STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035092	A. BUILDING _____ B. WING _____	07/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BELLA VITA HEALTH AND REHABILITATION CENTER	5125 NORTH 58TH AVENUE GLENDALE, AZ 85301

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, interviews, and record review the facility failed to implement and maintain standard infection control practices and CDC guidelines related to the use and doffing of PPE (personal protective equipment), hand hygiene, use of barriers and/or sanitization to prevent cross contamination, and transport of soiled linens. These failures placed residents on the non-COVID units at risk for exposure to infectious organisms and potential infections. Findings include: During the entrance interview on 7/9/20 at 9:45 AM the administrator and Director of Nursing (DON) reported the facility had a dedicated COVID unit and a unit for COVID status unknown for new and readmissions quarantine on the 300 halls. The units were physically separated from the rest of the building and had dedicated staff. The facility currently had 16 COVID positive residents who were admitted known positive and 18 residents on quarantine with COVID status undetermined. The administrator stated all residents house wide were maintained on droplet precautions per county directive and all staff wore N95 masks and eye protection. Hand hygiene, gown, and glove use On 7/9/20 at 10:30 AM, observational tour of the non-COVID units revealed two gowns hung on the outside of the resident room doors and were labeled bed A and bed B. With few exceptions, the resident room doors were closed. At 12:12 PM during observation of the lunch meal nursing assistant (NAC1) wore a facemask and goggles, she took a gown off a room [ROOM NUMBER] hook and donned the gown then gloves. Licensed nurse (LN1) stood at the threshold and handed NAC1 a lunch meal. NAC1 delivered the lunch meal to resident (R2) in bed B. Without changing the gown or gloves and with no hand hygiene, NAC1 delivered a meal to R1 in bed A. NAC1 did not offer or provide hand hygiene to the residents prior to eating. NAC1 took a urinal from R1 and emptied it in the toilet. When NAC1 came out of the bathroom, R2 had the nurse call light on. While still holding R1's urinal, NAC1 went to R2's bedside. NAC1 spoke with R2, turned off the call light and returned the urinal to R1. NAC1 did not change gloves or perform hand hygiene after handling R1's urinal and before entering R2's bedside space and handling R2's call light. When leaving the room, NAC1 removed the gloves but did not perform hand hygiene before removing the gown. At 12:20 PM NAC1 donned a gown and gloves then delivered the lunch meal to R9. R9 wore a face mask. NAC1 removed R9's facemask touching both the inside and outside of the face mask. NAC1 folded it in half with the outside of the mask out. NAC1 did not place a barrier to prevent contamination of the table by the face mask. NAC1 placed the folded face mask on the table next to the dinner plate. NAC1 did not change gloves or perform hand hygiene after handling the face mask. NAC1 proceeded to prepare R9's meal handling the drinking straw, drink glasses, and eating utensils while wearing the gloves contaminated by the face mask. NAC1 did not offer and did not provide hand hygiene to R9 before she ate. NAC1 removed gloves but did not perform hand hygiene before removing the gown. NAC1 used alcohol hand sanitizer after removing the gown. On 7/9/20 from 2:10 to 2:25 PM NAC3 measured resident vital signs on the non-COVID 500 hall. NAC3 placed supplies on a wheeled over bed table. Supplies included a spray bottle with clear solution, a blue plastic basket that held a blood pressure cuff, a stethoscope, and a thermos scanner thermometer. NAC3 donned a gown and gloves then wheeled the over bed table into room [ROOM NUMBER]. NAC3 placed the blue basket on R5's bedside table. NAC3 did not first sanitize or disinfect the bedside table and did not place a barrier on the table. NAC3 obtained R5's vital signs then returned the blue basket to the wheeled table. NAC used the spray bottle to spray the vital sign equipment she used. NAC did not sanitize the basket. NAC removed the gloves but did not perform hand hygiene before donning clean gloves. NAC3 wheeled the table to bed B and obtained R6's vital signs. NAC3 was observed to adjust her face mask three times while providing care in room [ROOM NUMBER]. NAC3 did not change gloves or perform hand hygiene after touching her face mask three different times. When leaving the room; NAC3 removed gloves but did not perform hand hygiene before removing the gown and performed hand hygiene after removing the gown. NAC3 wheeled the table with the vital sign supplies into the hall. NAC3 did not sanitize the table or basket and proceeded to another resident room. On 7/9/20 at 4:15 PM on the quarantine unit NAC5 donned 1 of 2 gowns that hung on the door of resident room [ROOM NUMBER]. The census provided by the facility indicated the residents in the room (R7 and R8) were on quarantine with unknown COVID-19 status. The facility infection control records showed R7 had a sample collected for COVID-19 testing collected on 6/30/20 with results pending and no symptoms of COVID-19. R8 had a sample collected on 7/3/20 with result pending and no symptoms of COVID-19. NAC5 entered the room to answer R7's call light. NAC5 provided care to R7 then without changing gloves or gown and with no hand hygiene NAC5 went to R8's bedside. At the threshold, NAC5 removed the gown first and then the gloves potentially contaminating the gown. NAC5 used ABHR (alcohol based hand rub) for hand hygiene after doffing PPE. NAC5 was interviewed immediately after exiting room [ROOM NUMBER]. When asked about the two gowns hanging on the door, NAC5 said the gowns were required to enter the room due to droplet precautions isolation. NAC5 said the gown closest to the door knob was for bed A and the other gown was for bed B. NAC5 said you wear the correct gown to provide care. NAC5 acknowledged he went into R8-bed B's space wearing the gown for R7-bed A's space. NAC5 said; But I only did it to check on him, it takes time to change gowns. When asked what distance must be maintained for social distancing to prevent spread of COVID-19, NAC5 said 6 feet. NAC5 added he got close to R8 but did not touch anything. Soiled Linen handling On 7/9/20 at 2:35 PM two environmental services staff (EVS1 and EVS2) pushed a large wheeled open bin-type cart filed with isolation gowns through the 500 hall. The 500 hall was a non-COVID unit. When interviewed; EVS2 said the soiled linens in the tub were the gowns the dayshift nursing staff used for droplet precautions. EVS2 said the gowns were changed out with clean gowns provided every shift. EVS2 said they were taking the gowns to the laundry to be washed so they could be used again. When asked about the process for transporting soiled linen through the facility, specifically if the soiled linen should be covered. EVS2 immediately responded; Oh yes, I will get a blanket now, sorry. EVS2 obtained a clean blanket and covered the soiled linen. During observation in the laundry room on 7/9/20 at 2:50 PM EVS3 said she supervised staff who worked in the laundry. EVS3 said the facility laundered the gowns used for droplet precautions after every shift. EVS3 said EVS 1 and EVS2 reported to her that they forgot to cover soiled the soiled linen during transport through the building. EVS confirmed it was a facility expectation that soiled linen be covered during storage and transport. EVS3 said she reminded EVS1 and EVS2 of the expectations. In an interview on 7/9/20 at 3:00 PM with the DON and the facility Infection Preventionist (IP), the DON stated all residents on all units were on droplet precautions. The IP said disposable PPE was used on the COVID unit and re-usable washable gowns were used on the non-COVID units. DON said the re-usable cloth gowns were used to preserve disposable supplies for the COVID unit. When informed about observations of inconsistent order of doffing PPE, the DON stated the order for doffing was: gloves-hand hygiene-gown-then hand hygiene and the mask and goggles stay on. The IP showed an instruction sheet that was posted in various location throughout the facility that read: Doffing PPE 1. Remove gloves 2. Hand hygiene 3. Gown, untie all ties and place on hook with clean side towards hallway 4. HCP (health care personnel) may now exit patient room. 5. Hand hygiene 6. Remove face shield/goggles (may be left on) 7. Hand hygiene and a notation; whenever touch goggles or facemask- perform hand hygiene. The procedures stated above are consistent with CDC guidelines. When asked about the gowns hanging on the outside of the resident room doors, the IP said the practice was approved by the county PHS and the CDC. Documentation was requested. The facility provided an email from Maricopa County (PHS) that read: For a facility that has the entire facility on contact droplet precautions and residents restricted 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) their rooms, it is permissible to hang the gown outside the door. 1 gown to be used by 1 staff to care for 1 resident. The gown with the staff name labelled, can be hung outside the door, provided the hallway is clear, no residents are walking the hall way, the gown is not in anyone's way and no one is touching the gown, except the staff who dons and doffs that gown. The facility reported a response from Dr. NS at CDC who reported there was no specific guidance on where to store the gowns. Depending upon the space and facility layout, you can hang the gowns inside or outside as space and situation allows. When informed the gowns were not labelled with the staff person's name. The DON said nursing assistant were assigned to specific residents so there should not be shared use of the gowns. When asked what staff do if the resident required two nursing assistants to provide care. The DON said the second NAC would wear a disposable gown. The IP said staff on the COVID Unit use disposable PPE. The DON and IP concurred that improper doffing of extended use PPE could result in contamination with potential for transmission of COVID-19. The IP said all care-giving staff were trained on facility policy and procedure and how to use PPE including donning and doffing. The IP said the procedures for extended use of gowns and donning and doffing would be reviewed with the staff. Regarding the observations of no barrier used when used facemask was placed on a resident's table and no barrier or sanitization of shared vital sign equipment and the wheeled table used to transport supplies. The DON said a barrier should have been used to prevent cross contamination and the entire wheeled table and basket should have been sanitized when leaving a resident room or better practice was to leave unnecessary table and supplies outside of the room. The CDC: Disinfection and sterilization guidelines included: 4.d. If dedicated, disposable devices are not available, disinfect noncritical patient-care equipment after using it on a patient who is on contact precautions before using this equipment on another patient.