STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035070	A. BUILDING _____ B. WING _____	09/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASAS ADOBES POST ACUTE REHAB CENTER	1919 WEST MEDICAL STREET TUCSON, AZ 85704

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, clinical record review, 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 to residents and staff, including COVID-19. Findings include: Regarding new admissions An interview was conducted on September 1, 2020 at 10:50 a.m. with the Administrator (staff #174). During the interview he identified Hall 300 as the observation hall and said that a new admission is tested twice for COVID-19, usually within the first 48 hours, and if the resident tests negative both times, the resident is transferred from the observation hall to another hall. He stated that the facility is not observing new admissions for symptoms of COVID-19 for 14 days. An interview was conducted on September 1, 2020 at 2:15 p.m. with the Business Office Manager (staff #2), who stated that resident #2 was admitted on [DATE] to the observation hall and transferred to another hall on August 20, 2020, resident #3 was admitted on [DATE] to the observation hall and transferred to another hall on August 23, 2020, and resident #4 was admitted to the observation hall on August 17, 2020 and transferred to another hall on August 20, 2020. Review of facility documentation revealed resident #2 was admitted to the observation hall on August 18, 2020 and transferred from the observation hall on August 20, 2020 to another hall. Review of the COVID-19 test results for resident #2 dated August 14 and August 21, 2020 revealed the resident was negative for COVID-19. Review of facility documentation for resident #3 revealed the resident was admitted to the observation hall on August 14, 2020 and transferred to another hall on August 23, 2020. The COVID-19 test results for resident #3 were negative for specimens collected on August 14 and 16, 2020. Review of facility documentation revealed for resident #4 revealed the resident was admitted to the observation hall on August 17, 2020 and transferred from the observation hall to another hall on August 20, 2020. The COVID-19 test result for resident #4 collected July 28, 2020 with a report date of August 1, 2020 revealed a positive result. No other testing results were provided. An interview was conducted on September 1, 2020 at 4:55 p.m. with the Administrator (staff #174), who stated that he had made the decision last week to stop isolating and observing new admissions for symptoms of COVID-19. He said that the facility tests a new resident twice within the first 48 hours for COVID-19 and if the results are both negative, the resident is transferred out of the observation hall. He said that he has not received training on infection control and he thought that [MEDICAL CONDITION] has an incubation period of a few days. Review of the facility's Infection Control and Prevention Policy, Emerging Infectious Disease: Coronavirus Disease 2019 (COVID-19), revised May 4, 2020, revealed the goal is to implement recommended appropriate infection control strategies, guidance and standards from the local, State and Federal agencies for an emerging infectious disease event. It is the policy of the facility to include preparatory plans and actions to respond to the threat of COVID-19, including but not limited to infection prevention and control practices in order to prevent transmission, including the observation of new admissions for 14 days. Review of the facility's New Admission/COVID-19 Placement policy, not dated, revealed new admissions are admitted to Hall 300, which is the designated new admission unit. Residents are tested twice for COVID-19 (at least 24 hours apart), and if both tests come back negative, the resident is discontinued from isolation precautions, and transferred to Hall 200 or other long-term care hall. If a resident test positive, the resident is transferred to the COVID unit. COVID recovered new admissions are tested twice for COVID-19 (at least 24 hours apart), and if both tests come back negative, the resident is discontinued from isolation precautions and transferred to Hall 200 or other long-term care hall. If a resident test positive, the resident is transferred to the COVID unit. The CDC Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19 dated May 8, 2020 states facilities should consider how to manage new admissions or readmissions when COVID-19 status is unknown. Options may include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. Residents could be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their exposure or (admission). Testing at the end of this period could be considered to increase certainty that the resident is not infected. The CDC Preparing for COVID-19 in Nursing Homes dated June 25, 2020 revealed residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms of COVID-19 for 14 days after their admission. Testing at the end of this period can be considered to increase certainty that the resident is not infected. The CDC Clinical Questions about COVID-19: Questions and Answers updated August 4, 2020 revealed to ensure a patient was not exposed and might subsequently develop [DIAGNOSES REDACTED]-CoV-2 infection, nursing homes should place the patient transferred from the hospital who is not known to have [DIAGNOSES REDACTED]-CoV-2 infection in transmission-based precautions in a separate observation area or in a single-person room for 14 days after admission. The CDC Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19) updated September 10, 2020 states the incubation period for COVID-19 is thought to extend to 14 days, with a median time of 4 to 5 days from exposure to symptoms onset. One study reported that 97.5% of persons with COVID-19 who develop symptoms will do so within 11.5 days of [DIAGNOSES REDACTED]-CoV-1 infection. Regarding hand hygiene and equipment On September 1, 2020 at 3:00 p.m., a certified nursing assistant in training (staff #181) was observed taking the blood pressure, oxygen level, and temperature of residents residing in 6 rooms on hall 400. Staff #181 was observed donning and doffing gloves between residents without sanitizing her hands and without sanitizing the blood pressure cuff and oximeter. She said she had received training on personal protective equipment (PPE) and knew she was supposed to sanitize her hands before donning and doffing gloves and that she had not done that. She stated that she had received training on disinfecting the blood pressure cuff and oximeter when working on the COVID unit. Staff #181 stated she was trained to disinfect the equipment after each resident to prevent the spread of the COVID-19 virus. Staff #181 stated she was not sure what she was supposed to do on Hall 400 since none of the residents had COVID-19. Review of staff #181's training documentation revealed she received training on hand sanitizing, PPE, and taking vital signs on August 21, 2020. An interview was conducted on September 1, 2020 at 5:05 p.m. with the Director of Nursing (DON/staff #173), who stated it was her expectation that staff sanitize their hands before donning and after doffing gloves. She said hand hygiene training is provided to all staff and the reason for hand hygiene is to prevent the spread of infection. The DON stated if staff are not sanitizing their hands before donning gloves and after doffing gloves, it increases the risk of infection. She also said that staff are trained to disinfect medical equipment between residents. The DON stated it was her expectation that staff disinfect the blood pressure cuff and oximeter between residents to prevent the spread of infection. Review of the facility's Infection Control and Prevention Policy, Emerging Infectious Disease: Coronavirus Disease 2019 (COVID-19), revised May 4, 2020, states standard precautions assume that every person is potentially infected or colonized with a pathogen that could be transmitted in the healthcare setting. HCP (healthcare personnel) should perform hand hygiene before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process. The facility's Infection Control, General Cleaning and Maintenance of Equipment policy reviewed August 2018, states all resident care equipment will

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) be cleaned and decontaminated after use and to follow the manufacturer's instructions. The CDC Hand Hygiene in Healthcare Setting for Healthcare Providers last reviewed January 31, 2020 states to perform hand hygiene prior to donning gloves and to perform hand hygiene immediately after removing gloves. The CDC Infection Prevention and Assessment Tool for Nursing Homes Preparing for COVID-19 dated May 8, 2020 states shared equipment like blood pressure cuffs/machines need to be cleaned and disinfected after each use. Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease (COVID-19) Pandemic updated July 15, 2020 revealed all non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to the manufacturer's instructions and facility policies. The guidance included HCP should perform hand hygiene before putting on and after removing PPE, including gloves. The CDC guidelines for Using PPE updated August 19, 2020 included performing hand hygiene before donning PPE and after doffing PPE. Regarding soiled linen During an observation conducted on Hall 400 on September 1, 2020 at 4:25 p.m., a Certified Nursing Assistant (CNA/staff #120) was observed carrying soiled linens in his hands from a resident's room into the hallway. The CNA was not observed to be wearing gloves and the soiled linens were not in a bag. The CNA was holding the linens against his torso and upper arms. An interview was immediately conducted with the CNA, who stated that he had just changed the bed linens in the resident's room and that holding the soiled linens against his torso and arms would probably contaminate his clothing and arm. He said soiled linens were supposed to go into a plastic bag, but that there were no plastic bags in the resident's room. The CNA said that he probably received training on disposing of soiled linens when he was in school, but did not remember. The CNA then returned to the resident's room, placed the soiled linens on the floor, and went to look for a plastic bag. When he returned, he put the soiled linens in a clear plastic bag and took it to the soiled utility room. He left the room without sanitizing the floor. He stated that he did not know if he could or could not put soiled linens on the floor, but it could probably cause contamination. During an interview conducted on September 1, 2020 at 5:05 p.m. with the DON (staff #173), the DON said staff are to put soiled linens into a plastic bag prior to leaving the resident's room. She said staff should not hold dirty linens close to the body or place soiled linens on the floor because the contact can spread an infection. Review of the facility's policy for laundry reviewed May 2017, states soiled linen should not come into contact with the floor or furniture and do not hold linen against the uniform when transporting. Review of the facility's Infection Control and Prevention Policy, Emerging Infectious Disease: Coronavirus Disease 2019 (COVID-19), revised May 4, 2020, states management of laundry should be performed in accordance with routine procedures. The CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel during the Coronavirus Disease 2019 (COVID-19) Pandemic updated July 15, 2020 states management of laundry should be performed in accordance with routine procedures. Regarding isolation gowns During an interview conducted on September 1, 2020 at 10:50 a.m. on Hall 400 with the Administrator (staff #174) and the DON (staff #173), two gowns were observed hanging on hooks with the label CNA above each hook in a resident's room on isolation for [MEDICAL CONDITION] (Clostridioides difficile) infection. Staff #173 was unable to say how each CNA identified his or her gown. Staff #174 said that would be a question for the CNAs. Staff #173 acknowledged that it was possible for the CNAs to use the wrong gown which could cause contamination. Staff #173 said the staff is supposed to use the same gown for the entire shift and then the gown goes to the laundry to be washed. In an interview conducted with the DON (staff #173) on September 1, 2020 at 2:40 p.m., the DON stated that she and the wound nurse were the acting Infection Control Preventionists. She said that she had begun changing the process for storing gowns in the residents' rooms that are on isolation. The DON stated that the CNAs would continue to hang their gowns on a hook in the resident's room, but the labels for the gowns would be changed to CNA1 and CNA2. She stated that the CNA assigned to the room would use the hook labeled CNA1 and if the another CNA was needed to assist the resident, the second CNA would hang his or her gown in the room on the hook labeled CNA2. An interview was conducted on the observation hall 300 on September 2, 2020 at 10:45 a.m. with a CNA (staff #160). She stated that she has always tried to hang her gown under the CNA label located closest to the door. She said that before today, she would just tell the other CNA where she hung her gown in each resident's room, so they kind of knew which gown were theirs. The CNA stated it was possible to become confused and use the wrong gown. She said that the process was changed today and that she is now supposed to hang her gown on the hook labeled CNA1 if she is assigned to that resident's room and CNA2 if another CNA is assigned to the resident's room. The facility's policy Personal Protective Equipment: Conservation During Crisis or Pandemic Policy, revised March 23, 2020, states re-use is defined as the practice of using the same piece of protective equipment by one health care worker for multiple encounters with different patients or the same patient, but removing it after each encounter, then reapplying for the next encounter. The CDC Strategies for Optimizing the Supply of Isolation Gowns updated March 17, 2020 regarding the extended use of isolation gowns revealed that for the care of patients with suspected or confirmed COVID-19, HCP risk from re-use of cloth isolation gowns without laundering among multiple HCP sharing one gown is unclear. The goal of this strategy is to minimize exposures to HCP and not necessarily prevent transmission between patients. The guidance included care should be taken to ensure that HCP do not touch outer surfaces of cloth gown during care. Cloth isolation gowns could potentially be untied and retied and could be considered for re-use without laundering in between. The CDC 2007 guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings updated July 2019 revealed isolation gowns used as PPE may become contaminated with potential pathogens after care of a patient colonized or infected with [MEDICAL CONDITION].