STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035175	A. BUILDING _____ B. WING _____	07/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MARAVILLA CARE CENTER	8825 SOUTH 7TH STREET PHOENIX, AZ 85042

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** Based on observation, interview and record review, the facility failed to properly prevent and/or contain COVID-19. COVID-19 is an infectious disease by a new virus causing respiratory illness with symptoms including cough, fever, new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death. Specifically: 1. Failed to utilize a barrier for a multi-resident use glucometer after use and allow sufficient dwell time for Super Sani cloth disinfecting wipes, per manufacturer's instructions, when cleaning/disinfecting shared glucometer for 2 of 3 unsampled residents (R) (R6 and R7) blood sugar monitoring observation. 2. Failed to allow sufficient dwell time for Super Sani cloth disinfecting wipes, per manufacturer's instructions, when cleaning/disinfecting shared pulse oximeter and blood pressure (BP) cuff for 3 of 3 unsampled residents (R8, R9, R10) vital signs monitoring observation. 3. Failed to perform hand hygiene when passing fluids to 3 of 4 unsampled residents (R11, R12 and R18) for Certified Nursing Assistant (CNA)2. 4. Failed to properly wear face masks that covered their nose while within 6 feet of unsampled residents (R4, R13, R14) for 2 staff members observed (Certified Nursing Assistant (CNA)3 and Licensed Nurse (LN) 2. 5. Failed to maintain adequate social distancing between four unsampled residents (R11, R15, R16 and R17) observed without masks while Activities Aide (AA) 1 and AA2 provided assistance and supervision in the smoking area. These failures increased the risk for the spread of infection and its associated complications. Findings include: During an interview on 7/6/20 at 12:00 PM with Administrator, Director of Nursing (DON) and Regional Administrator, Administrator stated that the facility census was 130 and there were 17 residents positive with COVID-19 in two separate COVID-19 observation units. Each observation unit had a separate entrance and exit and all staff were expected to wear N95 masks and face shields with staff in the COVID-19 unit expected to wear gowns, N95 masks and face shields. 1. Glucometer During a concurrent observation and interview on 7/8/20 at 7:15 AM showed LN1 enter R6's room with gloved hands, Assure Platinum glucometer (Glucometer is a blood glucose meters device that measure blood glucose levels), lancet, alcohol swab, and strip. LN1 placed strip into glucometer, swab resident's finger with alcohol and then pricked finger with lancet with a small bead of blood shown. LN1 brought glucometer towards blood and blood was shown on the strip inserted in glucometer. Blood sugar reading was obtained. LN1 placed used glucometer on resident's over bed table. LN1 removed gloves, exited room and discarded supplies. LN1 placed used glucometer on the medication cart and then removed one sani cloth from Super sani cloth, purple top, container and wiped glucometer and then placed it on the medication cart. The glucometer appeared wet for about 40 seconds. The glucometer did not remain wet for two minutes. LN1 then entered R4's room, resident was sound asleep and LN1 stated that she would return later. LN1 then entered R7's room and placed strip into glucometer, swab resident's finger with alcohol and then pricked finger with lancet with a small bead of blood shown. LN1 brought glucometer towards blood and blood was shown on the strip inserted in glucometer. Blood sugar reading was obtained. LN1 again placed used glucometer on resident's over bed table. LN1 removed gloves, exited room and discarded supplies. LN1 removed one sani cloth from Super sani cloth, purple top, container and wiped glucometer with two or three quick wipes and placed glucometer in basket on medication cart. The glucometer did not remain wet for two minutes. During concurrent record review and interview on 7/8/20 at 7:30 AM when asked how long glucometer stayed wet after wiping with sani cloths, LN1 stated that it could have been longer. LN1 and surveyor reviewed the label of the Super Sani-Cloth container which showed directions to disinfect nonfood contact surfaces only. Unfold a clean wipe and thoroughly wet surface. Allow treated surface to remain wet for a full two (2) minutes. LN1 stated that she didn't know the glucometer needed to remain wet for two minutes and stated that the glucometer did not stay wet for two minutes. When asked about placing the used glucometer on the resident's over bed table and medication cart without a protective barrier or not cleaning surfaces after, LN1 stated that she did not want to place the used glucometer in the basket because it would contaminate the alcohol swabs and other items in the basket. LN1 stated that today was her second day as she was a [MEDICATION NAME] and oriented with LN2 yesterday. LN1 stated that she observed LN2 perform blood sugar checks yesterday but doesn't recall use of protective barrier. Observation on 7/8/20 at 7:30 AM during above interview with LN1 showed a brownish red smear on the front and back of the glucometer just used and wiped by LN1. Surveyor showed LN1 the smears and the glucometer was thoroughly wiped with the brownish red smears removed. Review of facility document, Summary of Recommended Isolation Precautions, revised date 3/08, showed under Resident-Care Equipment Handle used resident-care equipment soiled with blood, body fluids, secretions, or excretions in a manner that prevents skin and mucus membrane exposures, contaminated of clothing, and transfer of microorganisms to other residents or environments. Insure that reusable equipment is not used for the care of another resident until it has been cleaned and reprocessed appropriately. Review of CDC's website, at www.cdc.gov, section titled, Infection Prevention During Blood Glucose Monitoring and Insulin Administration, showed that if the glucose meters must be shared, the device should be cleaned and disinfected after every use per the manufacturer's instructions. Centers for Disease Control and Prevention Guidelines for Environmental Infection Control in Health-Care Facilities (2003), https://www.cdc.gov/infectioncontrol/guidelines/environmental/index.html, accessed 6/17/20, showed under Recommendations - Environmental Services on subsection Cleaning and Disinfecting Strategies for Environmental Surfaces in Patient Care Areas, .3. Use barrier protective coverings as appropriate for noncritical surfaces that are 1) touched frequently with gloved hands during the delivery of patient care; 2) likely to become contaminated with blood or body substances . Record review of R6's Minimum Data Set (MDS-assessment tool), dated 6/1/20, showed resident was admitted on [DATE] with [DIAGNOSES REDACTED]. In addition, some diabetes-related health issues, such as nerve damage and reduced blood flow to the extremities, increase the body's vulnerability to infection), [MEDICAL CONDITION] and chronic [MEDICAL CONDITIONS] (inflammation of the liver, virus can be transmitted contact with the blood or other body fluids of an infected person) and received insulin injections. Record review of R7's Minimum Data Set (MDS-assessment tool), dated 5/6/20, showed resident was admitted on [DATE] with [DIAGNOSES REDACTED]. and protect resident environment from contaminated used equipment. 2. BP and pulse oximeter disinfectant Observation on 7/6/20 at 1:20 PM showed Certified Nursing Assistant (CNA) 1 on Sunset neighborhood with mask and face shield and taking resident's vital signs in the tv common area. After taking vital signs, CNA1 sprayed solution onto blood pressure cuff and wiped solution with tissue. Director of Nursing (DON) approached CNA1 and gave CNA1 a container of Super Sani bleach cloths, orange top. CNA1 then walked into R8's room and obtained R8's blood pressure, pulse, temperature and oxygen saturation level which included wrapping blood pressure cuff around resident's arm and placing pulse oximeter (device used to measure oxygen saturation level) on resident's finger. After removing blood pressure cuff, CNA1 quickly wiped blood pressure cuff and pulse oximeter with a sani cloth. The blood pressure cuff and pulse oximeter did not remain wet for four minutes. CNA1 then used the same blood pressure cuff and pulse oximeter on R9. After using the blood pressure cuff and pulse oximeter of R9, CNA1 again quickly wiped the blood pressure cuff and pulse oximeter with a sani wipe for a few seconds. The blood pressure cuff and pulse oximeter did not remain wet for four minutes. CNA1 then used the same blood pressure cuff and pulse oximeter on R10. After using the blood pressure cuff and pulse oximeter of R10, CNA1 again quickly wiped the blood pressure cuff and pulse

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035175	A. BUILDING _____ B. WING _____	**07/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MARAVILLA CARE CENTER	**8825 SOUTH 7TH STREET PHOENIX, AZ 85042**

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	(continued... from page 1) oximeter with a sani wipe for a few seconds. The blood pressure cuff and pulse oximeter did not remain wet for four minutes. During an interview on 7/6/20 at 1:30 PM when asked about wiping blood pressure cuff and pulse oximeter with the sani wipes, CNA1 stated that he wiped these items down because you never know, germs jump. When asked how long the blood pressure cuff and pulse oximeter remained wet after use with super sani cloth CNA1 stated, maybe 25 to 30 seconds. Review of Super Sani cloth bleach wipes container, orange top, with Environmental Protection Agency (EPA) registration number 9480-8 with surveyor and CNA1 showed to clean, disinfect and deodorize-use a wipe to remove heavy soil. Unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full four (4) minutes. During an interview on 7/6/20 at about 1:40 PM when informed of observations and interview with CNA1, DON stated that she will train CNA1 right now and stated that staff used to use the Super Sani Cloth purple top wipes that had a two minute dwell time, but that product is not available right now. When informed of observation that CNA1 did not allow a two minute dwell time of blood pressure cuff and pulse oximeter between use on several residents, DON nodded head in acknowledgment and stated that expectation is for staff to use disinfecting products per manufacturer's instructions. Review of facility document, Summary of Recommended Isolation Precautions, revised date 3/08, showed under Resident-Care Equipment Handle used resident-care equipment soiled with blood, body fluids, secretions, or excretions in a manner that prevents skin and mucus membrane exposures, contaminated of clothing, and transfer of microorganisms to other residents or environments. Insure that reusable equipment is not used for the care of another resident until it has been cleaned and reprocessed appropriately. CDC's Preparing for COVID-19: Long-term Care Facilities, Nursing Homes, https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, accessed 7/8/20, showed Ensure EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment. Use an EPA-registered disinfectant from List N on the EPA website to disinfect surfaces that might be contaminated with [DIAGNOSES REDACTED]-CoV-2. Ensure HCP (health care personnel) are appropriately trained on its use. 3. Lack of hand hygiene Observation on 7/8/20 at 8:15 AM showed CNA2 delivering coffee and other beverages to residents during breakfast meal service. CNA2 entered R11's room, placed beverage cup down and then raised resident's over bed table and moved over bed table closer to resident. CNA2 then set beverage down on resident's over bed table. CNA2 exited room and did not perform hand hygiene. CNA2 went to beverage cart, picked up cup, poured water, picked up packets of sugars and entered R12's room. CNA2 placed down beverage cup and raised resident's over bed table and moved over bed table closer to the resident. CNA2 set beverage down on resident's over bed table. CNA2 exited R12's room. No hand hygiene was performed. CNA2 went to beverage cart and poured water in cup and obtained sugars and entered R18's room. No hand hygiene was performed before entering R18's room. In R18's room, CNA2 placed beverage cup on resident's over bed table. After exiting R18's room, CNA2 performed hand hygiene from wall mounted hand sanitizer. During an interview on 7/8/20 at 9:15 AM after asking when CNA2 performs hand hygiene when passing beverages during breakfast, CNA2 stated that she was taught to hand sanitize between each resident but didn't do that this morning. Review of facility document, Summary of Recommended Isolation Precautions, revised date 3/08, showed under Hand Washing Wash hands immediately .between resident contacts, and when otherwise indicated to avoid transfer of microorganisms to other residents or environments. During interview on 7/8/20 at 10:50 AM DON stated that the expectation was for staff to sanitize hands after delivering beverages as part of meal service. 4. Face masks Observation on 7/6/20 at 12:55 PM showed Licensed Nurse (LN)2 wearing N95 mask and face shield. N95 mask was not fully covering LN2's nares (opening of nose) while standing within 6 feet of R4 while administering insulin in resident's stomach. During an interview on 7/6/20 at about 1:05 PM when asked if mask was covering her nose, LN1 stated that her mask was not covering her nose and was loose and just started wearing these white masks yesterday. LN1 touched her face shield and stated that she thought it wasn't necessary for the mask to cover her nose because she had on a face shield. Observation on 7/6/20 at 2:10 PM showed CNA3 on Rio Neighborhood taking vital signs for R13 and R14. While standing within 6 feet for both residents, CNA3's mask was not covering her nose and CNA3 continued to reposition mask with her hands. No hand hygiene was performed after touching mask. During an interview on 7/6/20 at about 2:20 PM when about mask not covering her nose, CNA3 stated that her mask was loose and keeps falling down her nose. CNA3 stated that blue masks have been in use but last Thursday a switch was made to these white masks and the white masks are loose. Review of facility document, Summary of Recommended Isolation Precautions, revised date 3/08, showed under Mask, Eye Protection, Face Shield and Respiratory Precautions for Standard Precautions wear a mask and eye protection or a face shield to protect mucus membranes of the eyes, nose and mouth during procedures and resident care activities that are likely to generate splashes or sprays of blood, body fluids, secretions and excretions. Under Droplet Precautions section the document showed In addition to masks as required under Standard Precautions, wear a mask when working within 3 feet of the resident (Logistically, some facilities may want to implement the wearing of a mask whenever the room is entered). CDC's Preparing for COVID-19: Long-term Care Facilities, Nursing Homes, https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, accessed 7/8/20, showed Implement Source Control Measures: HCP (Health care personnel) should wear a facemask at all times while they are in the facility. When available, facemasks are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. Care must be taken to avoid touching the respirator, facemask, or eye protection. If this must occur (e.g., to adjust or reposition PPE) (personal protective equipment), HCP should perform hand hygiene immediately after touching PPE to prevent contaminating themselves or others. HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Face shield is for eye protection and offers separate protection from N95 or facemask. During interview on 7/8/20 at 10:50 AM DON stated that the expectation was for staff to wear face masks when in the facility and the face masks should be covering the staff's nose. 5. Social distancing During a concurrent observation and interview on 7/8/20 at about 9:05 AM showed R15 and R11 sitting within 6 feet of each other in the smoking area. No masks were worn. R16 and R17 were also sitting within 6 feet of each other in the smoking area. No masks were worn. Activities Aide (AA)1 and AA2 were both in the smoking area talking with residents. When asked about the purpose of being in the smoking area AA1 and AA2 stated that they were helping residents light cigarettes, providing music and sensory stimulation and talking and engaging with residents. When asked if R11 and R15, as well as R16 and R17 were social distancing from each other and less than 6 feet apart, AA1 and AA2 stated, no, not six feet apart. Review of CDC Preparing for COVID-19 in Nursing Homes, https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, accessed 7/8/20, showed Implement aggressive social distancing measures (remaining at least 6 feet apart from others). Remind residents to practice social distancing During Exit interview on 7/8/20 at AM with DON, Administrator and Regional Administrator, DON stated that the expectation was for staff to ensure residents were social distancing by keeping six feet apart but sometimes residents like to sit next to each other.