STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035266	A. BUILDING _____ B. WING _____	**07/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVANCED HEALTHCARE OF MESA	**5755 EAST MAIN STREET MESA, AZ 85205**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement and maintain an infection control program designed to prevent the development and transmission of communicable diseases and infections when they: 1. Failed to complete steps during the doffing (removal) process designed to prevent spread of pathogens from contaminated Personal Protective Equipment (PPE) to staff. Four of four facility staff observed to potentially contaminate themselves during the removal of their PPE while exiting rooms under transmission based precautions for COVID-19. 2. Rehab staff were observed to have drinks on their mobile desks in the hallways directly outside of rooms under transmission based precautions for COVID -19. These failures placed all residents and staff at risk for exposure and infection of the highly transmissible [DIAGNOSES REDACTED] CoV-2 virus which causes COVID-19. Findings: 1. PPE Observed housekeeping staff 1 (HKS1) cleaning room [ROOM NUMBER] on 7/6/2020 at 11:25 AM. Signage posted on the door read the room was under Droplet Precautions and PPE was stored in a cabinet just outside the room. HKS1 wore PPE while in the room, a yellow gown, a mask, a face shield, and gloves. Upon completion of cleaning, HKS1 proceeded to doff the PPE at the doorway. She untied the waist ties of the gown, then reached a gloved hand under the gown neck and lifted it over her head. Observed gloved hand touch her shirt, neck, hair and face. She then placed the gown in a linen bin. HKS1 then removed 2 pairs of gloves, discarded them, and proceeded to clean her hands with an alcohol based hand rub. She then stepped outside the room and re-gloved, cleaned the face-shield and discarded her mask and gloves, and performed hand hygiene. HKS1 interviewed immediately following the doffing process at 11:30 AM. When asked if she had tried to untie the neck ties of the gown, HKS1 stated No I just pull it over head. When asked how she keep the contaminated glove from spreading infectious material to her shirt, neck, hair and face, she stated I try not to touch. Observed Registered Nurse (RN) 2 provide resident care on 7/7/20 at 11:38 AM. RN2 donned (put on) PPE and entered Resident A's room. RN2 wore a gown, a face shield, a mask, and gloves. Upon completion of a capillary blood glucose reading, RN2 came to the doorway and asked another staff to get her additional supplies to recheck the blood sugar reading. While standing in the doorway RN2 stated my mask just broke. She then removed her gloves and grasped the ear loops of the mask, touching the side of her face, and removed the mask. She did not perform hand hygiene after removing gloves, before touching the sides of her face while removing the mask. Once additional supplies and PPE were handed to RN2, she donned a new mask and completed the resident care tasks. RN2 doffed her PPE at 11:48 AM, removed gloves, then mask, then gown, placed gown in a bin, and then performed hand hygiene. RN2 stepped out of the room and proceeded to remove and clean the face shield and the glucometer with disinfectant, and then performed hand hygiene. RN2 did not perform hand hygiene after removing her gloves and before touching her head to remove the mask. During an interview with RN2 on 7/6/2020 at 11:50 AM, she described the transmission based precautions used were to prevent the spread of potential COVID-19, and PPE needed was a new mask, goggles or face shield, a gown and gloves. She described that the gowns were reused after washing, the face shield was also reused after disinfection. The resident should also wear a mask while staff are in the room, if possible. She clarified that if the resident had confirmed COVID-19 or it was suspected, then staff would wear an N95 respirator and use a disposable gown. She confirmed that she had recently had training on the donning and doffing of PPE. She stated that hand washing was done after all PPE was removed. When asked if she had missed a step between doffing her gloves, and touching her mask straps she rubbed her hands together in a hand washing motion and stated oh yeah, they are dirty. Observed RN2 in Resident B's room, in full PPE on 7/6/2020 at 12:05 PM. Sign outside of Resident B's door read Droplet Precautions. RN2 doffed her PPE in the following sequence: removed gloves, removed outer mask (worn over the source mask), removed gown, readjusted source mask on her face, and then performed hand hygiene. She then removed face shield and stepped outside of the room and disinfected the face shield. RN5 did not perform hand hygiene following the removal of gloves and prior to touching her head, or after removal of a contaminated gown and readjusting her source mask. When asked about the lack of hand hygiene she stated okay. Observed Nursing Assistant (NA) 4 don PPE to bring a lunch tray to Resident C on 7/6/2020 at 12:11 PM. Sign outside of Resident C's door read Droplet Precautions. After setting up Resident C's lunch tray, NA4 proceeded to doff her PPE. NA4 removed gloves, removed goggles, removed mask, touched neck while untied gown ties, removed gown and then washed hands. She stepped out of the room and donned her source mask. NA4 then donned gloves and disinfected the used goggles. NA4 did not perform hand hygiene following the removal of gloves, and touched her neck after touching contaminated goggles and mask, potentially spreading microorganisms. During an interview immediately following the observation, NA4 described the steps of doffing. She stated they were, 'gloves off first, then mask. Remove gown, put it in the bin, remove goggles, clean them and hang them up.' When asked if she was trained to wash hands at any points in the doffing process, she said at the end. When asked to clarify if she was trained to wash her hands after removing gloves, or at any other times during the removal of PPE, she again confirmed it was only at the end. Observed NA5 set up a lunch tray for Resident A on 7/6/2020 at 12:25 PM. NA5 was wearing a gown, mask, gloves, and eye glasses. Resident 5 requested a salad. NA 5 doffed her PPE in the following sequence, removed gown and placed it in a bin, untied face mask ties and removed, then removed gloves and performed hand hygiene. Upon exit, NA5 doned her source mask hanging outside the doorway. NA5 did not wear a face shield or goggles while in the room, and did not perform hand hygiene after removing a contaminated gown and touched her head with contaminated gloves. NA5 walked down the hallway toward the kitchen area. NA5 returned at 12:29 PM with a salad and donned PPE, entered room and assisted the resident. Observed NA5 doff PPE before exiting the room at 12:35 PM. NA 5 untied gown and removed it, placing in a bin; removed gloves, removed face mask and then washed hands. She exited the room, and donned her source mask, then removed face shield and disinfected it. NA 5 did not perform hand hygiene after removing gloves and before touching her head to remove the mask. During an interview on 7/6/2020 at 12:30 PM, NA5 described the steps for doffing as I usually take the gown off first, then the gloves. Then mask off, wash hands and come out here. Surveyor asked if the facility had educated her on when to wash hands during the doffing process, she stated she was taught to hand wash after all PPE is removed. When asked about not wearing a face shield while in Resident A's room, she stated yeah, I realized it on my way out. Interviewed the Clinical Nurse Manager (CNM) and the Director of Nursing (DON) on 7/6/2020 at 1:00 PM who together fulfill the Infection Preventionist's responsibilities. Together they confirmed the facility used the CDC Guidelines as their standard for policy, procedure, and plan development related to infection control. The CNM stated that she provided the staff in-services, and the DON described other duties she managed such as monitoring and tracking. The DON explained that all residents in the facility were under droplet transmission based precautions to prevent the potential spread of COVID-19 due to the wide-spread community transmission in Maripcopa County, previous out breaks in the facility, and the short stay nature of the residents served. This was a decision made in conjunction with the Medical Director. Surveyor asked what the expected steps for doffing PPE were. The CNM stated the sequence of steps was to remove gloves, remove gown, remove mask, remove face shield, and after all PPE removed, wash hands. The DON clarified that hand hygiene was expected after removing gloves, and signage posted indicated hand hygiene was to be done after touching any contaminated PPE. Reviewed facility's COVID-19 Emergency Plan dated 1/31/2019. Under the heading of Admissions point 5 read Asymptomatic patients . should be placed on a quarantine isolation

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) (or other transmission-based precautions if directed by the . medical director) for 14 days even with negative test(s). Under the heading Transmission-Based Precautions it read to Follow standard, contact, and droplet precautions. Facility record dated 6/13/2018, titled Infection Control Standard Precautions Policy and Procedure reviewed on 7/7/2020. Under the heading of Procedure, point 2. Hand Washing read, wash hands after touching . contaminated items . Wash hands immediately after gloves are worn. Under point 3. Gloves it read, Remove gloves promptly after use, before touching non-contaminated items . and wash hands immediately to avoid transfer of microorganisms to other patients and environments. 2. Drinks in care area During PPE observations on 7/7/2020 at 11:45 AM, a potable desk was observed in the hallway outside of an unexampled resident's room. On the desk were papers, a clipboard, theraband (a resistance bands used for physical therapy exercises), and a cup with a straw covered by a glove. Therapy Assistant TA7 was in the resident's room working with the resident, wearing a gown, face shield, mask, and eye protection. During a phone interview on 7/8/2020 at 08:40 AM, the Rehab Manager was asked about drinks left on potable desks in the hallways outside of rooms. The Rehab Manager stated that that staff were spending time away from their usual work areas and were trying to stay hydrated. When asked if this was an acceptable practice she stated No, it not. She then added, We will address this. The Administrator who was also on the call, confirmed they were making a change, as that was not a good practice.