STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035275	A. BUILDING _____ B. WING _____	07/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVANCED HEALTH CARE OF GLENDALE	16825 NORTH 63RD AVENUE GLENDALE, AZ 85306

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, staff interviews, facility documentation, review of the Centers 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: An entrance conference was conducted on July 23, 2020 at 8:21 a.m., with the Clinical Nurse Manager (Licensed Practical nurse/LPN/staff #20) and the Minimum Data Set (MDS) nurse (LPN/staff #11). Both staff members stated that currently there were no COVID-19 positive residents in the building. They stated the current census was 25 residents. Review of the facility map and census information provided by the facility indicated there were three residents who were tested for COVID-19, one resident was on hallway #1 and two residents were on hallway #2. During an interview with the Infection Preventionist (staff #22) on July 23, 2020, she stated there were three residents that are currently being ruled out for COVID-19 and results are pending, and they should have the results this afternoon or tomorrow morning. She stated that all residents in the building are on quarantine isolation and strict contact isolation is followed, when staff are providing direct patient care. She also stated that 14 staff had tested positive for COVID-19 in July 2020. An observation was conducted on hallway #1 on July 23, 2020 at 9:16 a.m. A registered nurse (RN/staff #44) was standing in the hallway outside of a resident's room. Staff #44 was wearing a mask, goggles, a lab coat and gloves. Staff #44 then entered the resident's room without applying a gown over her lab coat. Once inside the room, the nurse did not don a gown and administered medication to the resident. An interview was conducted with staff #44 on July 23, 2020 at 9:22 a.m. She stated that she had received training on infection control procedures. She stated the training started in March and has been ongoing. She said when entering a resident's room, the Personal Protective Equipment (PPE) that should be applied depends on the type of isolation they are one. She said that she has been instructed that gowns are only needed when providing direct patient care, which means direct contact. An interview was conducted with a CNA (staff #1) on July 23, 2020 at 11:42 a.m. She stated that today she is working on hallway #2 and there are currently two residents that are under suspicion of having COVID-19. She stated they do not move residents to the COVID unit, until they test positive. Staff #1 further stated that she has been instructed to wear a mask, face shield and gown while in the hallways. She stated that if she plans on having direct resident contact, she has been instructed to don gloves and use either a disposable gown or a gown assigned to the resident. An interview was conducted with the Infection Preventionist (LPN/staff #22) on July 23, 2020 at 2:14 p.m. She stated that residents are admitted to the facility 72 hours after a negative result. She stated that the facility will request two negative results if the resident was positive at any time. She stated that during the initial quarantine period which is 14 days from admission, there is strict PPE adherence. Staff #22 stated that positive residents are placed in the COVID unit and transferred out to COVID facilities as soon as possible. She stated that all staff had one-to-one training on PPE and their policies. She further stated that staff are required to wear masks, face shields, and gowns when in the facility at all times. She said they don them when they enter the facility. She also stated that each resident has a designated gown that staff don when they enter a resident's room. She stated that gloves are to be worn when providing direct resident contact. -An observation was conducted on hallway #2 on July 23, 2020 at 9:29 a.m. A Certified Nursing Assistant (CNA/staff #1) removed a yellow bag liner from a bin that contained contaminated gowns. The CNA was not wearing any gloves, a gown or face shield/goggles. At this time, an interview was conducted with staff #1. She stated the reason she was not wearing gloves was because she didn't have any. Another interview was conducted with staff #1 on July 23, 2020 at 11:42 a.m. She said that she had received infection control training from the Infection Preventionist. She said that she should not have touched the yellow bag without gloves. Further observations on hallway #2 revealed there were multiple boxes of gloves and additional PPE available throughout the unit. -An observation was conducted of a medication cart on hallway #2 on July 23, 2020 at 9:32 a.m. At this time, there was an oxygen pulse oximeter that was lying on top of the cart without a barrier. An interview was conducted with a CNA (staff #40) on July 23, 2020 at 9:40 a.m. in hallway #2. She stated the oxygen pulse oximeter's are sometimes shared between residents because there are not enough to go around. She said that each pulse oximeter is sanitized in-between each resident and then stored in the storage area. She stated the pulse oximeter is wiped down with sanitizer wipes with a 5 minute dry time. At this time, an interview was conducted with a case manager (LPN/staff #10) whose medication cart had the oxygen pulse oximeter on top of the cart. The nurse stated that the CNA's leave the pulse oximeter on the cart after they use it, but she does not know the cleaning process for that piece of equipment. An interview was conducted with the Infection Preventionist (staff #22) on July 23, 2020 at 2:14 p.m. She stated that no one should have to share pulse oximeter equipment. She stated all staff have been trained on cleaning procedures, but some of the staff covering (staff #10) received the training some time ago. She stated that all staff should know the dry time of the cleaning products. According to an email from the Administrator received on July 23, 2020 at 8:00 p.m., two of the residents tested were positive for COVID-19. Both residents resided on hallway #2. An interview was conducted with the Infection Preventionist (staff #22) on July 24, 2020 at 12:40 p.m. Staff #22 stated that over the last 10 days, 9 residents have tested positive for COVID-19. She stated the majority of them have been on hallway #2. She stated the facility has been attempting to isolate the cause of the contamination with increased monitoring and education. She stated that two of the residents had been in the facility for more than 72 hours. She said this could suggest that it was facility acquired. She stated that all residents were tested on [DATE]. An interview was conducted with the Administrator and the Director of Nursing (DON/staff #30) telephonically on July 24, 2020 at 2:16 p.m. The DON stated it is their expectation that all staff continue with a heightened level of infection control. She stated she feels there are areas where some procedures need improved focus after the increased positives results for residents and staff. She stated that all staff need to follow the policies and the monitoring of practices needs to be increased. She said it is important to have all of the management team on the same page to prevent this type of outbreak of COVID again. She stated that in the future, tightening up procedures and moving residents more swiftly will help to decrease the risk of exposure. During the interview, the Administrator stated there was a lack of rigid processes and thinking that the facility was out of the woods when a resident tested negative. He stated in the past we wanted to save PPE equipment so there would not be a shortage. He stated that having tight restrictions on PPE seemed to be the wrong path. He said there are many resources available to us with the county health department and sister facilities. A facility policy titled, Soiled Laundry & Linen Handling included that the purpose of this procedure is to provide a process for the safe and aseptic handling, washing, and storage of linen. Staff should consider all soiled linen to be potentially infectious. A facility policy titled, Soiled Laundry & Bedding revealed that soiled laundry/bedding shall be handled in a manner that prevents gross microbial contamination of the air and person handling the linen. Anyone who handles soiled laundry must wear protective gloves and other appropriate protective equipment (e.g. gowns if soiling of clothing is likely; protective eye wear, mask as needed). Review of a policy regarding COVID-19 Emergency Plan revealed that if equipment is utilized for multiple patients, it should be disinfected using an EPA-registered disinfectant for healthcare settings prior to use on another patient. The facility will have proper

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) adherence to currently recommended infection control practices. All recommended PPE should protect staff having prolonged close contact with patients infected with COVID-19 A policy titled, COVID-19 stated that in accordance with an executive order of April 8, 2020, the facility implements the following policy guidelines effective April 9, 2020: The facility shall immediately comply with all infection control guidance from the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC), including ensuring all staff use appropriate PPE when interacting with residents, per CDC guidelines. Review of the Centers for Disease Control and Prevention Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) during the Coronavirus Disease Pandemic dated July 15, 2020, revealed that residents with known or suspected COVID-19 should be cared for using all recommended PPE, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face) gloves and gown. Because of the higher risk of unrecognized infection among residents, universal use of all recommended PPE for the care of all residents on the affected unit (or facility-wide depending on the situation) is recommended when even a single case among residents or healthcare personnel is newly identified in the facility. This could also be considered when there is sustained transmission in the community. HCP working in facilities located in areas with moderate to substantial community transmission are more likely to encounter asymptomatic or pre-symptomatic patients with [DIAGNOSES REDACTED]-CoV-2 infection. If [DIAGNOSES REDACTED]-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP should follow Standard Precautions (and Transmission-Based Precautions if required based on the suspected diagnosis). They should also wear eye protection in addition to their facemask to ensure the eyes, nose, and mouth are all protected from exposure to respiratory secretions during patient care encounters. For HCP working in areas with minimal to no community transmission, HCP should continue to adhere to Standard and Transmission-Based Precautions, including use of eye protection and/or an N95 or equivalent or higher-level respirator based on anticipated exposures and suspected or confirmed diagnoses. Universal use of a facemask for source control is recommended for HCP.