STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035183	A. BUILDING _____ B. WING _____	**09/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIO VISTA POST ACUTE AND REHABILITATION	**10323 WEST OLIVE AVENUE PEORIA, AZ 85345**

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 observations, facility documentation, 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 maintained. The deficient practice could result in the spread of infection to residents and staff, including COVID-19. Findings include: An entrance conference was conducted on September 2, 2020 at 3:15 p.m. with the Administrator (staff #43) and the Director of Nursing (DON/staff 79). During the conference it was revealed there were no COVID-19 positive residents in the facility. It was also revealed that there were residents on observation for symptoms of COVID-19, including [MEDICAL TREATMENT] residents. While on a tour of the facility with the DON and the Assistant Director of Nursing (ADON/staff #16) on September 2, 2020 at 3:40 p.m., the ADON pointed out a linen closet next to the nurses' station and stated that staff are supposed to get a clean gown out of the linen closet and don the gown before entering a resident's room on observation for symptoms of COVID-19. The ADON stated that staff are to doff the gown prior to leaving the resident's room and hang the gown on a hook in the resident's room. She also stated that at the end of the staff shift, the CNAs are to place the gowns in a plastic bag and take them to the laundry. Observation of the hooks revealed CNA labels were posted, however, there was no indication of what gown belonged to what CNA. The ADON and DON were unable to explain how it would be determined which gown belonged to which staff. An interview was conducted on September 3, 2020 at 12:30 p.m. with a Certified Nursing Assistant (CNA/staff #33) in training working on the hall where [MEDICAL TREATMENT] residents were being observed for symptoms of COVID-19. The CNA stated clean gowns are hung by someone in the rooms of the residents on observation for the CNAs and the nurses to don and use for their shift. Observations conducted of 5 residents' rooms with staff #33 revealed one room had two hooks and one label for a nurse between the hooks, one room had a label for a CNA but not for a second CNA, and one room with two gowns hanging on a hook labeled therapy. Staff #33 stated that she always tries to hang her gown on the hook labeled CNA that is closest to the door, so she knows which gown is hers. She also said that she and the other CNA try to let each other know where they are hanging their gowns. Regarding one of the resident's rooms, the CNA stated the room was assigned to the other CNA and that she had been in room earlier to help the resident. She pointed to the gown hanging closest to the door and identified it as her gown. Staff #33 was unable to explain how the other CNA would know that she had assisted the resident or used the gown hanging on the hook closest to the door. Staff #33 checked the two gowns that were observed hanging on a hook labeled therapy for names, however, there were no names. The CNA stated she did not know how staff would know which gown belong to which staff. A nurse within close proximity, stated that staff #33 was right about gowns already hanging in the residents' rooms and that she also uses the gowns that are already hanging in the rooms. An interview was conducted on September 3, 2020 at 1:50 p.m. with the Infection Control Preventionist (ICP/staff #150) and the ADON (staff #16). Staff #150 stated that staff are to get a clean gown from the linen closet before staff enters the resident's room on observation. She stated that when the staff is done assisting the resident, the staff is supposed to hang the gown on a hook in the resident's room. The ICP said there should be hooks labeled for the nurses and the CNAs. She also stated that staff are to use the same gown for the entire shift. She said at the end of their shift, the CNAs are to remove the gowns from the rooms and send them to the laundry to be washed to avoid transmission of [MEDICAL CONDITION] to staff. Staff #16 agreed with staff #150 and acknowledged that this was the process that she had explained during the interview conducted with her on September 2, 2020 at 3:40 p.m. During the interview with staff #150, the DON (staff #79) joined the interview and instructed staff #16 to begin re-training staff on the use of gowns immediately. Review of the facility's Infection Prevention and Control Program policy reviewed January 2020 revealed goals included decreasing the risk of infection to residents and personnel and ensuring compliance with state and federal regulations relating to infection control. The facility's Emerging Infectious Disease (EID): Coronavirus Disease 2019 (COVID-19) policy revised May 4, 2020 states the goal is to implement recommended appropriate infection control strategies, guidance and standards from the local, State and Federal agencies for an EID event. CDC's optimization strategies for PPE offer options for use when PPE supplies are stressed, running low, or absent. As PPE availability returns to normal, healthcare facilities should promptly resume standard practices. The policy included putting on an isolation gown upon entry into the patient room or area and that cloth gowns should be laundered after each use. The CDC Strategies for Optimizing the Supply of Isolation Gowns updated March 17, 2020 regarding the extended use of isolation gowns revealed that for the care of patients with suspected or confirmed COVID-19, HCP (healthcare personnel) risk from re-use of cloth isolation gowns without laundering among multiple HCP sharing one gown is unclear. The goal of this strategy is to minimize exposures to HCP and not necessarily prevent transmission between patients. The guidance included care should be taken to ensure that HCP do not touch outer surfaces of cloth gown during care. Cloth isolation gowns could potentially be untied and retied and could be considered for re-use without laundering in between.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE