STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035282	A. BUILDING _____ B. WING _____	10/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SANTE OF SURPRISE	14775 WEST YORKSHIRE DRIVE SURPRISE, AZ 85374

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, 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 followed. The deficient practice could result in the spread of infections, including COVID-19 to residents and staff. Findings include: During an observation conducted on October 15, 2020 at 9:11 a.m. of the observation unit, the doors of the residents' rooms were observed open. An interview was conducted with a Licensed Practical Nurse (LPN/staff #99) on October 15, 2020 at 9:13 a.m. When asked if residents room doors needed to be closed if the residents were on isolation precautions, the LPN replied yes and closed one of the resident's room door. On October 15, 2020 at 9:20 a.m., a Certified Nursing Assistant (CNA/staff #45) was observed to remove his lab coat, hang it on a resident's room door on isolation, and go tell the nurse the resident requested some pain medication without performing hand hygiene. Staff #45 then went back to the resident's room, donned the lab coat and began taking the resident's vital signs without performing hand hygiene or donning gloves. Following this observation, an interview was conducted with an LPN (staff #99), who stated yes, that resident was on isolation precautions and staff should don PPE (personal protective equipment) to provide care to the resident. The LPN then asked if she could enter the resident's room and educate staff #45. Several minutes later, as staff #99 exited the resident's room, staff #45 was observed providing resident care wearing gloves and a lab coat. An interview was conducted with staff #45 on October 15, 2020 at 9:32 a.m. Staff #45 stated that he had been trained on the correct PPE to don when caring for residents on isolation precautions. He stated that he had sanitized his hands at the nurses' station prior to donning the lab coat. Staff #45 also stated he would have donned gloves in the resident's room but that he was unable to locate the gloves. Staff #45 then re-entered the resident's room and was able to locate a box of gloves in a cabinet. He then placed the box of gloves on top of the counter. An interview was conducted with the Director of Nursing (DON/staff #21) and the Infection Preventionist (IP/staff #7) on October 15, 2020 at 11:50 a.m. The DON stated that the observation signs on the residents' doors are to alert staff that the resident is on isolation precautions for 14 days after admission. The DON stated residents on observation are on droplet isolation precautions. The DON further stated that the expectation is that staff will don proper PPE when caring for residents on observation. The IP stated that staff need to wash or sanitize their hands before entering the resident's room and before exiting the resident's room. Staff #7 stated staff are to don a lab coat, KN-95 mask, eye protection and gloves. The DON stated staff #45 used poor judgement was re-educated. The DON said the room doors to residents that are on isolation precautions should be closed unless contraindicated by their medical condition. She also said this was not the case for the residents on the observation unit. The CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel during the Coronavirus Disease 2019 (COVID-19) Pandemic updated July 15, 2020 revealed patients with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection should be placed in a single-person room with the door closed and should have a dedicated bathroom. Review of the CDC guidelines, updated August 19, 2020 included that the recommended PPE for healthcare personnel caring for residents with confirmed or suspected COVID-19 included an N95 or higher face mask, isolation gown, one pair of clean non-sterile gloves, and a face shield or goggles. The CDC guidance on when to perform hand hygiene revealed multiple opportunities for hand hygiene may occur during a single care episode. Hand hygiene should be performed immediately before touching a patient and after touching a patient or the patient's immediate environment. The facility policy titled Coronavirus Disease (COVID-19) - Infection Prevention and Control Measures included this facility follows recommended standard and transmission-based, precautions, environmental cleaning and social distancing practices to prevent the transmission of COVID-19 within the facility. While in the building, personnel are required to strictly adhere to established infection prevention and control policies, including: Hand hygiene, Respiratory hygiene, and Appropriate use of PPE. For a resident with known or suspected COVID-19, staff are to wear gloves, isolation gown, eye protection and an N95 or higher-level respirator if available (a facemask is an acceptable alternative if a respirator is no available). The policy further included the resident is placed in a private room with a dedicated bathroom (if available) and to close the door.
F 0886 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	Based on facility documentation, interviews, the Centers for Medicare & Medicaid Services (CMS), and policy review, the facility failed to provide adequate documentation that they had contacted state and local health departments for assistance due to testing supply shortages. Findings include: A review of the line listing for infection control revealed the following: -On September 15, 2020, an LPN (staff #9) tested positive for COVID-19. The facility tested on ly the staff and residents that staff #9 had direct interactions with. -On September 18, 2020, a Certified Nursing Assistant (CNA/staff #11) was tested for COVID-19 because she had symptoms in her screening on September 17. An interview with the Administrator revealed the facility received a positive result for staff #11 on September 23, 2020. -On September 21, 2020, a Certified Nursing Assistant (staff #10) tested positive for COVID-19. Staff #10 was tested because she had worked directly with staff #9. -On September 23 and September 25, 2020, the residents that staff #11 was in direct contact with were all tested for COVID-19. Seven of those tested came back positive for COVID-19. An interview was conducted with the Administrator (staff #69) on October 15, 2020 at 10:10 am. She stated that there was a communication within the organization in the middle of September regarding the shortage of testing supplies. She stated that the reason the facility performed focus testing verses testing the entire facility was based on shortage of supplies. A request was made for documentation that the facility had contacted state and local health departments to assist with the shortage of testing supplies. An interview was conducted with a Corporate Clinical Resource (staff #666) and the Infection Preventionist (staff #7) on October 15, 2020 at 10:58 am. She presented copies of internal emails, dated September 9, 22, and 30, 2020 explaining the steps that were attempted with the outsourced laboratories to obtain testing supplies. Staff #666 stated that the infection control nurse reached out to the county health department and spoke with someone that gave her an email address. The infection Preventionist (staff #7) stated she had spoken with several people at the county health department but was unable to give any specific names. Staff #7 later presented a hand-written note dated September 17 that the county was contacted and she spoke with 3 individuals. There were no names in the note. The note stated she was asked to email the county if she did not receive a call back. The note included staff #7 emailed the county health department on September 30, 2020. There was no documentation of the county replying to that email. The CDC guidance stated that when there is an outbreak (defined as one new COVID-19 positive resident or staff) all staff and residents who were previously negative must be tested until no new cases are identified - this should be done every 3 to 7 days and can't be stopped until there are no new cases for 14 days. The facility policy titled HCP and Patient Testing for COVID-19 included the facility will conduct testing of all health care personnel, patients or guests in accordance with 42 CFR 483.80(h). If the 48-hour turn-around time cannot be met due to community testing supply shortages, limited access or inability of laboratories to process tests within 48 hours, the facility will have documentation of its efforts to obtain quick turnaround test results with the identified laboratory or laboratories and contact with the local and state health departments. When prioritizing

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 0886 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) individuals to be tested , facilities should prioritize individuals with signs and symptoms of COVID-19 first, then perform testing triggered by an outbreak. This testing includes all staff and all residents.