STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035105	A. BUILDING _____ B. WING _____	07/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHEA POST ACUTE REHABILITATION CENTER	11150 NORTH 92ND STREET 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.

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F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** Based on interview and record review the facility failed to maintain to accurately document the presence of possible COVID-19 signs and symptoms on the monitoring tool implemented for residents for 4 of 9 sampled residents (Residents 22, 18, 15 and 9). These records did not contain an accurate representation of the actual experience of the residents and could mislead healthcare providers and public health experts when reviewing these records and/or evaluating the residents' progress and/or changes in conditions. Findings: Resident 22's electronic health record reviewed on 07/09/2020 for documentation of monitoring for signs and symptoms of COVID-19. The Temp Summary page read on 07/01/2020 at 22:22 temperature as 100.1 F. The O2 Sats Summary read on 07/02/2020 at 16:12, Oxygen saturation on room air was 73% (a normal range for oxygen saturations is generally above 95% for health adult, and above 88% for person with significant lung disease). A nursing progress note dated 07/02/2020 read MD notified of Temp of 100.1 @ 2200 7/1/2020. Covid 19 testing was done 6/11/2020 and was negative. Slight cough noted without (shortness of breath, nausea or vomiting, or headache). MD ordered Covid 19 screen to be done. No progress notes addressed the low oxygen level recorded. The facility's COVID-19 symptom monitoring was located on the Medication Administration Record (MAR). Directions on the July 2020 MAR read Document Temp/O2 sats and monitor for the following symptoms: Fever, Cough, Shortness of breath or difficulty breathing, Chills, Repeated shaking with chills, Muscle pain, Headache, Sore throat, New loss of taste or smell, GI Symptoms: Diarrhea/Nausea/ Vomiting every shift **Notify NP/MD if present There is a space for Licensed Nurses to record the presence or absence of symptoms under -/+, Blood pressure, temperature, pulse, respirations, oxygen saturations, and initial for the shift. While both the abnormal temperature reading and oxygen saturation readings were recorded, the space for symptom presence was marked with negative notation. Interviewed Licensed Nurse (LN) 3 on 07/10/2020 at 09:35 AM about COVID-19 monitoring and documentation of resident signs and symptoms. LN3 stated the nurses monitored residents throughout their shift for signs and symptoms such as temperature and O2 sats, cough, respiratory things or chest pains. Any kind of pains really. She demonstrated how the monitoring was entered into the electronic monitoring task and showed the surveyor how the resident's most recent vital signs were displayed and selected for entry. The last step before signing off LN3 said was you enter a negative sign if there were no signs or symptoms, and plus sign if they were. You have to enter a note as well . a change of condition note or COVID-19 note. When asked how a nurse would document a positive symptom if she had already signed off the monitoring, she stated they would have make a change of condition note, or they could enter a COVID-19 note, but they could not go back into the monitoring and change it. When asked who looks at the monitoring, she stated The nurses, the DON, and nursing assistants When asked if physician would also use it to evaluate the resident's history she said Oh yes the physicians too. During an interview on 07/10/2020 at 11:46 AM the DON confirmed she was aware of Resident 22's temperature spike on 07/01/2020. When asked if she was aware the negative entry for symptoms she stated she was not. When asked if she was aware of the documented low saturation reading of 78% recorded on 07/02/2020. She said she was not. She stated her expectation when a reading was low like that, was the nursing assist should alert the nurse and recheck the reading. When asked if she thought it may be a data entry error, she replied The nurse should have seen it and struck it out. The DON agreed that the COVID-19 monitoring did not reflect an accurate account of the monitoring being done. Resident 18's electronic health record reviewed on 07/09/2020 for documentation of monitoring for signs and symptoms of COVID-19. Progress notes revealed a nursing noted dated 07/09/2020 at 10:46 AM which read, Respiratory rate, rhythm, sound deviates from baseline. Active (symptom): cough. Another nursing note dated 07/09/2020 at 07:50 AM read Productive cough noted and continues to have temps @ 99.6. O2 Sats remain above 90% . Stat Chest Xray ordered per Dr. The COVID-19 signs and symptom monitoring recorded on the MAR for the day shift on 07/09/2020 read negative. Resident 15's electronic health record was reviewed on 07/09/2020 for documentation of monitoring for signs and symptoms of COVID-19. Progress notes revealed two separate nursing notes dated 07/07/2020 that described the presence of a productive cough. A nursing noted dated 07/08/2020 also described a productive cough. A Change of Condition for COVID-19 positive note dated 7/9/2020 at 06:30 AM read that Resident 15 developed acute symptoms which included altered mental status, cough, congestion, shortness of breath, low blood pressure and low oxygen readings while on 4 liters of oxygen. The resident was transferred to an acute care hospital at 04:30 AM. Resident 15's COVID-19 signs and symptom monitoring recorded on the MAR for negative for the Day shift on 07/07/2020, Day shift on 07/08/2020, Evening shift on 07/08/2020 and were not recorded for the Evening shift of 07/07/08 or the Night shift of 07/07/2020. The MAR did reveal a positive notation for the Night shift of 07/08/2020 when the resident was sent to the hospital. Resident 9's electronic health record was reviewed on 07/09/2020 for documentation of monitoring for signs and symptoms of COVID-19. The Temperature summary read on 07/04/2020 at 11:11 AM the resident's temperature was 100.2 F. Progress notes reviewed did not reveal a note addressing this temperature, however a nursing note dated 07/04/2020 at 12:33 PM read that Tylenol 500mg had been administered. A different nursing note dated 07/04/2020 at 14:53 read the resident had occasional loose productive cough that lung sounds were diminished. Resident 9's COVID-19 signs and symptom monitoring recorded on the MAR for both the Day shift and Evening shift read negative. The temperature reading of 100.2 was also not recorded on the monitoring for either shift. During the interview with the DON on 7/10/2020 these inaccuracies were discussed. When brought to the attention of the DON, she stated The monitoring on the MAR does not reflect the actual monitoring they are doing.
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 failed to develop and maintain an infection control program designed to prevent the spread of [DIAGNOSES REDACTED] CoV-2 (the novel coronavirus which causes COVID-19), when they failed to quarantine two of nine sampled residents (Resident 22 and Resident 15) for 14 days following admission to the facility, per the Centers for Disease Control's (CDC) guidelines. These failures had the potential to spread [DIAGNOSES REDACTED] CoV-2 and infect other residents and staff and cause a potential outbreak in the facility. Findings: Resident 22: During the entrance conference on 07/08/2020 at 1:00 PM, the Director of Nursing (DON) and the Administrator in Training (AIT) explained that the facility had 3 resident hallways, 100, 200, and 300. The 100 hallway was the unit where newly admitted residents were co-horted during the 14 day observation period, and the other two hallways were for long term care residents. The end of hallway 100 was where COVID positive residents would be housed. They also explained that the whole care area of the facility was under isolation precautions, and any who entered the care area would need don (put on) Personal Protective Equipment (PPE). Observed the donning and doffing area prior to entering the resident care area on 07/08/2020 at 1:15 PM. Stations were clearing marked with instructions at each station directing staff to don or doff PPE and perform hand hygiene. Each step was consistent with CDC guidance on the donning and doffing sequence. Observed door to

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) Resident 22's room was closed on 07/08/2020 at 1:30 PM. The resident's room was located on the 300 hallway. A small portable cart with PPE was just outside the doorway between two resident rooms. Two staff members were observed to exit Resident 22's room at 1:40 PM. Both staff removed an outer isolation gown, hung it on the wall and washed their hands. When they entered the hallway they had a base layer isolation gown, a mask, and eye protection and again, performed hand hygiene. One of the staff members carried a closed bag of trash down the hallway and the other staff stopped and was interviewed by the surveyor. Licensed Nurse (LN) 1 stated on 07/08/2020 at 1:45 PM that she had worked in the facility for about 2 years. When asked if the PPE cart indicated one of the rooms, or residents were on isolation precautions, she stated One room is but was unsure of which room. She then clarified that the facility had just today implemented every resident was on transmission based precautions due to a facility outbreak of COVID-19. When asked what precautions they used, she explained that in addition to all staff wearing an isolation gown, mask, and eye protection when entering the care area of the facility, staff were to don (put on) another isolation gown that was kept just inside of each resident's room. Double gown and wear gloves. Then doffing the outer gown after completing care for the resident place it back on a hook by the door so it could be reused, then remove gloves and wash hands. Resident 22's electronic health records were reviewed on 7/9/2020. The Admission Record read Resident 22 was admitted to the facility on [DATE] from another skilled nursing facility with a primary [DIAGNOSES REDACTED]. The Census List indicated Resident 22 had been admitted to a room on the 100 hallway on 04/30/2020 and moved to a room on the 300 hallway on 05/07/2020. A single SAR-CoV-2 respiratory test collected on 05/06/2020 read negative. An Order Recap report of all orders between 04/30/2020 and 07/31/2020 revealed an order which read Isolation Precautions- contact, droplet every shift dated 4/30/2020 and discontinued on 05/07/2020, 7 days after admission. Progress notes revealed a note written by the Case Manager on 05/07/2020 and read Resident cleared from isolation and moved to a long term care room. CDC Guidance titled Responding to Coronavirus (COVID-19) in Nursing Homes dated reviewed: April 30, 2020 provided guidance for new admissions and readmission to the facility. It read, Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19. All recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. Testing residents upon admission could identify those who are infected but otherwise without symptoms and might help direct placement of asymptomatic [DIAGNOSES REDACTED]-CoV-2-infected residents into the COVID-19 care unit. However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. Testing should not be required prior to transfer of a resident from an acute-care facility to a nursing home. New residents could be transferred out of the observation area or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g., date of admission). Testing at the end of this period could be considered to increase certainty. During an interview with the DON on 07/10/2020 at 11:46, the DON was asked about Resident 22's quarantine period and subsequent precautions being discontinued at less than 14 days when moved from the new admissions co-horted on the 100 hallway. The DON described the facility's admission policy as allowing the discontinuation of the observation period after two negatives tests for COVID-19. When asked if the transmission based precautions would have been continued once moving to the long term care hallway, she sated If we moved him over to the long term care side then he would not have been on the isolation. When informed the surveyor only identified one test in the resident's medical record, collected on 05/06/2020, the DON reviewed Resident 22's medical record and stated I don't see the second one here. The DON agreed to provide additional documentation of a second test if located. This additional documentation was not provided to surveyor. Surveyor requested the new admissions policy and procure on 07/10/2020 as the topic was not addressed in the Emerging Infectious Disease (EID) Emergency Plan Coronavirus 2019 (COVID-2019) provided during the entrance conference. The surveyor was provided the New admission/14 day observations Policy and Procedures dated 05/20/2020. It read in part, New admits with unknown COVID 19 results will be swabbed for COVID 19. The (sic) will remain on droplet/isolation precautions until results are reported. If the results are positive the (sic) will be transferred to a COVID 19 facility. If results are negative, they will come off droplet/isolation but will be required to wear the mask with all care of out of room. All new admissions will continue to be monitored during this initial 14 day period. Resident 15: On 07/08/2020 at 2:10 PM, observed Resident 15's room at the end of the 100 hallway. The door was closed and a small portable cart with PPE was just outside the doorway between two resident rooms. Two signs were posted on the door. One read Droplet precautions and the other read Doffing PPE Example 1. Resident 15's electronic health records were reviewed on 7/9/2020. The Admission Record indicated the resident was most recently admitted on [DATE] from an acute care hospital. The Order Recap Report for the time period 06/16/2020 to 07/31/2020 read Patient to be sent out to (local) hospital for blood transfusion related to a [DIAGNOSES REDACTED]. The resident's Census List read the resident was admitted to a room on the 100 hallway on 06/17/2020, and then moved to the 200 hallway on 06/26/2020 (Day 9 of admission). Two separate isolation orders were identified on the Order Recap Report. One dated prior to admission on 06/10/2020 and discontinued on 06/23/2020 read Isolation Precautions- contact, droplet every shift. The other was initiated on 07/07/2020 and read Isolation Precautions- contact, droplet every shift for covid+. Lab results in the record revealed a COVID-19 test was collected on 06/18/2020 (1 day after admission) which read negative and one collected on 06/30/2020 (Day 13 after admission and 4 days after being moved off of the 100 hallway.) The 06/30/2020 COVID-19 test was not reported back to the facility until 07/07/2020 and it read COVID-19 was detected. The Census List revealed Resident 15 was transferred back to the 100 hallway on 07/07/2020. Reviewed Progress Notes for 06/26/2020, the day resident was transferred off of the 100 hallway, there were no notes relating to the room move. A nursing note dated 07/03/2020 read Resident 15 had developed a temperature of 100.0 and audible chest congestion. The note indicated the physician was notified, new orders were received, and a COVID-19 test was pending. An Interdisciplinary Team (IDT) note dated 07/07/2020 read Chart reviewed, discussed with members of IDT. Resident placed on contact droplet isolation with skilled respiratory assessment due to (+)Covid19 on 7/7/20. A review of the June and July Medication Administration Record [REDACTED]. During the time between June 23rd and July 7th no entries on the MAR indicated [REDACTED]. One nursing note during this time documented the use of precautions. This note dated 6/30/2020 read Patient on isolation droplet, contact precautions. A Change of Condition for COVID-19 positive note dated 7/9/2020 at 06:30 AM read that Resident 15 developed acute symptoms which included altered mental status, cough, congestion, shortness of breath, low blood pressure and low oxygen readings while on 4 liters of oxygen. The resident was transferred to an acute care hospital at 04:30 AM. The DON was interviewed on 07/10/2020 at 12:30 PM regarding Resident 15. When asked why an isolation order had been implemented on 06/10/2020 before the resident was readmitted , she replied We put the building on isolation on June 10th, because of the positive (case). . She was not put on isolation. When asked to describe what the building on isolation involved, she described that all staff donned the following PPE before entering the care area, gown, face mask, and eye protection. Gloves and hand hygiene was performed between each resident contact. This type of facility isolation was implemented to extend the limited supply of PPE. She clarified, that for residents on the 100 hallway where new admissions were co-horted reusable gowns were used on top of the base layer gown to maintain the transmission based precautions in place. Double gowning only occurred in the rooms for people who were on Precautions. The surveyor asked to clarify that staff wore the same PPE for all residents except those on transmission based precautions. The DON stated Yes. Starting on June 10th. When asked if Resident 15 was placed on the isolation precautions upon return from the hospital on [DATE], she replied When she came from hospital, she was considered a new admission. She was unable to explain the discontinuation of the isolation order. She confirmed the resident was moved off of the new admission co-hort hallway (100) on 06/26/2020, onto a long term care hallway, before the 14th day after admission. During the same interview, the DON explained that on 07/07/2020 when two residents tested positive for COVID-19, the facility implemented the double gowning for every resident in the facility. Surveyor clarified that prior to 07/07/2020, the residents on the long term care hallways were not under individual transmission based precautions, just the facility isolation implemented on 06/10/2020. The DON confirmed this. During a phone interview on 7/11/2020 at 10:51 AM, the Administrator was questioned about the development of the policy on New admissions/14 day observation. He stated that in mid-May, 2020 they had changed to testing for COVID-19 twice, We had a whole host of calls with the State. Due to an expected in-flux of residents in mid-May he thought the smartest thing to do was to get the residents off the new admission unit as quickly as possible, and their understanding was that testing residents changed their status to known. When asked how he could ensure that a resident who was tested before the completion of their observation period, would not then convert to positive after the test and

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) before the 14th day, he was not able to describe how that was achieved. The CDC's Clinical Questions about COVID-19: Questions and Answers on Transmission read, Based on existing literature, the incubation period (the time from exposure to development of symptoms) of [DIAGNOSES REDACTED]-CoV-2 and other coronaviruses (e.g., MERS-CoV, [DIAGNOSES REDACTED]-CoV) ranges from 2-14 days. https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html