STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035132	A. BUILDING _____ B. WING _____	07/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CORONADO HEALTHCARE CENTER	11411 NORTH 19TH AVE PHOENIX, AZ 85029

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 observation, interview, and record review the facility failed to implement and maintain standard infection control practices related to donning and doffing PPE (personal protective equipment) intended to prevent facility transmission of COVID-19. The facility failed to sanitize and store blood sugar testing equipment to prevent cross contamination and potential transmission of blood borne illness. These failures placed residents on the non-COVID units at risk for infections. Findings include; During the entrance interview on 7/10/20 at 8:15 AM the facility administrator and DON (Director of Nursing) said the facility experienced an outbreak of COVID-19. The administrator reported the facility established a separate COVID unit and designated an area of the facility to quarantine residents with unknown COVID-19 status including all new admissions or readmissions for 14 days. The units have dedicated staff and are physically separate from the remainder of the building. The administrator reported all residents were on droplet precautions due to a County public health requirement implemented this week. The administrator said the facility is accepting admissions but does not plan to accept residents for admission who are known positive for COVID-19. During observation of care on 7/10/20 at 10:00 AM, reusable washable gowns hung on hooks just inside the room. Two were label A and two were labeled B. Nursing assistants (NAC1 and NAC2) wore masks and goggles. They donned gowns marked A bed and gloves as they entered room [ROOM NUMBER]. The two NACs assisted resident (R1) onto the bedpan. While R1 was on the bedpan, NAC2 emptied the urinal in the resident bathroom. Upon exiting the bathroom, NAC2 held the urinal in one hand and with the other hand, removed the trash bag that lined the trash can and placed the bag with trash on the floor. NAC2 said extra plastic bags could be found at the bottom of the trash can. NAC2 reached into the trash can and obtained a plastic bag which she fanned out then placed the urinal in the plastic bag and placed it at the bedside. NAC2 returned the trash bag with trash to the trash can. NAC2 removed her gloves and washed her hands with soap and water. NAC2 reached her right hand under her gown to get gloves out of her pocket which she then donned. When asked if the plastic bag she obtained from the trash can would be considered clean or dirty; NAC2 said Well the trash can was dirty, but the plastic bag at the bottom of the can had not been used yet. NAC1 provided incontinent care for R1. NAC1's gown was not tied at the neck. During care, NAC1 leaned over the bed. The gown fell off his right shoulder exposing his arm and upper right chest area. After cleansing R1's skin of bowel movement, NAC1 removed the soiled linen from the bed then removed his soiled gloves and donned clean gloves. NAC1 did not perform hand hygiene after removing the soiled gloves and before donning clean gloves. After completion of care, NAC2 removed the gown first and hung it on the hook, then removed the soiled gloves. NAC2 potentially contaminated the gown by removing it with soiled gloves. On 7/10/20 at 10:30 AM, licensed nurse (LN1) donned gloves while standing at the medication cart in the corridor. LN1 carried supplies to perform a blood glucose test into room [ROOM NUMBER]. LN1 placed the glucometer (device to measure glucose level in the blood) on the bedside table with no barrier. The fingerstick (prick finger to obtain a drop of blood) supplies were in a plastic cup which served as a barrier. LN1 donned a gown that hung on a hook labeled bed A. LN1 did not tie the neck tie on the gown. When LN1 leaned over R2's bed to perform a fingerstick, the gown fell forward. LN1 reached up and readjusted the gown wearing the gloves used to perform the fingerstick. LN1 held the glucometer up to the blood drop on R2's finger. The glucometer indicated an error. LN1 removed the gloves, then the gown and hung the gown on the hook. LN1 returned to the medication cart located in the corridor outside room [ROOM NUMBER] where she performed hand sanitization with ABHR (Alcohol based hand rub). LN1 obtained new lancet and test strip which she placed in a clean plastic cup. LN1 returned to room [ROOM NUMBER] and donned gown and gloves. LN1 performed the glucose test then placed the glucometer which still held the test strip with blood on the bedside table with no barrier. LN1 again doffed the gloves and gown, performed hand hygiene with ABHR, and returned to the cart where she prepared insulin in a syringe. LN1 wore gloves at the medication cart which she wore into room [ROOM NUMBER] then donned a gown. LN1 gave R2 the insulin injection then doffed gloves and gown, picked up the glucometer using a paper towel as a barrier to carry it to the medication cart. LN1 sanitized her hands at the medication cart then sanitized the glucometer using bleach wipes. On 7/10/20 at 10:55 AM LN2 requested NAC2 to obtain a pulse (heart rate) for R3 for medication administration. NAC2 entered room [ROOM NUMBER]. NAC2 wore a mask and goggles and donned gloves but no gown when entering the resident room. NAC2 obtained R3's pulse. NAC2 reported the pulse to be 38. LN1 requested NAC2 to recheck the pulse. NAC2 again entered room [ROOM NUMBER] without donning a gown. Immediately following the observation, LN2 and NAC2 were interviewed and asked if a gown was required to enter a resident room to check a pulse on a resident. NAC2 said a gown was required only for care, I thought only for care. When asked if checking a pulse was considered resident care, NAC2 said she did not know. LN2 said she wore a gown every time she entered a president's room because all residents were on droplet precautions. LN2 said NAC2 should wear a gown when checking vital signs such as a pulse check. On 7/10/20 at 11:35 AM, LN3 entered room [ROOM NUMBER] to give medications. At the threshold, LN3 obtained a gown that hung on a hook near the door. LN3 first tied the neck ties, then pulled the neck of the gown over her head. LN3 donned gloves then entered the room. LN3 doffed PPE correctly when exiting the room. At 11:38 AM LN3 prepared supplies to perform a blood glucose test and also prepared a syringe of insulin and oral medications. LN3 entered room [ROOM NUMBER]B. LN3 again tied the gown neck ties before donning the gown which resulted in fanning of the gown in the room. LN3 performed the blood glucose test on R4 then put the glucometer in her pocket. LN3 doffed the PPE and returned to the medication cart. LN3 removed the glucometer form her pocket and placed it directly into the top drawer of the medication cart. During an interview immediately conducted at the medication cart, LN3 was asked: Was that the glucometer you just put in the drawer? LN3 responded, Oh boy, I forgot to clean it. LN3 opened the drawer to reveal a separate basket/bin containing two glucometers and a few lancets and alcohol wipes. LN3 immediately removed the two glucometers and wrapped them in bleach wipes, then discarded the lancets and alcohol wipes and sanitized the bin. LN3 said the glucometers were shared devices intended for use with multiple residents however at this time R4 was the only resident who required blood glucose testing on the unit. This was verified through record review. On 7/10/20 at 2:40 PM during observation of care on the 200 hall, NAC3 stood at the doorway of 202. NAC3 said R5's call light was on. NAC3 wore a face mask and goggles. NAC first donned gloves. Next, NAC3 obtained a gown from a hook just inside the room. The gown was tied at the neck and NAC3 struggled to pull the tied gown over her head. NAC3 returned to the doorway and stated R5 desired fresh ice water. NAC3 doffed the gloves and then the gown. NAC3 pulled the gown down over and off her arms which resulted in the gown being turned completely inside out. NAC3 hung the gown back on the hook, used ABHR and exited the room. NAC3 returned in a few minutes with the ice water. NAC3 set the ice water on a table just inside the room. NAC3 donned gloves and prepared to don the gown when the DON (Director of Nursing) was walking past. The DON stopped and cued NAC3 to remove the gloves and don the gown first. NAC3 said she knew how to put on PPE. The DON cued NAC3 several times to remove the gloves and don the gown first. NAC3 attempted to don the gown and DON cued NAC3 to untie the neck ties first. NAC3 donned the gown however it was on inside out. NAC3 then donned gloves to enter the room. Surveyor stopped NAC3 and questioned if the gown was on inside out. NAC3 responded Oh, I did not notice. The DON instructed NAC3 to use the other gown that hung in the room and discard the contaminated gown when she finished in the room. Following the observation, the DON stated all staff were trained and

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
	035132	A. BUILDING _____ B. WING _____	**07/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CORONADO HEALTHCARE CENTER	**11411 NORTH 19TH AVE PHOENIX, AZ 85029**

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) checked off regarding donning and doffing PPE. The DON stated he did not recognize CNA3 and would check on her. The DON later reported CNA3 was temporary agency staff and new to the facility. The DON said the agency staff are supposed to be trained in the use of PPE. In an interview on 7/10/20 at 3:00 PM LN4 said she was the facility infection preventionist (IP). IP said the facility followed CDC guidelines. IP said all staff were trained how to don and doff PPE. The facility currently practiced extended use and re-use of PPE to preserve PPE for the COVID and quarantine units. All staff wore N95 masks and face shield or goggles every day. N95 masks were used for 5 days unless damaged or soiled and each staff had a face shield or goggle which were sanitized and re-used per CDC guidelines. Disposable gowns were used on the COVID unit with reusable washable gowns on the other units. IP said each room had two gown hooks for each bed; one for the LN and one for the nursing assistant assigned to that room. The gowns were changed out every shift. IP correctly stated the CDC guidelines for re-use of gowns: 1 gown used by 1 staff for 1 resident. The signage posted throughout the facility directing how to don and doff PPE was consistent with CDC guidelines. When informed of the observation conducted at 10:00 when NAC1 and NAC2 each wore a bed A gown to provide care to the resident in bed A, IP said if two NACs were required to provide the care, one NAC should have used a disposable gown and not the gown designated for the LN. IP stated staff should not reach under the isolation gown to access pockets. When informed about the observation of the blood glucose testing, IP stated the glucometers should not be carried in pockets, should be sanitized immediately after use, and a barrier should be placed to protect surfaces from potential blood contamination by the glucometer, used lancets or used test strips. The CDC guidance for glucometers: Recommended Practices for Preventing Blood borne Pathogen Transmission during Blood Glucose Monitoring and Insulin Administration in Healthcare Settings Blood Glucose Meters *Whenever possible, blood glucose meters should be assigned to an individual person and not be shared. *If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared. General *Unused supplies and medications should be maintained in clean areas separate from used supplies and equipment (e.g., glucose meters). Do not carry supplies and medications in pockets. Regarding donning and doffing of PPE. IP said she provided staff training reminders as recently as 7/9/20 and provided documentation. The document titled Infection Control In-serviced 7/9/20 read in part; Hand Hygiene before/after caring for a patient, any time you remove gloves, whenever soiled. *No gloves in hallway *perform after touching mask. Contact Droplet Precautions:* hang gowns on available hooks. Staff will use set gown for A bed and B beds switch if soiled, contaminated, as needed, every 12 hr. shift. Wear masks/goggles at all times. Donning *don't tie the neck before donning gown *don gown then gloves *Gowns must be tied at neck and waist. Doffing *remove from most dirty to least dirty: remove gloves then gown, wash hands *hang gown on hook. Glucometers: Clean after EACH use with bleach wipes. * Contact time = 30 seconds *Do not put dirty glucometer directly on the cart. In a final interview on 7/10/20 at 4:30 PM, the DNS stated the described observed practices were not acceptable and added education and training was ongoing with all staff regarding infection control. The DON stated staff should wear all PPE to check a resident's vital signs and said he was unaware that staff used the etra trash bags in the trash cans, they were considered contaminated once placed in the trash can.