STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035062	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DESERT HAVEN CARE CENTER	2645 EAST THOMAS ROAD PHOENIX, AZ 85016

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, staff interviews, review of the Center for Disease Control (CDC) recommendations, and policies and procedures, the facility failed to ensure that infection control standards were followed. The deficient practice could result in the spread of infection, including COVID-19 to residents and staff. Findings include: -Regarding donning and disposal of PPE On June 5, 2020 at 9:10 a.m., an entrance conference was conducted with the Director of Nursing (DON/staff #7). He stated that there were COVID-19 positive residents residing in the facility. Staff #7 stated there was no shortage of Personal Protective Equipment (PPE), and that they were implementing extended wear. He stated that in addition to conventional yellow PPE isolation-type paper gowns, they utilized brown vinyl gowns that are wiped down and/or laundered between uses. An observation was conducted of the Pine (presumptive COVID-19 positive) unit on June 5, 2020 at 9:30 a.m. A laundry staff member (staff #54) was observed removing clean linen from a cart into a linen closet on the hallway. Staff #54's gown was observed loosely tied at the neck and untied at the waist. The neck opening of the gown hung halfway down staff #54's right arm and her back side was completely uncovered. Staff #54 stated she has attended in-service education regarding the proper donning of PPE. She stated her gown was not supposed to drop off her, but that the gown was too big for her. At 9:40 a.m. on June 5, 2020, an observation was conducted on the Magnolia unit. A Certified Nursing Assistant (CNA/staff #44) was observed leaving a resident's room donned in a brown vinyl gown that was unfastened at her neck and hanging off her left shoulder. Staff #44 walked down the hallway to a small utility closet near the nurses' station. She was observed to doff the brown gown and hang it on a hook in the closet. Staff #44 stated that she has attended in-service meetings regarding the proper donning of PPE. She stated her gown did not fasten or tie at the neck because it was ripped on one side. The CNA agreed that the gown hanging off her provided little protection. On June 5, 2020 at 9:50 a.m., an observation was conducted on the Oak unit with the Infection Preventionist (staff #15). She stated COVID-19 positive residents resided on the unit. She stated all the residents on the unit were considered to be presumptive COVID-19 positive. Staff #15 stated her expectation is for staff to don full PPE (gown, gloves, N95 face mask, and goggles or face shield) to provide resident care. During the observation on the Oak unit, a CNA (staff #16) was observed sitting at the desk in the nursing station wearing a cloth face mask. The cloth face mask partially covered the lower lip of the CNA's mouth and was primarily positioned on his chin. The CNA's nose was fully exposed. Following this observation, an interview was conducted with staff #16. He stated that he has attended the in-services regarding the proper donning of PPE. The CNA stated his practice is to switch back and forth between wearing a cloth face mask and an N95 mask. He stated his N95 mask was at the back of the nurses' station. He said that he had pulled his cloth face mask down to his chin because he had been talking on the telephone and the other person on the other end could not hear what he was saying. An observation was conducted outside the shower room on the Oak unit at 10:02 a.m. A CNA (staff #20) was observed spraying down a shower chair with disinfectant after providing a shower to a resident. Staff #20's N95 face mask was observed to be positioned under his chin with his nose and mouth completely uncovered. The CNA did not have on a face shield or goggles. At the direction of the Infection Preventionist, (staff #15), staff #20 pulled his mask up to cover his nose and mouth. Several minutes later, staff #20 was observed wearing his face shield far back on his head with his face exposed. Staff #20's face mask was pulled down to cover his mouth and chin, but his nose was fully exposed. Staff #20 stated that he had attended the in-service meetings regarding the appropriate way to don PPE. The CNA further stated he had just given a resident a shower and he was too hot to wear his face shield over his face or to don his mask over his nose. At 10:07 a.m. on June 5, 2020, a CNA (staff #10) was observed walking into a resident's room without donning a gown prior to entering the resident's room. He stood in the center of the resident's room, approximately 6-8 feet inside the room, for several minutes speaking with the resident. An interview was conducted with staff #10 following this observation. The CNA stated that he had attended the facility in-service meetings regarding donning PPE. He stated that he was told that he only needs don PPE if he has direct contact with a resident. The CNA stated that he did not need to don a gown just to speak to the resident. An observation was conducted of the dining room on the Oak unit at 12:00 p.m. on June 5, 2020. A CNA (staff #11) was observed sitting at one of the dining room tables with her cell phone. The CNA's mask was attached by the ear-loops, but was positioned under her chin with her nose and mouth completely exposed. Staff #11 stated she has attended several in-services regarding the proper donning of PPE. She stated the latest in-service she attended was yesterday (June 4, 2020). During a lunch observation conducted on the Oak unit at 12:07 p.m., three CNAs were observed donning yellow isolation gowns. The CNAs did not tie the gowns at the neck or the waist. The CNAs each took a meal tray from the tray ladder and delivered the meal trays to residents who were in their rooms. Upon exiting the residents' rooms, the CNAs were observed to doff the gowns, roll the gowns into a ball, and carry the gowns down the hallway to the soiled linen room, where they put the gowns into the trash. The CNAs were then observed to return to the area of the tray ladder, sanitize their hands, and don a clean isolation gown. One CNA (staff #10) was observed coming out of a resident's room no longer wearing his isolation gown. He stated he doffed his gown in the resident's room and that he put the gown into the trash can that was located in the resident's bathroom. The resident's bathroom was observed located on the opposite side of the room, approximately 11 feet from the resident's room door. On June 5, 2020 at 1:50 p.m. an interview was conducted with the Infection Preventionist (staff #15). She stated that staff are required to don gloves, gown, N95 mask, and eye protection prior to providing care to presumptive COVID-19 positive residents. She said that cloth masks are only allowed to be worn over an N95 mask. Staff #15 stated that if staff dons one of the yellow gowns during resident care, the expectation is that they doff the gown upon leaving the resident's room and place it into one of the red plastic bags that are located outside the resident's door in the PPE cart. She stated staff are expected to take the red bag containing PPE to the soiled utility room for disposal in the regular trash. She stated that it did not meet her expectation for staff to doff isolation gowns, roll them into a ball, and carry them down the hallway for disposal. She also stated staff has been educated regarding the appropriate way to wear their masks and other PPE. During an interview conducted on June 5, 2020 at 1:52 p.m. with the DON (staff #7), he stated that he had not really stressed with the staff the importance of tying isolation gowns at the waist or neck. The facility's policy titled Limiting Transmission of COVID-19 Guideline revealed the objective of the COVID-19 guideline is to limit transmission by limiting how germs can enter the facility, isolating symptomatic residents as soon as possible, and protecting healthcare personnel. The policy stated the facility will implement appropriate transmission-based precautions when indicated which included donning all recommended PPE (i.e., gloves, gown, eye protection and respirator or facemask) when COVID-19 has been identified in the facility for the care of all residents on the unit (or facility-wide based on the location of affected residents), regardless of symptoms (based on availability). The facility's Safework Practices diagram instructs the gown should be donned so that it fully covers the torso from neck to knees, arms to ends of wrists, and wraps around the back, and to fasten the gown in back of the neck and the waist. The diagram included the sequence for safe removal of PPE which included removing all PPE before exiting the resident room, (with the exception of the respirator), folding or rolling the gown and gloves into a bundle, and discarding into a waste container. Review of the CDC's Interim Infection Prevention and

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) Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings included removing gown and gloves and discarding them into a dedicated container for waste before leaving the resident room or care area, and immediately performing hand hygiene. The CDC's guidance Preparing for COVID-19 in Nursing Homes updated May 19, 2020 revealed cloth face coverings should not be worn by staff instead of a respirator or facemask if PPE is required. The Key Strategies to Prepare for COVID-19 in Long-Term Care Facilities CDC guidance stated that if COVID-19 is identified in the facility, restrict all residents to their rooms and have health care personnel (HCP) wear all recommended PPE for care of all residents (regardless of symptoms) on the affected unit (or facility-wide depending on the situation). This includes: an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and gown. The guidance stated that this approach is recommended because of the high risk of unrecognized infection among residents. Recent experience suggests that a substantial proportion of residents could have COVID-19 without reporting symptoms or before symptoms develop. -Regarding allowing symptomatic staff to work On June 5, 2020 at 1:00 p.m., a review of the facility staff screening documentation was conducted. An Infection Control Visitor/Vendor Questionnaire dated April 6, 2020 revealed a Licensed Practical Nurse (LPN/staff #25) was experiencing signs or symptoms of a respiratory infection (i.e., cough) when she reported for work that day. Her temperature was noted to be 97.7, within normal limits. Staff #25 signed the document. Additionally, the review of the document revealed it had been reviewed, signed, and entry had been permitted by the DON (staff #7). At 1:50 p.m. on June 5, 2020, an interview was conducted with the DON (staff #7). He stated that coughing does not preclude a staff member from work. He said that staff must also have a fever of at least 100.4 degrees Fahrenheit (F). He stated that a group of symptoms precludes a staff member from work, not just one symptom. He stated that he reviews the staff members' symptoms on a case-by-case basis. A telephone interview was conducted with the LPN (staff #25) on June 6, 2020 at 1:44 p.m. She recalled that she did indicate she had a cough on her screening sheet in early April. She stated she was not sure if her cough was related to allergies [REDACTED]. The LPN stated she was tested for COVID-19 on April 15, 2020 and that her result was positive. She stated she had a fever, cough, and lost her sense of smell. She said she remained off work for 3 weeks and that she did not return to work until approximately 7 days after her symptoms had disappeared. Staff #25 stated she was not retested and that she has been fine. However, review of the line-list surveillance tool provided by the facility revealed no data, including date of onset, COVID-19 testing dates or results, relative symptoms, associated complications, or date of resolution had been collected or recorded regarding staff #25's illness. A Staff and Visitor COVID-19 Screening Questionnaire dated May 2, 2020 revealed staff #25 returned to work. A Staff and Visitor COVID-19 Screening Questionnaire dated June 4, 2020 revealed a dietary staff member (staff #51) had experienced a cough, shortness of breath, and/or difficulty breathing within the last 72 hours. Further review of the dietary staff schedule dated June 4, 2020 revealed staff #51 worked his shift on that date. The COVID-19 Screening Checklist - for Visitors and Staff provided by the facility and published by CMS and the Center for Disease Control (CDC) stated all individuals (staff, other healthcare workers, family, visitors, government officials, etc.) entering the building must be asked the following questions, which included if the individual had any of the following respiratory symptoms: fever, sore throat, cough, or new shortness of breath. If the individual answered yes to any of those symptoms, they should be restricted from the building. The CDC's Criteria for Return to Work for Healthcare Personnel with Suspected or Confirmed COVID-19 updated May 5, 2020 revealed the symptom-based strategy and the test-based strategy. The symptom-based strategy states excluding HCP from work until at least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); and at least 10 days have passed since symptoms first appeared. The test-based strategy includes excluding HCP from work until resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath), and negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of [DIAGNOSES REDACTED]-CoV-2 RNA from at least two consecutive respiratory specimens collected greater than or equal to 24 hours apart (total of two negative specimens). -Regarding open resident room doors On June 5, 2020 at 9:30 a.m., an observation was conducted on the Pine (presumptive COVID-19 positive) unit with the Infection Preventionist (staff #15). Droplet precaution and required PPE signs were observed posted on each of the residents' doors. Multiple PPE carts were observed along the entire hallway. Staff #15 stated that all the residents on the unit were considered to be presumptive positive for COVID-19. She stated that the residents were on droplet/isolation precautions and that they were being observed and monitored closely. Staff #15 stated the expectation is for staff to don N95 masks and either a face shield or goggles while on the unit. She stated that staff are instructed to don full PPE prior to providing resident care which includes gowns and gloves. It was also observed that many of the residents' room doors were opened. Staff #15 stated the residents' doors should be closed; but that these residents eat in their rooms and the aides help them in the rooms. An observation was conducted of the Oak unit on June 5, 2020 at 9:50 a.m. with the Infection Preventionist (staff#15). Staff #15 stated the COVID-19 positive residents and their roommates are asymptomatic. She stated that the COVID-positive residents usually stay in their rooms, but that the residents like their doors to remain open. Further observation of the unit revealed the rooms doors of residents that were not COVID-19 positive as well as the rooms of residents that were COVID-19 positive doors were opened except for two rooms. The facility's policy titled Limiting Transmission of COVID-19 Guideline stated the guideline will be implemented to limit the transmission of COVID-19 among staff, visitors, and residents of the facility. The objective is to limit transmission by limiting how germs can enter the facility, isolating symptomatic residents as soon as possible, and protecting healthcare personnel. The policy stated the necessary steps will be taken to prevent sustained community transmission, and that if there is sustained community transmission or case(s) of COVID-19 in the facility, the facility will restrict residents (to the extent possible) to their rooms except for medically necessary purposes. The CDC's Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings included isolating symptomatic residents as soon as possible and placing residents with suspected or confirmed COVID-19 in private rooms with the door closed, and with private bathrooms (if possible). -Regarding the Smoking Patio During an observation conducted of the smoking patio on the Oak unit on 6/5/2020 at approximately 9:55 a.m., five residents and two CNAs (staff #11 & staff #22) were observed on the patio. Two of the residents were observed approximately 1.5 feet apart from one another. One of the two residents mask was positioned with his nose exposed and the other resident's mask was positioned on his chin. Staff #11 and staff #22 were sitting together approximately 6 feet from the residents, wearing masks and no other PPE. After approximately 3 minutes of observation, staff #11 moved one of the residents away from the other resident. An interview was conducted with the Infection Preventionist (staff #15) on 6/5/2020 at approximately 1:50 p.m. Staff #15 stated the Oak unit is considered presumptive COVID-19 positive because there are COVID-19 positive residents on the Oak unit. She said staff on the Oak unit are required to wear full PPE to care for all residents and that staff may wear a mask and eye protection in the hall. Staff #15 stated that staff had received in-service training regarding keeping residents 6 feet apart from each other. She also stated that staff do not need to wear a gown in the smoking area. The facility's policy titled Limited Transmission of COVID-19 Guideline revealed that if COVID-19 is identified in the facility, residents will be restricted to their rooms (to the extent possible) except for medically necessary purposes. If residents have to leave their room, they will wear a face mask, perform hand hygiene, limit their movement in the facility and perform social distancing (efforts are made to keep them at least 6 feet away from others). The CDC guidance titled Healthcare Infection Prevention and Control FAQs for COVID-19 dated May 29, 2020 revealed that for those residents that might congregate in outdoor smoking areas, resident numbers are to be limited. Staff should be positioned to observe the residents and ensure residents are [MEDICATION NAME] appropriate physical distancing.