STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065415	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pikes Peak Post Acute	2719 N Union Blvd Colorado Springs, CO 80909

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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48458 Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of infectious disease on three of nine units. Specifically, the facility failed to: -Ensure housekeeping staff wore gloves and performed appropriate hand hygiene while cleaning residents' rooms; -Ensure housekeeping staff wore masks appropriately while the facility was in a flu outbreak; and, -Ensure staff sanitized dining tables and the floor prior to the next meal. Findings include: I. Housekeeping failures A. Facility policy and procedure The Cleaning and Disinfecting Residents' Rooms policy, revised August 2013, was provided by the regional director of clinical services (RDCS) on 1/30/25 at 2:39 p.m. It read in pertinent part, Use heavy-duty gloves and other personal protective equipment (PPE), as indicated, for housekeeping tasks. Gloves, protective eyewear and masks may be indicated to reduce exposure levels to disinfectant chemicals as well as to protect employees from exposure to blood and OPIM (other potentially infectious materials) while cleaning or disinfecting. Perform hand hygiene after removing gloves. B. Observations On 1/29/25 at 8:42 a.m. housekeeper (HK) #1 was observed cleaning room [ROOM NUMBER]. HK #1 reached her ungloved hand into a clean bucket, retrieved a mophead and applied the mophead to her mop. After using the mop, HK #1 removed the dirty mophead and disposed of it with ungloved hands. (continued on next page)

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 - Few	-HK #1 did not perform hand hygiene after removing the dirty mophead with her ungloved hands. HK #1 proceeded to empty the trash can with her ungloved hands. -HK #1 did not perform hand hygiene after emptying the trash can. HK #1 licked her fingers and opened a clean trash bag with her ungloved hands, which she had not sanitized after removing the dirty mophead with her ungloved hands or emptying the trash can. HK #1 did not perform hand hygiene after licking her fingers. On 1/29/25 at 8:50 a.m., HK #1 was observed cleaning room [ROOM NUMBER]. HK #1 reached her ungloved hand into a clean bucket, retrieved a mophead and applied the mophead to her mop. After using the mop, HK #1 removed the dirty mophead and disposed of it with ungloved hands. -HK #1 did not perform hand hygiene after removing the dirty mophead. HK #1 proceeded to reach her ungloved hand into the bucket of clean mopheads again to retrieve another mophead. C. Staff interviews HK#1 was interviewed on 1/29/25 at 9:00 a.m. HK #1 said she should have worn gloves to obtain and dispose of the mophead. She said she should have used hand sanitizer after touching the dirty mophead. HK #1 said some residents' trash cans looked clean so she did not always wear gloves. HK #1 said she should have worn gloves to empty the trash. -During the interview, HK#1 was observed wearing a mask under her nose, despite the fact that the facility was in a flu outbreak during the survey. The housekeeping supervisor (HKS) was interviewed on 1/29/25 at 9:30 a.m. The HKS said HK#1 should have worn gloves and changed gloves between tasks when cleaning the residents' rooms, including when removing trash from the rooms and when she discarded the dirty mopheads. The HKS said HK #1 should have used hand sanitizer before applying gloves and between changing gloves. The infection preventionist (IP) was interviewed on 1/29/25 at 1:55 p.m. The IP said HK #1 should have worn gloves at all times while cleaning the residents' rooms and changed gloves and performed hand hygiene between dirty and clean tasks. The IP said HK#1 should have washed her hands with soap and water after licking her fingers. The IP said HK #1 should have covered her nose when wearing her mask. II. Failure to sanitize dining tables and the floor between meals A. Observations On 1/27/25 at 11:32 a.m. the dining room in the 100 hallway was observed. There were five tables in the dining room. There were bread/dessert crumbs on three dining tables and beverage cup liquid markings and other stains present on four of the dining tables. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:09 p.m. stains and crumbs were still present on the 100 hallway dining tables and there were four residents sitting at the tables waiting for lunch and drinking beverages. At 12:43 p.m. meal service began and the dining tables in the 100 hallway dining room had not been cleaned. On 1/28/25 at 9:15 a.m. the dining room on the 100 hallway was observed again. There were crumbs on the floor and dirty marks/dried beverage spots on two of the four dining tables after the breakfast meal. At 12:26 p.m. there were still crumbs on the floor and the same spots on the tables in the 100 hallway dining room. Three residents were sitting at the dining tables awaiting lunch. On 1/29/25 at 11:30 a.m. the dining room on the 100 hallway was observed. There were bread/dessert crumbs on three of the dining tables, crusty substances on three of the dining tables' edges and beverage spots on one dining table. The dining table closest to the entrance of the dining room still had liquid spots in the same locations observed on 1/27/25 and 1/28/25 (see above). Crumbs were present on a chair and on the floor under the dining tables. A plastic cup lid was on the floor. At 11:55 a.m. a housekeeper was cleaning the 100 hallway and walked with the housekeeping cart past the dining room. The housekeeper did not clean the dining room. At 12:41 p.m. the 100 hallway dining room was observed in the same condition. The dining tables, chair and floor had not been cleaned. At 12:56 p.m. two residents were observed in the 100 hallway dining room. They sat at a dining table and began drinking coffee. The dining tables had not been wiped/sanitized and the room was in the same condition. At 12:57 p.m. a resident sat at another dining table that had not been wiped/sanitized. At 12:59 p.m. meal service began in the 100 dining room and the dining tables had not been cleaned. At 3:49 p.m. the dining tables were in the same condition with crumbs and dried beverage stains. In addition, there were two plastic beverage cup lids on the floor and additional crumbs on the floor. At 5:15 p.m. two of the beverage stains on a dining table were able to be partially removed when wiped with a wet paper towel. At 5:31 p.m. two residents were observed eating at a dining table which had not been cleaned. B. Resident interview Resident #40 was interviewed on 1/30/25 at 10:30 am. Resident #40 said many times the dining room was not cleaned after meals. Resident #40 said she had gone into the dining room for Bingo at 2:30 p.m. on several occasions and there was still food on the tables or trays with food stacked in racks in the dining room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Staff interview The dietary manager (DM) was interviewed on 1/29/25 at 5:39 p.m. The DM said the dietary aides were responsible for cleaning the dining room tables and serving areas in the 100 hallway dining room. He said the dietary aides were supposed to clean the dining rooms after every meal. The DM said there were cleaning logs for the other dining rooms, however, he said he did not think there was a cleaning log for the 100 hallway dining room. The DM said there should be a cleaning log for the 100 hallway dining room. The DM said the staff should ensure the tables were clear of food debris and stains and remove trash so residents would feel comfortable sitting at the tables. The DM said the cleaning of the 100 hallway floor was the responsibility of the dietary aides and housekeeping was also responsible for cleaning the floors. The DM said he was going to communicate with the nursing staff to assist with cleaning the 100 hallway dining room. The DM said he would also communicate with the housekeeping supervisor to establish a 100 hallway dining room cleaning schedule for the housekeeping department.