was an ABHR dispenser across from the screening desk and a bathroom with soap and water. The nursing home administrator (NHA) greeted the surveyors and requested that one of the surveyors use alcohol based hand rub (ABHR) after being screened, however, the other two surveyors were not instructed to perform hand hygiene before entering resident areas. E. Layout of first floor Inside the back door on the first floor was the laundry area, kitchen, a time clock, an elevator and stairs to access the two upper floors. Continuing north was a set of double doors, beyond the double doors was a common area, the nurses station, an elevator and stairwell and two resident hallways, East and West. On 6/30/2020 at 5:30 a.m., located across from the nurses station on the first floor between the stairs and the elevator was a table and couch. On the table was a hand written note on a piece of paper which read for staff to not use the stairs. Licensed practical nurse (LPN) #3 was interviewed about the sign at 5:31 a.m. She said the sign was to keep staff from using the stairs and elevator. If employees entered through the back door on the first floor then they were to use the stairs or elevator near the back door to go to the second floor to be screened. They were not to use the stairs and elevator across from nurses station to prevent cross contamination between the floors. -At 5:51 a.m., an unidentified staff member entered through the double doors and walked past a resident and the nurses station to use the elevator across from the nurses station. -At 5:56 a.m., two staff members, certified nurse aide (CNA) #5 and a nurse entered from the double doors, walked past the nurses station and used the stairwell and elevator across from the nurses station. -At 6:17 a.m., CNA #5 was interviewed. She said she usually entered the back door, clocked in, went upstairs to the second floor to get screened then returned to the first floor. -At 6:00 a.m., registered nurse (RN) #5 entered through the double doors, walked past the nurses station, performed the narcotic count of a medication cart then went to be screened on the second floor. At 6:04 a.m. she returned to the first floor through the double doors. RN #5 was interviewed at 6:22 a.m. She stated she came in through the back door, went to the second floor for the employee screening process, and then returned to the first floor. RN #5 said she used to go through the front door and probably still should. -At 6:02 a.m., LPN #2 entered through the double doors and performed a narcotic count of a medication cart then exited the floor through the stairwell near the nurses station. She returned to the first floor at 6:09 a.m. She pushed the medication cart to the East hallway. LPN #2 was interviewed at 6:10 a.m. She confirmed that she entered through the back door and went to the second floor to get a bottle of Tylenol for the medication cart. She said at times she went to the front entrance for the screening process then entered through the back door. At 6:39 a.m., the central supply director brought a cart of supplies to the first floor medication room. She confirmed she arrived around 5:30 a.m. to the facility and entered through the back door, and went to the second floor for the screening process. She said the front door was usually locked and the night shift staff took too long to let her in so she used the door code on the back door to enter the first floor. She said she either used the elevator near the back door or the stairs and elevator near the nurses station and went to the second floor for the employee screening process. She said that she usually went up and down the halls looking for the night nurse to do the screening process because they were not usually at the nurses station. She said, I know I should probably come through the front door but I don't like waiting for them. F. Layout of second floor The main entrance was located on the second floor. Upon entering the facility through two sets of double glass doors on the left side was a receptionist desk and to the right side was a bathroom and an ABHR dispenser. On the side of the double doors was a trash can with a sign that read, Used masks to be thrown away. Past the reception area down the hallway to the nurses station was a common area with couches. There was a sign located on the outside of the stairwell that read for staff to not use the stairwell across from the nurses station. There were two resident hallways, East and West along with a short hallway that led past the nurses station with a therapy gym, a back door leading to the outside of the building, a resident lounge and dining rooms. G. Observations of screening process for staff Observations and staff interviews were conducted on 6/30/2020, on the second floor, during shift changes from 4:30 a.m. to 7:50 a.m. -At 4:30 a.m., three surveyors entered the facility and were greeted at the door by RNs #1 and #2. The nurses had the surveyors remain outside and allowed one in at a time to the screening area. RN #2 asked the screening questions, however asked the person being screened, Do you have any new symptoms?, without providing the specific symptoms so the person being screened would know what the symptoms were to provide a more accurate response. Both RN #1 and #2 failed to instruct surveyors to perform hand hygiene. Registered nurse (RN) #1, who was conducting screening with staff was interviewed at 5:00 a.m. She stated the second floor nurses were responsible for screening staff between the hours of 8:00 p.m. to 8:00 a.m. She said her training included screening the staff for signs and symptoms of COVID-19, exposure risk of COVID-19 and taking staff temperatures prior and after their scheduled shift. She said she documented responses in the log under each staff members' name. She said the IPCN was contacted for further instructions with 'yes' responses. -At 5:05 a.m., a staff member walked in from the back entrance to the nurses station without a face mask. The staff member was reminded by another staff member to put her mask on, so she left through the back door and returned wearing a face mask to be screened by RN #1. After she was screened, at the end of her shift, she exited the facility wearing a surgical mask, did not doff the mask prior to exiting and performing hand hygiene. There was no trash receptacle or hand hygiene station at the back door. From 5:15 a.m. to 6:25 a.m., three staff members entered from the stairwell across from the nurses station, seven staff member entered from the back door, one staff member entered from the elevator across from the nurses station, three staff members entered from the front door and into the resident area to be screened at the nurse station by RN #1. The staff formed a line in front of the nurses station up to five staff deep and did not keep social distancing, they stood in close proximity to each other. RN #1 asked the screening questions, however asked the person being screened, Do you have any new symptoms?, without providing the specific symptoms so the person being screened would know what the symptoms were to provide a more accurate response. RN #1 failed to instruct staff to perform hand hygiene before going to other floors to work. -At 6:05 a.m., RN #1 was screening the next staff member and before asking the screening questions the staff member said, No to all the questions. RN #1 accepted the answers and documented on the log, sent the staff member to the floor to work and failed to instruct on hand hygiene. -At 6:06 a.m., RN #1 screened a staff member who said, We are doing all these questions again, the answer to all of them is still no. RN #1 acknowledged the answers and documented on the log, sent the staff member to the floor to work but failed to instruct on hand hygiene. -At 6:25 a.m., dietary aide (DA) #1 entered the back door and walked through the resident area to the nurses station to be screened. She stood in line at the nurses station with several other staff members waiting to be screened. They stood close to each other and did not maintain social distancing. DA #1 stated that she was on the first floor to clock in and went to the kitchen to put on a hair net because the staff waiting in line to be screened was too long and she did not want to waste time. -At 7:00 a.m., the transportation driver entered through the front entrance and walked through the resident area to the nurses station to be screened. Then he walked down the West hall and returned to the nurses station. He then walked down the East hallway and asked the CNA where the nurse was to be screened. He walked back to the nurses station and was screened by RN #4. -At 7:20 a.m., an unidentified staff member was waiting at the nurses station while another staff member was being screened. RN #4 screened the oncoming staff and asked them both concurrently, Do you have any COVID symptoms? the staff answered 'no' and went to the floor. RN #4 failed to ask specific symptoms, obtain temperatures, and instruct staff to perform hand hygiene before going to the floors to work. -At 7:21 a.m., RN #4 screened another unidentified staff member and asked if she had COVID symptoms, touched the thermometer to the staff member's head, failed to clean the thermometer and did not instruct the staff member to perform hand hygiene before excusing the staff member to the floors for work. -At 7:23 a.m., RN #4 screened RN #6 after her night shift. RN #4 did not instruct RN #6 to remove PPE (mask) prior to exiting the facility and perform hand hygiene. RN #6 exited the building with her mask on. RN #6 said that she would take it off in her car and she usually took her mask home. She said if she needed to make stops like the gas station she would wear the same mask. -At 7:31 a.m., the staff development coordinator went to her office which was located in the resident area across from the second floor nurses station and then walked the resident hallways to locate the nurse to be screened. RN #4 screened her and asked her Do you have any COVID symptoms? but failed to ask specific symptoms, took the staff member's temperature but failed to instruct on hand hygiene. H. Record review The staff and visitor screening logs from 6/29/2020 to 6/30/2020, revealed a log entry type of system which contained sections for the name of the visitor/staff, temperature, a 'yes/no' response to having any symptoms of COVID-19, a 'yes/no' response to exposure risk from a person with laboratory tested positive COVID-19, a 'yes/no' response to traveling out of the country. If the visitor/staff answered 'yes' the log did not include the specific details of the 'yes' response in order

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) for the facility to track, monitor and report for a potential outbreak of COVID-19. The bottom of the log contained a list of symptoms for the screener to read from, which included the following questions: New/change in cough, sore throat, shortness of breath, difficulty breathing, chills, shivering, loss of taste and/or smell, runny nose, diarrhea, nausea, vomiting, headache, and muscle aches. I. Interviews The nursing home administrator (NHA) and director of nursing (DON) were interviewed 6/29/2020 at 2:30 p.m. The NHA said staff entered through one entrance, the main entrance. The screening desk was staffed between 8:00 a.m. to 8:00 p.m. After 8:00 p.m. the night shift nurse on the East side of the second floor was responsible for screening staff. The NHA was interviewed on 6/30/2020 at 9:49 a.m. She stated that since the last survey the employee screening changed from being at the front and back entrances of the building to just the front entrance. She said this was to gain control of the flow and limit access points and ensure that all accessible entrances had a screening station. III. Personal protective equipment (PPE) A. Facility policy and procedure The Guide to Infection Prevention and Control policy, last revised on 5/29/2020, was provided by the director of nursing (DON) via email on 6/30/2020. It read in pertinent part, The facility should train associates on personal protective equipment (PPE), this training should include appropriate don/doff process. B. Professional reference The Centers for Disease Control and Prevention (CDC) (4/3/2020) Using PPE, retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html (7/8/2020). It read in pertinent part, How to put on (don) PPE gear: Do not wear a respirator/face mask under your chin or store in a scrubs pocket between patients. C. Training The 3/6/2020 Sequence for Putting on Personal Protective Equipment (PPE) staff in-service read, in pertinent part, Masks or respirators should be secured with ties or elastic at the middle of the head and neck and fit snug to face and below the chin. Keep (your) hands away from (your) face and perform hand hygiene. D. Observations and interviews On 6/29/2020 on the first floor -At 5:10 p.m., licensed practical nurse (LPN) #1 was observed wearing her surgical mask over her mouth but below her nose while standing at a medication cart. -At 5:12 p.m., LPN #1 was in a dining room assisting an unmasked female resident to eat. The surgical mask for LPN #1 was still below her nose. LPN #1 left the female resident, got a tissue and wiped the nose of a male resident sitting nearby. LPN #1 failed to perform hand hygiene after assisting the female resident to eat, before picking up a tissue and wiping the nose of the resident, before she retrieved keys from her pocket and before she touched the medication cart drawer. On 6/29/2020 on the third floor -At 4:32 p.m., recreational therapist assistant (RTA) #1 and #2 delivered drinks to residents in their rooms from the hydration cart in the hallway. RTA #1 pulled her mask down to speak to the surveyor. RTA #1 said that she pulled the mask down so that she could be understood easier. She said that the residents struggled to understand so she pulled down the mask to make herself understood easier. E. Interviews The nursing home administrator (NHA), director of nursing (DON) and Infection prevention and control nurse (IPCN) were interviewed on 6/30/2020 at 9:45 a.m. The IPCN stated education was provided on how to wear a face mask to ensure it fit snug to the face over the nose and below the chin. IV. Hand hygiene A. Facility policy and procedure The Hand Hygiene policy, last revised on 5/7/2020, was provided by the nursing home administrator (NHA) on 7/1/2020. It read in pertinent part, The facility should provide education to associates (staff) on hand hygiene routinely, and this education should include but is not limited to: When to perform proper hand hygiene with alcohol based hand rub and with soap and water, when coming on duty and prior to leaving for the day, before and after all resident contact, after contact with potentially infectious material, before applying gloves, after removal of gloves, after touching your face mask or cloth face covering. Prior to removal of face shield/eye protection and/or respirator during the doffing (removal) of PPE process. B. Professional reference The Centers for Disease Control and Prevention (CDC), (1/31/2020) Hand Hygiene in Healthcare Settings, retrieved from: https://www.cdc.gov/handhygiene/providers/index.html (7/9/2020). It read in pertinent part, Multiple opportunities for hand hygiene may occur during a single care episode: immediately before touching a patient, after touching a patient or the patient's immediate environment, immediately after glove removal. Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment. Perform hand hygiene immediately after removing gloves. Hand hygiene means cleaning your hands by using either handwashing (washing hands with soap and water), antiseptic hand wash, antiseptic hand rub (i.e. alcohol-based hand sanitizer including foam or gel). The Centers for Disease Control and Prevention (CDC), (6/25/2020) Preparing for COVID-19 in Nursing Homes, Core Practices, retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html (7/9/2020). It read in pertinent part, Care must be taken to avoid touching the respirator, facemask, or eye protection. If this must occur (e.g., to adjust or reposition PPE), healthcare providers should perform hand hygiene immediately after touching PPE to prevent contaminating themselves or others. The CDC Interim Infection Prevention and Control (3/13/2020) Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes. Retrieved online from: ttps://www.cms.gov/files/document/qso-20-14-nh-revised.pdf (7/9/2020). It read in pertinent part, Remind residents to practice social distancing and perform frequent hand hygiene. C. Training The 3/6/2020 How to Safely Remove Personal Protective Equipment (PPE) staff in-service read in pertinent part, If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer. Discard in a waste container. Wash hands or use an alcohol-based hand sanitizer immediately after removing all PPE. Perform hand hygiene between steps if hands become contaminated and immediately after removing all PPE. The 3/26/2020 More Coronavirus Education staff in-service read, in pertinent part, Do not touch your facemask. If you touch or adjust your facemask immediately wash your hands. The 4/29/2020 Response to State Survey Related COVID-19 staff in-service read, in pertinent part, Handwashing should be completed after using the toilet, before eating, and before and after your shift, and when your hands are visibly soiled. Help the residents with hand hygiene. Residents should be encouraged to wash their hands after using the bathroom, before they eat, and prior to leaving their rooms. D. Observations and interviews On 6/29/2020 on the first floor -At 4:40 p.m. certified nurse aide (CNA) #1 adjusted a cloth face mask from under the chin of a male resident to cover his nose and mouth. CNA #1 went to the soiled utility room, entered the door code, turned the door handle and entered the room. CNA #1 did not perform hand hygiene after adjusting the mask of the resident and prior to touching the key pad or door handle of the soiled utility room door. From 4:45 p.m. and 5:03 p.m., CNA #1 retrieved meal trays. She delivered a tray with food and drink to two residents sitting at a table near the nurses station. She placed their food and place settings on the table in front of them and added sugar to a drink. She removed the empty tray and placed it back on the delivery cart in the hallway. CNA #1 picked up more trays with food and drink and continued into other resident rooms. CNA #1 knocked on the closed doors, used one hand to open the doors and entered. She exited the resident rooms without performing hand hygiene and placed the empty trays on the delivery cart in the hallway. CNA #1 failed to perform hand hygiene before leaving each resident room, prior to handling food trays and prior to touching door knobs of resident rooms. -At 5:12 p.m., LPN #1 assisted an unmasked female resident to eat in a dining room. LPN #1 left the female resident, got a tissue and wiped the nose of a male resident sitting nearby. She threw the tissue in the trash and reached into her scrub top pocket to retrieve the medication cart keys. She unlocked the medication cart, retrieved gloves and returned the keys to her pocket. LPN #1 went to the dining room sink and returned with wet paper towels to wipe the hand and forearm of the male resident. LPN #1 failed to perform hand hygiene after assisting the female resident to eat, before picking up a tissue and wiping the nose of the resident, before she retrieved keys from her pocket and before she touched the medication cart drawer. Between 5:16 p.m. and 5:39 p.m., CNA #1 retrieved dirty dishes from resident rooms #101, #117 and #116. CNA #1 knocked on the closed doors, used one hand to open the doors and entered. She retrieved the dirty dishes, scraped solids from plates and poured liquids from drinking glasses into receptacles on the food delivery cart. CNA #1 failed to perform hand hygiene before exiting resident rooms, after handling the dirty dishes and prior to touching door knobs of resident rooms. -At 5:20 p.m., CNA #2 retrieved dirty dishes from resident rooms. CNA #1 knocked on the closed doors, used one hand to open the doors and entered. She retrieved dirty dishes, scraped solids from plates and poured liquids from drinking glasses into receptacles on the food delivery cart. CNA #1 failed to perform hand hygiene before exiting resident rooms, after handling the dirty dishes and prior to touching door knobs of resident rooms. On 6/29/2020 on the second floor -At 5:30 p.m. CNA #6 delivered a meal tray to Resident #2 but failed to provide and/or encourage hand hygiene for the resident. The resident was sitting in a recliner and did not have ease of access to the sink to wash her hands since she reported that she required assistance with mobility. There were no hand hygiene products located near her so she could perform hand hygiene. Resident #2 stated she would like clean hands before she ate her meal. She said that usually the staff left the meal tray on her bedside table but did provide and/or encourage hand hygiene. -At 5:32 p.m. CNA #7 delivered a meal tray to Resident #3 but failed to provide and/or encourage hand hygiene for the resident. The resident was sitting in a recliner and did not have ease of access to the sink to wash her hands at the sink since she reported that she required assistance with mobility. There were no hand hygiene products located near her so she could perform hand hygiene. Resident #3 stated she wanted to wash her

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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	(continued... from page 3) hands at the sink before she ate her meal and did not want to use other hand hygiene products. She said usually the staff took her to wash her hands at the sink but sometimes the staff forgot and she would not get her hands washed. She said when that happened it would bother her because she liked clean hands. CNA # 7 was interviewed at 5:40 p.m. She said usually she offered hand hygiene with ABHR or hand washing with soap and water before the meal tray was delivered to the resident. On 6/29/2020 on the third floor -At 5:14 p.m., unit manager (UM) delivered the meal tray to Resident #1, set the meal tray on the counter next to the sink, washed her hands with soap and water, then set the meal in front of Resident #1 on the bedside table. The UM opened the containers on the meal tray, removed the lid from the main dish and left the room. She failed to encourage and/or provide hand hygiene for the resident. -At 5:14 p.m., CNA #13 delivered the meal tray to Resident #4, set the meal tray on the bedside table next to the resident, then washed her hands in the sink with soap and water. The CNA removed the lid on the main dish, opened containers and handed the resident eating utensils. The CNA failed to encourage and/or provide hand hygiene to the resident. -At 5:15 p.m., CNA #12 delivered the meal tray to a resident in room [ROOM NUMBER], she washed