STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035259	A. BUILDING _____ B. WING _____	**05/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE GARDENS OF SCOTTSDALE	**6001 EAST THOMAS ROAD SCOTTSDALE, AZ 85251**

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 interview and record review the facility did not assure that staff followed infection prevention and control techniques when one of six staff (Staff 35) breeched protocol while caring for a resident (R1) who was on transmission based precautions (TBP). This deficient practice had the potential for the spread of contagious disease to up to seven residents. Findings Include: During observations on 5/13/2020 between 11:40 and 11:48 AM, Staff 35 and one other Staff person were in R1's room assisting the resident put on a brace. R1 was admitted on [DATE] with multiple fractures requiring a back brace to support her body as she recovered. The resident was a new admission. The facility policy required that all new admissions be placed on TBP droplet precautions (Quarantine) for 14 days or until a COVID-19 test was negative. Review of the facility's TBP policy included directions for how to follow Droplet precautions that required the staff to don (put on) mask, gown and gloves while caring for the resident. Staff 35 had on a gown that was not tied at the neck and kept slipping down during care. After Staff 35 had touched with R1, she reached under the gown and put her gloved hand into her pocket and removed something that she used while taking care of the resident. Staff 35 kept struggling to keep the gown from falling down during care. At approximately noon, with the DON we returned to see if Staff 35 was still in R1's room. She was and we observed Staff 35 still struggling with keeping the gown on. The DON said the staff should have tied the gown at the neck tightly so it did not fall down. When told of the earlier observation the Director of Nursing (DON) stated Staff 35 should not put her contaminated hands under the gown after it is on. At 1:20 PM during an interview when told of the observation I made during her care of R1 between 11:40 and 11:48 am, Staff 35 stated forgot to take a dry erase marker out of her pocket to write some things on the resident's white board. When asked what training she received regarding maintaining infection control during care of a resident on TBP, she stated she should not have reached under the gown. She stated she had received training but she did not realize it at first. She stated she should have removed her gloves and washed her hands before and after getting the marker from her pocket. When asked about the difficulty she had with her gown, she stated the facility did not have small gloves. She had small hands and she had to wear the medium or large gloves which made it difficult for her to tie the gown ties. When asked if she let her manager know she said she usually carried a pocket full size small gloves; however did not have any on this day. Discussed this with the Infection Preventionist/Control staff (IPC). She stated they had plenty of small size gloves; however Staff 35 did not let them know she needed any.

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