STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035101	A. BUILDING _____ B. WING _____	07/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHANDLER POST ACUTE AND REHABILITATION	2121 WEST ELGIN STREET CHANDLER, AZ 85224

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** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record reviews, interviews, review of the Centers for Disease Control (CDC) guidelines and policy review, the facility failed to maintain an effective infection control program, by failing to utilize Personal Protective Equipment (PPE) appropriately between caring for COVID positive residents and non COVID residents. The deficient practice could result in the transmission of COVID-19 to residents and staff. Findings include: -Resident #2 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A [DIAGNOSES REDACTED]. Review of the clinical record revealed the resident had resided in the same room on the long term care unit since January 15, 2020, which was the same room as resident #1. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed resident #2 scored a 13 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. A nursing note dated June 24, 2020 revealed the resident had an elevated temperature and was staying in his/her room related to the facility's COVID-19 protocol. A second nursing note on June 24 indicated the resident had a fever, cough and congestion. A physician's orders [REDACTED]. A laboratory report collected on June 25, 2020 and reported on July 2, 2020, included the resident tested positive for COVID-19. Review of the resident's vital sign documentation revealed that on June 24, 26, 27, 28, 29, 30 and July 1 and 2, the resident's temperature was above 100 degrees Fahrenheit (F). A physician's orders [REDACTED]. A psychosocial well being care plan revealed the resident was positive for COVID-19 on July 2, 2020. The resident was considered to be at risk for severe illness, secondary to age. The goal was to minimize complications of the condition. Interventions were to adhere to transmission-based precautions, observe strict isolation precautions including droplet precautions at all times, and to monitor for signs and symptoms of fever, cough, shortness of breath, chills, headache, sore throat, loss of taste or smell, runny nose, congestion, loose or watery stools, nausea, vomiting, and diarrhea. A physician's orders [REDACTED]. Review of the clinical record revealed the resident was receiving oxygen via nasal cannula on July 7 and 8, 2020. -Resident #1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The clinical record indicated that resident #1 had been in the same room of the long term care unit since admission, which was the same room as resident #1. Review of the quarterly MDS assessment dated [DATE] revealed a BIMS score of 6, indicating severe cognitive impairment. The physician orders [REDACTED].#1 was placed on contact and droplet isolation precautions. According to the psychosocial care plan, the resident was on isolation precautions and was at risk for signs and symptoms of COVID-19. A goal included to minimize exposure of COVID-19 in the facility. An intervention included to follow the CDC/public health protocols for COVID-19. Review of a lab report collected on June 26, 2020 and reported on July 1, 2020, revealed the resident's COVID-19 result was canceled, due to an improper swab being submitted in the sample tube. However, a nursing note on July 1, 2020 included the provider had been notified that resident #1 had a negative result for COVID-19. There was no clinical record documentation regarding the discrepancy between the lab results which were canceled and the nursing note stating that the resident's COVID status was negative. Prior to entering the long term care unit on July 8, 2020, the Administrator stated they have a designated COVID area (long term care unit), but not all residents on that unit are COVID-19 positive. An observation was conducted of the long term care unit at 10:00 a.m. on July 8, 2020. There were several isolation rooms with signs on the doors, indicating to see the nurse before entering. Inside the rooms were two reusable gowns on hooks. At this time, the Director of Nursing (DON/staff #70) stated that there are three COVID-19 positive residents on this hallway, which included resident #2. She said that resident #1 (resident #2's roommate) was negative for COVID-19. In an interview with a Certified Nursing Assistant (CNA/staff #66) at 11:05 a.m. on July 18, 2020, she said that when she cares for a resident who is on isolation, there are two gowns on hooks in each the room. She said this is also true for the rooms with COVID positive residents. She said there are some rooms where one resident is COVID-19 positive, and the other is not. She said if she needed to provide care to both of the residents in the room, she would use one of the gowns for one resident and the other gown for the other resident. She said that she wasn't sure if one of the gowns was supposed to be for the nurse and one was for the CNA. During an interview with a Licensed Practical Nurse (LPN/staff #24) at 11:10 a.m. on July 8, 2020, he stated that there are two gowns in each isolation room, and that one is for the nurse and the other is for the CNA. He said this is true even in rooms where one resident is COVID-19 positive, and the other is negative or unknown. He said if he was providing care to a COVID-19 positive resident, he would sanitize his hands, don the gown inside the room designated for the nurse, and put on gloves. He said he already has a surgical mask and eye protection on, as they stay on all day. He said that he would then provide care for the resident. He said if a COVID-19 negative resident needed assistance, he would get another gown as they are available, but are not in the room. An interview was conducted with a CNA (staff #10) at 11:15 a.m. on July 8, 2020. She said that when providing care for residents on isolation, there are two gowns in the room on hooks. She said that one of them is for the nurse and the other is for the CNA. She said that the same gown could be used for both residents regardless if one of the residents is COVID-19 positive and the other is not. She said she would only remove her gloves, sanitize, and get new gloves when switching from resident to resident. She said she would not change gowns. Another interview was conducted with the DON at 11:23 a.m. on July 8, 2020. In regards to gowns for isolation rooms, she said the gowns are kept on hooks inside the room. Staff #70 said there is one gown for the CNA and one gown for the nurse, and they use that gown each time they go into a resident's room to provide care. She said that there is only one gown for each staff member and that if there are two residents in the room, the staff will use the same gown for both residents, regardless if the residents are COVID-19 positive, negative or unknown. She said that they have been in contact with the county health department since the beginning of COVID-19 and have followed their instructions. She said that she told the county that they have rooms with one COVID-19 positive resident and a COVID-19 negative or unknown resident, and were told them not to move either resident. She said they heard that moving residents out of rooms could spread [MEDICAL CONDITION]. She said the county was also aware of their procedure regarding reusable gowns and were okay with one gown being used for the entire room, because the COVID-19 negative or unknown resident has already been exposed, and it is possible that they will become COVID-19 positive as well. She said essentially, the entire room becomes an isolation room so one gown can be used for both residents. She said that she has been working with one of the county's epidemiologists (staff #141). A follow up interview with the DON (staff #70) was conducted on July 8, 2020 at 12:30 p.m. She said the facility does have policies regarding isolation precautions and include gown usage, but there is no specific policy addressing the use of gowns between residents with COVID-19 and residents that are negative for COVID-19 or have an unknown status. In an email communication with a senior epidemiologist (#121) for the county public health department dated July 8, 2020 at 3:03 p.m., she said that the county recommends using the same gown between 2 COVID-19 positive residents, but not between positive and negative or unknown residents. In an interview with the DON (staff #70) at 11:45 a.m. on July 9, 2020, she said that she needed to review resident #1's clinical record to determine what happened with the COVID-19 test. At 12:20 p.m., she stated that she reviewed the clinical record for resident #1 and concluded that the sample was canceled and was not noticed, and was instead determined to be a negative test. She said that she contacted the physician who said the resident was presumptive positive and did not wish to do another swab of the resident. The facility's Infection Control

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) policy revealed that reusable cloth gowns can be used for isolation precautions due to PPE shortages. The policy included that assigned staff will have a gown designated for them for the shift and that the staff should hang the gown on a designated hook after each use. The policy included that the gown would be laundered after the shift ends. The policy did not address the practice of wearing the same gown when caring for COVID-19 positive residents and non COVID residents or those with an unknown status. Review of CDC guidance regarding Strategies for Optimizing the Supply of Isolation Gowns updated March 17, 2020, revealed that considerations can be made to extend the use of isolation gowns (disposable or cloth) such that the same gown is worn by the same staff member when interacting with more than one patient known to be infected with the same infectious disease when they are housed in the same location (i.e., COVID-19 patients residing in an isolation cohort). The CDC guidance for Preparing for COVID-19 in Nursing Homes updated June 25, 2020, revealed that if extended use of gowns is implemented, the same gown should not be worn when caring for different residents, unless it is for the care of residents with confirmed COVID-19 who are cohorted in the same area of the facility and these residents are not known to have any co-infections.