STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035134	A. BUILDING _____ B. WING _____	08/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIM COUNTRY HEALTH & RETIREMENT COMMUNITY	**807 WEST LONGHORN ROAD PAYSON, AZ 85541**

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 facility documentation, staff interviews, review of the Centers for Disease Control (CDC) recommendations and policies and procedures, the facility failed to maintain an emergency preparedness plan that included a method to secure required supplies and resources (i.e., Personal Protective Equipment/PPE) during an emergency or natural disaster, and failed to ensure the infection control program included the necessary components regarding collection, analysis and interpretation of surveillance data to identify infections, infection risk and communicable diseases. The deficient practice could result in PPE shortages, and the spread of infections, including COVID-19 to residents and staff. Findings include: -Regarding emergency procurement of PPE: Review of the facility's Epidemic Policy and Procedures revealed the purpose was to inform staff of precautions to be taken in the event of an epidemic. The policy included that preventing transmission of infectious illness within healthcare settings required a multifaceted approach; and that the spread of an infectious virus can occur among residents, health care providers and visitors. The policy listed core prevention strategies that included adherence to infection control precautions for all resident care activities and implementing environmental and engineering infection control measures. The policy also included a component regarding staffing shortages which addressed how the residents' needs would be met during a pandemic declared emergency. However, the Emergency Preparedness policy and procedures did not include a plan for the procurement of PPE during emergency situations. An interview was conducted on [DATE] at 12:08 p.m., with the facility Administrator (staff #68). She stated the facility does not have an actual written policy for emergency procurement of PPE. She stated the facility has been able to obtain PPE and that she did not think they needed one. The CDC guidance titled, Optimize PPE Supply revealed that PPE is used every day by Healthcare Personnel (HCP) to protect themselves, residents and others when providing care. PPE helps protect HCP from many hazards encountered in healthcare facilities. The greatly increased need for PPE caused by the COVID-19 pandemic has caused PPE shortages, posing a tremendous challenge to the U.S. healthcare system. Healthcare facilities are having difficulty accessing the need for PPE and are having to identify alternate ways to provide resident care. The guidance stated that HCP and facilities along with their healthcare coalitions, local and state health departments and local and state partners should work together to develop strategies, that identify and extend PPE supplies, so that recommended PPE will be available when needed most. -Regarding COVID-19 Symptom and Testing Surveillance List for staff: Review of a document titled, COVID-19 Symptom and Testing Surveillance List for staff from [DATE] through [DATE] revealed sections to document staff data such as; temperatures, shortness of breath (y/n), cough (y/n), pulse oximeter reading, recent travel (y/n), hands washed and whether or not staff were employed elsewhere. However, the COVID-19 Symptom and Testing Surveillance List did not address the following areas as per the CDC: whether or not the staff member was experiencing COVID-19 symptoms including chills, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting or diarrhea. An interview was conducted on [DATE] at 10:05 a.m. with the Administrator. She stated that the IP (staff #37) was responsible for the screening logs. On [DATE] at 1:43 p.m., an interview was conducted with the IP (staff #37) and the Assistant Director of Nursing (ADON/staff #17). Staff #37 stated that she screens oncoming staff, as they report for their shifts in the morning. She stated that she came up with the screening form herself. She said that signs and symptoms would include feeling achy, fatigued or a new loss of taste or smell. She stated she did not add the additional symptoms to the screening document, because she asks about those symptoms as part of her verbal screening process. She stated that staff and residents have mandatory COVID-19 testing every week. However, she stated that it might be good to have that additional documentation included on the form. Review of the CDC guidance titled, Nursing Homes and Long-Term Care Facilities revealed that given their congregate nature and resident population served (e.g., older adults often with underlying chronic medical conditions) nursing home populations are at high risk of being affected by respiratory pathogens like COVID-19 and other pathogens, including [MEDICAL CONDITION]. The guidance stated that HCP should be screened at the beginning of their shift for fever and symptoms of COVID-19. Actively take their temperature (a fever is defined as either a measured temperature of greater than 100.0 F or a subjective fever) and document the absence of symptoms consisted with COVID-19. The CDC guidance listed the following as symptoms of COVID-19: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting and diarrhea. -Regarding the COVID Isolation Guide for residents: Review of a document titled, COVID Isolation Guide (an abbreviated surveillance line list maintained by the Director of Nursing (DON/staff#22) revealed sections to document the resident's room number, name, test date, result, when symptoms started, discontinuation of isolation date and the resident's code status. However, the COVID Isolation Guide did not included the resident's gender, whether the resident was short or long-term stay, clinical signs/symptoms (e.g., symptom onset date (mm/dd), fever (y/n), cough (y/n), myalgia (y/n), additional documented signs and symptoms including headache, shortness of breath, loss of appetite, chills, sore throat, diagnostic tests and outcomes (e.g. chest x-ray), type of specimen collected (e.g. no test performed, culture, Polymerase Chain Reaction (PCR), urine, [MEDICATION NAME] other: specify pathogen detected (e.g. negative results, bacterial, [MEDICAL CONDITION] or other) and outcome during outbreak (e.g. symptom resolution date mm/dd, hospitalized (y/n) or died (y/n). -Regarding the Respiratory Surveillance Line List for staff: A review of the respiratory surveillance line list data for staff revealed opportunities to provide a test date, staff name, date positive result was received/date put off work, positive or suspected, symptoms, return back to work date, lab company and the staff member's date of birth. However, the line list data did not included staff gender, whether employed, contracted, consulting, or volunteer, primary floor assignment, clinical signs/symptoms (e.g., symptom onset date (mm/dd), fever (y/n), cough (y/n), myalgia (y/n), additional documented signs and symptoms including headache, shortness of breath, loss of appetite, chills, sore throat, diagnostic tests and outcomes (e.g. chest x-ray) y/n, type of specimen collected (e.g. no test performed, culture, Polymerase Chain Reaction (PCR), urine) pathogen detected (e.g. negative results, bacterial, [MEDICAL CONDITION] or other and outcome during outbreak (e.g. symptom resolution date mm/dd, hospitalized (y/n) or died (y/n). On [DATE] at 1:43 p.m., an interview was conducted with the IP (staff #37) and the ADON (staff #17). Staff #17 stated that the Respiratory Surveillance Line List came from the CDC to her knowledge. However, she stated the form may have changed since this one was put out. Staff #17 stated the Administrator (staff #68) maintains the Respiratory Surveillance Line List for staff, and the Director of Nursing (DON/staff #22) maintains the COVID Isolation Guide for residents. An interview was conducted on [DATE] at 3 p.m. with staff #68 and #17. Staff #68 stated that to the best of her knowledge, she has provided all of the documentation that was requested. Review of the CDC Long Term Care Respiratory Surveillance Line List revealed a template for data collection and active monitoring of both residents and staff, during a suspected respiratory illness cluster outbreak at a nursing home or other LTC facility. Per the Surveillance Line List, this tool will provide facilities with a line listing of all individuals monitored for or meeting the case definition for the outbreak illness. Each row represents an individual resident or staff member who may have been affected by the outbreak illness. The information in the columns of the worksheet capture data which included the

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) following: the case demographics (e.g., name, age, gender of resident or staff, for residents only: Short stay (S) or Long stay (L), for staff only: whether employed, contracted, consulting or volunteer, location in the facility (e.g. for residents: building/floor/room/bed, for staff: primary floor assignment), clinical signs/symptoms (e.g. symptom onset date (mm/dd), fever (y/n), cough (y/n), myalgia (y/n), additional documented signs and symptoms including headache, shortness of breath, loss of appetite, chills, sore throat, diagnostic tests and outcomes (e.g. chest x-ray) y/n, type of specimen collected (e.g. no test performed, culture, Polymerase Chain Reaction (PCR), urine, [MEDICATION NAME]) pathogen detected (e.g. negative results, bacterial, [MEDICAL CONDITION] or other and outcome during outbreak (e.g. symptom resolution date mm/dd, hospitalized (y/n) or died (y/n). Review of the Centers for Medicare and Medicaid (CMS) Rule Toolkit for Long-Term Care Facilities revealed the facility must establish and maintain an Infection Prevention and Control Program (IPCP) designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The program must include, at a minimum, a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff and visitors. The IPCP must follow national standards and guidelines. Activities involved in program development and oversight may include but is not limited to: developing and implementing appropriate infection control policies and procedures, and training staff on them, and monitoring and documenting infections, including tracking and analyzing outbreaks of infections, as well as implementing and documenting actions to resolve related problems.