STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035263	A. BUILDING _____ B. WING _____	06/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARCHIE HENDRICKS SENIOR SKILLED NURSING FACILITY	HCO 1 BOX 9100 SELLS, AZ 85634

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to develop a care plan for two of 9 residents (R1 and R2) who were on Transmission Based Precautions (TBP)/Quarantine for COVID-19. This deficient practice had the potential for staff not to have the information they needed to prevent the spread of COVID-19. Findings include: On 6/9/2020 the surveyor toured the facility and found that there were eight rooms with transmission based precaution (TBP) signs on the doors. When asked why the residents were on TBP, Staff 102 stated the residents in those rooms went to a [MEDICAL TREATMENT] center to receive [MEDICAL TREATMENT] (a procedure to filter the blood) three times per week. Since they left the facility they were kept in TBP on quarantine. R1 was admitted with [DIAGNOSES REDACTED]. This [DIAGNOSES REDACTED]. The facility placed R1 on TBP/Quarantine. Review of R1's electronic health record (EHR) revealed the facility did not include a care plan for the TBP/Quarantine for COVID 19. R2 was a long term resident with [DIAGNOSES REDACTED]. Review of R2's electronic health record (EHR) revealed the facility did not include a care plan for the TBP/Quarantine for COVID 19. During telephone interview on 6/10/2020 at approximately 11:30 AM, when informed of this finding, Staff 102 and 108 reviewed the resident's EHR record and acknowledged that there was no care plan for TBP/Quarantine for COVID 19. Staff 102 stated the care plan should have included TBP/Quarantine for COVID 19 for both residents.
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility did no ensure that sanitizer solution in the kitchen was the correct dilution for the three compartment sink and one bucket of the Quatenary Aluminum solution (Quat) that was too dilute. And in one bucket having a bleach solution that was too concentrated. This deficient practice had the potential for inadequate sanitizing of food preperation tables and other surfaces in the kitchen. This could lead to the spread of pathogens. Findings Include: During a tour of the kitchen on 6/9/2020 at approximatey 11:00 AM, Staff 26 was standing at the three compartment sink placing washed and rinsed pots and pans in the final sanitizing solution. The three compartment sink had a Fill Line on the outside of the sink. Staff 26 stated if it has more that that the [MEDICATION NAME] may not be right. The sink was full of pots and pans and the solution in the sink was approximately six to eight inches above the fill line. When asked what the solution was, Staff 26 stated a Quat solution. When asked to test the strength of the solution Staff 26 tested it and the results showed 50 parts per million (PPM). Staff 26 stated it should be 200 PPM. When asked what happened, she said she had just filled the sink at 10 AM. There was a faucet pushed over toward the sanitizer sink that was leaking. Staff 26 stated she had not noticed that. The Dietary Service Supervisor (DSS) saw this and stated he did not know it was leaking; however would inform maintanence. The DSS instructed staff 26 to drain the sink and refill then test to assure it is strong enough. In the food preparation area was a red bucket with solution in it. When asked what the solutioin was in the bucket and what it was used for, Staff 24 stated it was bleach solution to sanitize the preparation tables. When asked to test the solution, Staff 24 did and found the results to show 400 PPM. The DSS stated it should have been below 100. Discussed the reason a bleach solution that was too strong caused a potential for contamination was because the bleach solution was a very caustic solution that damaged even stainless steel which provided cracks or scratches where microorganisms could hide. Staff 24 stated the solution had not been used. There was a cart near the plating table that had a red bucket of solution on it. When asked what the solution was and to test it, Staff 28 stated it was a Quat solution. The results of the test showed the strength of the solution was 50 PPM. She stated she had just filled the bucket about 30 minutes prior. She stated she had not tested the solution after she filled the bucket. She stated it had not been used. After sanitizer sink was refilled it read the correct dilution of 200 PPM. Staff 26 resanitized the pots and pans. When asked how often the sanitizer solution distribution system was checked for accuracy the DSS stated the vendor maintains it monthly. Review of the Policy and Procedure (P&P) titled Pots and Pan Sanitizer Solution read in pertainent part as follows: 2. Fill all tanks 2/3 full. a. Fill first tank with water and an effective concentration of detergent. b. Fill second tank with clean rinse water. c. Fill third tank with tepid water for sanitizing to fill line.* 3. Add sanitizing agent to third tank according to EPA-registered label use directions. Post amount. * a. To test concentration of sanitizer, a test kit is required. * 50 - 100 ppm is the required concentration of sanitizer-to-water ratio using a chlorine- based sanitizer. * 200 ppm or 150 -400 ppm (depending on which kind you use) is the required concentration of sanitizer-to-water ratio using a quaternary ammonia-based sanitizer . 7. Sanitize pots and pans in third tank by immersing in water with sanitizing agent for at least two minutes or per manufacturer guidelines. * Record wash temperature, rinse temperature, and ppm . 2. All surfaces and equipment should be washed with a sanitizing solution. 3. Sanitation buckets must be established with appropriate sanitizing solution, i.e., generally for chlorine based sanitizer, 50-100 ppm or quaternary solution, 150-400 ppm or 200 ppm depending on the product used and manufacturer guidelines. If pots and pans are washed and sanitized in the dishmachine fill the sanitation buckets from the pot and pan sanitizing dispenser and test with the litmus strip. Record on the Pot and Pan Test Strip/Sanitation Bucket Log (FORM 405) under PPM. 4. Sanitizing cloths should be placed in the sanitizing buckets to be used in sanitizing all work surfaces and equipment. 5. Dietary should change these buckets at least three (3) times a day and test with the appropriate litmus strips each time the solution is changed to assure accurate levels of sanitizer .
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** Based on observation, interview and record review the facility did not ensure staff implemented infection prevention and control techniques during housekeeping of rooms with residents in transmission based precautions (TBP). This deficient practice had the potential to spread contagions to other rooms. Findings Include: During observations on 6/9/2020 in morning three housekeepers were observed cleaning rooms in three hallways where residents rooms were. Two of the three were not observed cleaning TBP rooms; however were seen cleaning rooms near these rooms. One of the house keepers was assigned to the COVID 19/Quarantine unit, the 500 Hall. All of the residents in this unit (seven residents) were on TBP. At 11:15 AM, Staff 36 was observed coming out of one room and entering another room without changing the mop head or floor washing solution. 6/9/2020 at 1:35 PM, during an interview with the environmental supervisor (EVS) when informed of the observation of Staff 36 stated that a bleach solution was used to clean the floors. The water and mop head should be changed after every three rooms. When asked it that applied to rooms with residents on TBP, EVS stated yes. They only had to change the

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) water more often if the surface was visibly soiled or had blood on it. When asked for the facility policy on cleaning floors EVS provided the Thorough Room Cleaning form. This form indicated the thorough cleaning was to be done when residents are discharged or after TBP have ended. When asked for the policy the EVS stated the infection preventionist (IP) had the policy. During an interview on 6/9/2020 at 12:15 PM, when asked how often the floor washing water and mop head was changed Staff 36 stated she cleaned the water every three rooms and changed the mop head at the end of her shift. At 1:00 PM, during an interview with the IP stated house keepers should be following the Thorough Room Cleaning procedure for all rooms where residents are on TBP. When asked how many residents were on TBP the IP stated 9 residents. All but two were on the COVID/Quarantine unit (R1, R2 and R3) Two other residents (R4 and R5) were on the other two units. Staff 36 was assigned to Hall 500 (COVID/Quarantine); Staff 31 was assigned to 600 hall and Staff 38 was assigned to the 700 hall. At approximately 1:15 PM, Staff 31 and Staff 38 joined the IP and surveyor. When asked how often they changed the floor washing water and mop heads, Staff 38 stated she change the water and mop heads after each room. Staff 31 stated she changed the water and mop head after every three rooms. She stated that she cleans the room of residents on TBP last and then changes the water and mop head. She stated she always changed the water and mop head immediately after cleaning a TBP room.