STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035197	A. BUILDING _____ B. WING _____	07/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF YUMA	2470 SOUTH ARIZONA AVENUE YUMA, AZ 85364

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 observations, facility documentation, staff interviews, review of the Centers for Disease Control (CDC) and the World Health Organization (WHO) recommendations and policies and procedures, the facility failed to ensure that infection control standards were implemented on the COVID negative section. These deficient practices could result in the spread of infections including COVID-19 to staff and residents. Findings include: Review of the facility's floor plan revealed that part of the 200 Hall was designated as the active COVID section and another part was designated as the recovered COVID transitional section.The 400 and 500 halls were designated as the COVID negative section. Review of the resident census revealed that between July 8, 2020 and July 22, 2020, 16 residents had been admitted or readmitted to the facility from July 10-21, 2020 and were housed on the COVID negative section, and were current residents at the time of the survey. Observations were conducted on July 22, 2020 at 9:15 a.m. on the COVID negative section, where the 16 residents resided. Observations revealed there were no signs or instructions on the outside of this unit that notified staff/visitors regarding the personal protective equipment (PPE) that was required for this unit. There was also no sign/instructions outside of these resident's room indicating the type of isolation precautions that were in place (i.e. droplet, contact, airborne). Further observations revealed that multiple staff entered these rooms with a gown on and then exited the rooms without changing their gowns, and then entered other resident rooms. An interview was conducted on July 22, 2020 at 9:20 a.m. with a Certified Nursing Assistant (CNA/staff #95) on the COVID negative section. He stated that he did not know why there were no instructions for what personal protective equipment (PPE) was required for this section or any instructions indicating the type of isolation (i.e. droplet, contact, airborne). In an interview on July 22, 2020 at 9:45 a.m. with a CNA (staff #191), she stated that full PPE was required at all times to work on the COVID negative section of the facility. An interview with the Infection Preventionist (staff #29) was conducted on July 22, 2020 at 12:00 p.m. Staff #29 stated that the active COVID section was for confirmed cases of COVID-19; the recovered COVID transitional section was for residents who have recovered from COVID-19 and are being monitored for transfer off that unit or suspected cases of COVID-19 that require further monitoring; and the 400 and 500 Hall was the designated COVID negative section. She said there are no confirmed COVID in the building. She stated that the facility does not isolate new resident admissions or re-admissions for 14 days, but does monitor them for seventy-two (72) hours up to seven (7) days after admission for signs and symptoms of COVID. When questioned regarding the CDC recommended practice of a 14 day isolation for all new admissions or re-admissions, staff #29 had no explanation. She further stated that full PPE is required to work on the COVID negative section and that every resident is treated as though they are suspected of COVID. An interview with the Administrator (staff #1) was conducted on July 22, 2020 at 3:00 p.m. He stated that full PPE is required to be on the COVID negative section of the facility. -Additional observations were conducted on July 22, 2020 at 9:30 a.m. on the COVID negative section. One resident on the unit was on isolation precautions for COVID and another resident was on isolation for [MEDICAL CONDITIONS]. There were hanging containers on the doors which contained PPE. However, there was no signage on the outside of the doors notifying staff/visitors to check with staff prior to entering, there were no instructions regarding the type of isolation that the residents were on and no instructions regarding additional PPE that was required. In an interview on July 22, 2020 at 9:35 a.m., a CNA (staff #191) stated that she did not know why there were no isolation signs placed outside the resident rooms. An interview was conducted on July 22, 2020 at 10:00 a.m. with a CNA (staff #79) on the COVID negative section, who stated that there was one resident who was suspected of COVID and another resident who had [MEDICAL CONDITION]. Staff #79 acknowledged that there was no signage on the outside of these rooms to inform staff/visitors to check with clinical staff prior to entering, there were no instructions regarding the type of isolation that the residents were on (i.e. droplet, contact, airborne precautions) and no instructions for additional PPE that was required. Staff #79 stated that this was a concern, as staff and visitors should know. During an interview with the Infection Preventionist (staff #29) on July 22, 2020 at 12:00 p.m., she stated that the facility process is to hang yellow PPE containers on the resident's room doors to indicate an isolation resident. Staff #29 agreed that there were no signs for staff/visitors to see clinical staff prior to entering, or any instructions indicating the type of isolation that these residents were on and what PPE was required for these residents. She stated that full PPE is required to work on the COVID negative section and that every resident is treated as though they are suspected of COVID. An interview with the Administrator (staff #1) was conducted on July 22, 2020 at 3:00 p.m. He stated that a yellow container with PPE is placed on the resident's door to indicate the resident is on isolation. He agreed that there was nothing to instruct staff/visitors to check with staff/visitors before entering, or instructions to indicate the type of isolation and the required PPE that was needed. The Administrator stated that full PPE is required to be in the COVID negative section of the facility. Review of the WHO recommendations titled, Infection Prevention and Control guidance for Long-Term Care Facilities in the context of COVID-19 dated March 21, 2020, revealed that if a resident is suspected to have, or is diagnosed with [REDACTED]. According to the CDC recommendations titled, Responding to Coronavirus (COVID-19) in Nursing Homes dated April 30, 2020, all recommended COVID-19 PPE should be worn during care of residents under observation. Newly admitted or readmitted residents should be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. The CDC recommendations for the Coronavirus Disease 2019 included that infection control procedures including administrative rules and engineering controls, environmental hygiene, correct work practices and appropriate use of PPE, are all necessary to prevent infections from spreading during healthcare delivery. All healthcare facilities must ensure that their personnel are correctly trained and capable of implementing infection control procedures, and that individual healthcare personnel should ensure they understand and adhere to infection control requirements. Review of the CDC recommendations titled, Preparing for COVID-19 in Nursing Homes dated July 16, 2020 revealed that consideration can be made to extend the use of isolation gowns (disposable or cloth) such that the same gown is worn by the same healthcare personnel when interacting with more than one patient known to be infected with the same infectious disease when these patients are housed in the same location (i.e., COVID-19 patients residing in an isolation cohort). This can be considered only if there are no additional co-infectious [DIAGNOSES REDACTED]. A facility policy titled, Isolation-Categories of Transmission Based Precautions revealed the following for contact and droplet precautions: Regarding signs it stated that the facility will implement a system to alert staff to the type of precaution the resident requires. This facility utilizes the following system for identification of contact and droplet precautions: however, these sections were left blank. Review of a policy regarding [MEDICAL CONDITION] Outbreak, Infection Control Measures dated April 2, 2020 revealed if an outbreak of [DIAGNOSES REDACTED] CoV2 occurs within the facility, strict adherence to standard and transmission based precautions and other infection control measures will be implemented according to the most current CDC recommendations. A policy titled COVID-19 Policy and Procedure for Separation of LTC and New Residents dated April 17, 2020 revealed it is their policy to protect the health and well-being of our residents and staff during infectious disease outbreaks. The policy included that new residents will remain on the transition unit for a minimum of 14 days.

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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