STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065312	A. BUILDING _____ B. WING _____	04/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CROWLEY COUNTY NURSING CENTER	401 IDAHO AVE ORDWAY, CO 81063

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 establish and maintain and infection prevention and control program designed to provide a safe, sanitary environment and to help prevent the developlment and transmission of communicable disease and infections such as COVID-19 in three of four neighborhoods for seven of seven sample residents. Specifically, the facility failed to: -Follow proper housekeeping protocols to prevent cross-contamination; -Maintain proper cleaning standards and procedures; -Ensure residents had face covering while out of their rooms; and, -Ensure social distancing was followed during meals. Findings include: I. Improper housekeeping protocols A. Facility policies and procedures The Infection Control Policies and Procedures policy, revised 10/2012, was provided on 4/28/2020 at 10:14 p.m. by the director of nursing (DON). The goals of the infection control program are to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections. B. Observations of improper housekeeping protocols On 4/29/2020 at 11:30 a.m., Housekeeper (HSK) #1 was observed cleaning room #C-8. Housekeeper HSK#1 put on gloves, and grabbed a rag, cleaner, and toilet brush and walked directly into the residents' bathroom. HSK #1 removed the commode chair from the toilet. HSK #1 was observed to use her gloved hands, and pour in a disinfectant into the toilet. She sprayed the toilet bowl and cleaned the toilet bowl. She exited the resident's room and placed the bowl brush back into her cart. She proceeded to wet the mop head and rang it out in the bucket and reentered the resident restroom. She mopped the bathroom floor and exited the resident's room after mopping. She placed the mop back in the mop bucket. She grabbed a clean rag and immersed the rag in the bucket filled with a disinfectant. She reentered the resident's room. She wiped the toilet lid, seat and base with the rag. She wiped the commode chair with the same rage she cleaned the toilet bowl and base with. She replaced the commode chair over the toilet. She then walked outside of the room and placed the dirty rag into the plastic bag on her cart, and retrieved another rag and submersed the rag into the disinfectant and rang it out. She wiped the sink and counter lifting wash cloths and other personal items which were on the counter. She wiped the towel dispenser with the same rag. She walked over to the window and wiped the window seal and wiped the window seal. She then wiped the bedside table. She then walked outside of the room and placed the used rag in a plastic bag. She grabbed the second mop, and proceeded to ring the mop out. She reentered the resident room and mopped the resident's room working her way out the door. She completed cleaning the residents' room and then removed her gloves. She washed her hands in the residents sink. C. Staff interviews HSK#1 was interviewed on 4/28/2020 at 10:39 a.m. She said the process to clean a resident's room was to start in the bathroom and then go to the rest of the room. She said, the dwell time for the disinfectant was approximately 45 seconds. She said as long as the rag was wet it was okay. The laundry housekeeping manager (LHSKM) was interviewed 4/29/2020 at 11:59 a.m. The LHSKM was informed of the observation above. She said the housekeepers are supposed to go from clean to dirty, which was starting from the window working out towards the door with the restroom being the last task. She said it was her expectations that the housekeeper would have followed facility procedure when cleaning the residents' rooms. She said the disinfectant used to be in a spray bottle but it had been changed to the bucket and using the rags. She said she thought the dwell time for the Eco lab disinfectant. She said a negative outcome for not following cleaning procedure and lack of dwell time would be cross contamination. She said she would reach out to the ECO lab provider to clarify the dwell time on the disinfectant. The Eco lab tech was interviewed on 4/30/2020 at 8:47 a.m. He said the disinfectant could be used with a rag immersion and a towel. He said it could also be utilized in a spray bottle. He said the dwell time for either procedure would be five minutes in order to be an effective disinfectant. He said the spray bottle method would be the best method to accomplish the dwell time it required. He said he would reach out to the facility to educate the facility of proper application. II. Failed to ensure residents had face covering while out of their rooms Findings include: I. CDC recommended guidelines The Center for Disease Control (CDC), Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings (4/28/2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#minimize, (Update April 13, 2020) Patients may remove their cloth face covering when in their rooms but should put them back on when leaving their room or when others (e.g., HCP, visitors) enter the room. Screening for symptoms and appropriate triage, evaluation, and isolation of individuals who report symptoms should still occur. A. Observations of improper housekeeping protocols On 4/28/2020 at 10:09 a.m. Four residents were sitting in various places in the common area watching television. All four did not have on any face mask. On 4/28/2020 at 10:23 a.m. Two male residents were sitting in their recliners on the memory lane. They both did not have on any face mask. On 4/28/2020 at 11:48 a.m. a male resident was walking by the nurse station and was not wearing a mask. On 4/29/2020 at 9:08 a.m.-12:00 p.m. continuous observation of the facility revealed seven resident sitting in their wheelchairs on C hall. All seven residents did not not have on any face masks. On 4/29/2020 at 9:18 a.m., four residents were sitting in their wheelchairs on B hall. All residents' did not have on any face masks On 4/29/2020 at 9:32 a.m., one female resident was sitting in her wheelchair on D hall. She was not wearing a face mask. On 4/29/2020 at 10:03 a.m. a female resident was sitting in the common area watching television. She did not have a mask on. During the observations above no staff encouraged residents to wear mask when not in their personal rooms. B. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 4/29/2020 at 10:26 a.m. She said, No we do not have face masks for the residents'. Certified nurse aide (CNA) #3 was interviewed on 4/29/2020 at 10:35 a.m. She said one resident prefers to wear a mask but all other residents do not wear masks when they are out of their rooms. CNA #1 was interviewed on 4/29/2020 at 10:45 a.m. She said, No the residents do not wear masks. CNA #2 was interviewed on 4/29/2020 at 10:50 a.m. She said staff are the only ones who are required to have face masks. The nursing home administrator (NHA) was interviewed on 4/29/2020 at 11:59 a.m. He said he was not aware the resident required face mask on when they were out of their rooms. He said he would immediately get that corrected. The director of nursing (DON) was interviewed on 4/29/2020 at 12:06 p.m. She said she was not aware that the residents' were required to wear masks outside of their rooms. The DON said they would get a mask for residents' immediately. III. Ensure social distancing was followed during meals. A. Meal observations On 4/29/2020 at 11:45 a.m. the residents were being seated in the main dining room. There were approximately 23 residents' seated at various tables in the dining room. There were five tables with three residents seated at each table. The resident's seated at the five tables were the residents' who required assistance during meals. The distance between the residents seated in the dining room was approximately three feet to four and a half feet. The assisted tables also had one staff member seated with the three residents which resulted in the distancing being less than three feet of distancing between them all. The residents who were seated at the double tables were seated approximately four and a half feet of distancing between them. B. Staff interview The dietary manager was interviewed on 4/29/2020 at 11:48 a.m. She said they have had to adjust things when it comes to resident dining. She said we have 11 residents who required assistance during meals. She said the facility had moved the independent residents in the back activity area, which has allowed independent residents to social among themselves while keeping the social distancing. She said the facility had tried to keep the social distance of six feet

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) which was difficult because the alternative would be for all the residents to eat in their rooms. The nursing home administration (NHA) was interviewed on 4/29/2020 at 12:16 p.m. The NHA was asked to observe the residents during their meal. He said the distance between the residents in the dining room was not exactly six feet. He said the only alternative would be to make all the residents eat in their rooms which would not go well with the residents'.