STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035143	A. BUILDING _____ B. WING _____	07/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF SCOTTSDALE	**9494 EAST BECKER LANE SCOTTSDALE, AZ 85260**

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 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, including COVID-19 to residents and staff. Findings include: Upon entrance to the facility on [DATE] at 7:55 a.m., a box of clean surgical facemasks was observed on the reception counter to the left. The screener (staff #79) instructed the surveyor to put on a clean surgical facemask and to sanitize her hands. The surveyor asked her which task she should do first and staff #79 said put on the facemask first then she changed her mind and told the surveyor to sanitize her hands first. She then took the surveyor's temperature and asked questions from the screening tool. Once this was completed, she told the surveyor to sit down and wait in the reception area for someone to come and speak with her. Before walking away, the surveyor asked her if there was anything else that she needed to know. Staff #79 said sanitize your hands a lot, stay in the area that you are going to visit, and then she pulled a flyer on COVID-19 out from the underneath the screening tool and gave it to the surveyor. Observations during the screening process -On July 22, 2020 at 8:00 a.m., a female (staff #50) was observed entering the facility. She put a bottle on top of the counter. She picked up two clean surgical facemasks from the box on the reception counter by the outer edge using her thumb and index finger and put one back in the box. After she put the facemask on, she picked up the bottle on the counter and then sanitized her hands. Staff #79 then took her temperature and asked her the questions on the screening tool. Staff #79 did not educate staff about sanitizing her hands before donning the facemask, or provide education on the appropriate way to don a facemask. Staff #79 did not sanitize the counter after staff #50 removed the bottle from the counter. An interview was conducted on July 22, 2020 at 8:08 a.m. with staff #79, who said that she had received training on the screening process and was trained to instruct staff/visitors to sanitize their hands first and then obtain a clean surgical facemask from the box. She stated that she was supposed to give staff/visitors the flyer about COVID19 for education, tell them to sanitize their hands often, and stay in the area where they are working/visiting. She said that she realized she did not provide this information to the surveyor during the screening process and that she had to be asked. -On July 22, 2020 at 8:11 a.m., a female (staff #85) was observed entering the facility. Staff #79 took staff #85's temperature. Staff #85 was then observed to place a drink on the counter. Staff #85 took a surgical facemask out of the box, donned the facemask, and then sanitized her hands. Staff #79 did not educate staff #85 about sanitizing her hands before donning the facemask. Staff #79 did not sanitize the counter after staff #85 removed the drink from the counter. -On July 22, 2020 at 8:13 a.m., a female (staff #38) entered the facility with a surgical facemask on. Staff #38 was observed putting 2 plastic containers with green lids on the counter with a plastic bag of bananas on top of the containers and placing a silver thermal mug on the counter. Staff #38 then sanitized her hands. Staff #79 took her temperature and asked her the questions on the screening tool. Staff #79 did not offer staff #38 a clean surgical facemask. Staff #79 did not sanitize the counter after staff #85 removed the personal items from the counter. -On July 22, 2020 at 8:16 a.m., a female (staff #98) was observed entering the building, putting on a facemask, and then sanitizing her hands. Staff #79 took staff #98's temperature and asked the screening questions on the screening tool. Staff #79 did not educate staff #98 about sanitizing her hands before donning the facemask. A second interview was conducted on July 22, 2020 at 8:25 a.m. with staff #79. When asked if she realized that staff were putting on the facemask prior to sanitizing their hands, she said that she did not think it mattered what order it was done. When asked if she thought that there was risk of contamination if people touched the facemasks prior to sanitizing their hands, she said yes and then changed her mind and said they should sanitize hands first. She said that when staff/visitors take a facemask before sanitizing their hands, it increases the risk of contamination. When asked what she should do if staff touches more than one facemask, she said that she should throw the second facemask away because it could be contaminated. Staff #79 said that she did not realize staff #50 had touched two facemasks and had put one facemask back into the box. She stated that staff are supposed to don a clean facemask. When asked how she would know if a facemask was clean if staff was wearing the facemask when they entered the building, she said that she would not know. Staff #79 stated that she did not observe staff #38 entering the facility with a facemask on. When asked what she should do if she sees this, she said she would ask the person to put on a clean surgical facemask. She acknowledged that she did not provide education to any of the staff about performing hand hygiene prior to donning a facemask. Staff #79 stated she uses Sani-Wipes to clean the counter and that housekeeping sanitizes the reception area as well. She said she realized staff was putting personal belongings on the counter and there is a possibility of contamination, and that she should have sanitized the counter in between staff putting things on the counter and/or touching the counter area. An interview was conducted on July 22, 2020 at 12:40 p.m. with the Director of Nursing (DON/staff #66) and the Infection Control Preventionist (ICP/staff #40). Staff #66 stated the screener is supposed to have everyone sanitize their hands prior to putting on personal protective equipment (PPE). The DON stated that by not sanitizing hands before donning PPE increases the risk of contamination. Staff #40 said that if staff sanitized their hands prior to putting on a facemask and prior to putting personal belongings on the reception counter, there would not be an increased risk of contamination. Staff #40 stated that the counter should be disinfected in the morning, a couple of times throughout the day, and as needed i.e. if the counter was soiled. Staff #66 agreed that multiple staff touching their facemasks prior to sanitizing their hands increased the risk of the facemasks being contaminated. The DON stated that it was her expectation that staff remove a surgical facemask from the box by grabbing the string that goes around the ear to prevent contamination. Review of the facility's policy regarding Standard and Transmission Based Precautions, Screening/Communication/Visitation/Education revised July 20, 2020, revealed that visitors, vendors, and contractors should be educated on COVID-19, visitation restrictions, actions the facility is taking to protect them, the residents and associates, actions they can take protect themselves while in the facility, the important role of social distancing, how to properly don and doff appropriate PPE, hand hygiene, respiratory hygiene, and cough etiquette, and wearing a face mask during their presence in the facility as a means of source control. Review of the facility's policy regarding PPE use during a disaster revised April 1, 2020 states that during a disaster when supply chain disruption is expected or has occurred, the facility will implement strategies to extend the life of existing supply of PPE. A clean facemask will be provided by the facility at the beginning of each shift. The associate is responsible for this facemask for the duration of their shift. The policy included the associate should request a replacement if the mask becomes wet, soiled, or contaminated in some way. The facility's policy for Personal Protective Equipment (PPE) revised May 29, 2020, included the procedure for donning PPE, which instructs to sanitize hands prior to donning PPE. Review of the CDC recommendations for Facemask Do's and Don'ts for Healthcare Personnel dated June 2, 2020 revealed hands should be sanitized before the facemask is donned. The CDC Interim Infection and Prevention Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic updated July 15, 2020, stated healthcare personnel should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE. 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035143	A. BUILDING _____ B. WING _____	**07/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF SCOTTSDALE	**9494 EAST BECKER LANE SCOTTSDALE, AZ 85260**

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	(continued... from page 1) facility's policy Housekeeping Services revised July 10, 2020, stated that high-touch surfaces should be cleaned at least once daily. The facility's policy titled Coronavirus (COVID-19) ([DIAGNOSES REDACTED]-CoV-2) revised July 20, 2020 revealed the purpose is to provide a framework to minimize the risk of potential exposure to the Coronavirus COVID-19 in the long-term care facility. COVID-19 ([DIAGNOSES REDACTED]-CoV-2) mode of transmission might occur through contact with contaminated surfaces followed by self-delivery to the eyes, nose, or mouth. Ensure that high-touch surfaces in break rooms and work areas are frequently cleaned and disinfected (e.g., each shift) Review of the CDC Cleaning and Disinfecting Your Facility revealed facilities should practice routine cleaning of frequently touched surfaces and that more frequent cleaning and disinfection may be required based on level of use. High touch surfaces included countertops. Observation of donning a gown -During an interview conducted on July 22, 2020 at 9:45 a.m. with a Registered Nurse (RN/staff #54) on the observation (monitoring residents for signs and symptoms of COVID-19) unit, a Licensed Practical Nursing (LPN/staff #8) was observed donning a gown. He secured the gown around his neck with Velcro, but did not secure the gown around his waist; the back of the gown was open. He then entered a resident's room to administer medication. The interview continued with Staff #54, who said that she saw staff 8's gown was open at the back and that he had not used the Velcro to secure the gown around his waist. She said that the gown should cover the back of the body as well as the front. The RN said that if the clothing/body is exposed, it increases the risk of contamination. During this time, staff #8 exited the resident's room and acknowledged that he did not secure the gown at the waist area at the back of the gown and that it was open when he entered the resident's room. He said that leaving his back exposed increases the chances of contamination. An interview was conducted on July 22, 2020 at 12:40 p.m. with the DON and the ICP. The ICP said if the gown is not donned correctly, it increases the risk of contamination. She said the gown should be tied so that it covers the body. The facility's policy titled Personal Protective Equipment (PPE) revised May 29, 2020 revealed the purpose is to reduce the risk of and prevent the spread of infection to patients, visitors and staff. The facility should train associates on PPE, this training should include but is not limited to appropriate don/doff process. The policy included a procedure for donning PPE which stated to apply gown or upper torso covering with sleeves. Assistance may be needed by another staff. Review of the CDC Sequence for Putting on Personal Protective Equipment (PPE) revised July 20, 2020, stated the gown is to fully cover the torso from neck to knees, arms to end of wrists, and wrap around the back. The gown should fasten in the back at the neck and waist. The Centers for Disease Control and Prevention (CDC) recommendations for the Coronavirus Disease 2019, revealed 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.