

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>035154</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>07/09/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>PROVIDENCE PLACE AT GLENCROFT</b>		STREET ADDRESS, CITY, STATE, ZIP <b>8641 NORTH 67TH AVE GLENDALE, AZ 85302</b>	
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 0812  <b>Level of harm - Immediate jeopardy</b>  <b>Residents Affected - Some</b>	<p><b>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</b></p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b></p> <p>Based on observation, interview and record review the facility failed to assure that the dishwashing machine dispensed sufficient Chlorine sanitizer solution to meet the required concentration during the rinse cycle of 50 - 100 parts per million (ppm) to destroy pathogens. This deficient practice resulted in an Immediate Jeopardy (IJ) situation as it had a high likelihood of putting all residents and staff who eat from the utensils, dishes and beverage containers at risk for food borne illness and infections. On 7/9/2020 at 2:50 PM, the Administrator (Adm), Infection Preventionist (IP) and the Food Service Director (FSD) were notified of the IJ. During observations in the kitchen on 7/9/2020 at 1:40 PM, the FSD checked the concentration of the sanitizing solution for the dishwashing machine. Since the machine is a low temperature machine it requires chlorine sanitizing solution to sanitize the dishes. The litmus test results showed a concentration of less than 50 parts per million (ppm). The required concentration for chlorine solution is 50 - 100 ppm. The staff (Staff 52) responsible to test the concentration of the chlorine solution said she was supposed to test the solution before each dish-washing episode three times per day. She stated she did not test it before the lunch dish-washing episode today. She said she documented a reading of 100 ppm on the Dishmachine temperature log before the lunch dishwashing episode for today. When the dishwashing chlorine solution is less than required the dishes are not sanitized and have a high likelihood of spreading serious infection for all people who eat from the dishes. The facility has 56 residents who have been confirmed positive for COVID19 and 26 deaths as of the week ending 7/5/2020. The IP stated all staff had been exposed to [DIAGNOSES REDACTED]-CoV-2. Had the surveyor not asked to see the testing of the chlorine sanitizing solution it is likely that the staff would not have known the sanitizing solution was not concentrated enough. Many of the lunch dishes were already washed however they were not sanitized had already been put away and ready for use at the next meal. The facility provided a corrective action plan on 7/9/2020 at 4 PM that was not accepted due to several missing elements. A second corrective action plan was provided at 4:30 pm and was accepted. The corrective action taken included but was not limited to the following: 1. Stop using the dishwashing machine and use the three compartment sink to wash, rinse and sanitize the dishes. 2. All dishes in the dish area including dishes that had been put away were re-washed to assure proper sanitation prior to use. 3. The facility immediately called ECOLAB, the company that maintained the dishwashing machine, and the technician came and repaired the machine 7/9/2020 at 3:11 PM. 4. Kitchen employees onsite were re-educated immediately and all kitchen employees not onsite would be re-educated by 7/10/2020. Re-education included the appropriate use of the dish machine including how to test for chlorine concentration and documentation of wash and rinse temperatures and ppm level of chlorine. It included instruction for what to do if the dish machine was not reading properly, i.e., who to report the malfunction to and what to do, such as do not use the dishwashing machine instead use the three compartment sink. On 7/10/2020 at 9 AM, the surveyor observed the dishwashing process and asked Staff 52 to test the chlorine sanitizer concentration. Staff 52 made two attempts to test the solution and did it incorrectly. When asked if the management had provided additional training this morning, Staff 52 stated, Yes. When asked why she had difficulty testing the chlorine concentration, Staff 52 stated, I already know how to do it. The Vice President (VP) of Dining Services tested the concentration and it read 100 ppm. The VP stated they had just trained Staff 52 first thing that morning. Interviewed five other kitchen staff and they acknowledged they had received training that morning and on 7/9/2020 and were able to perform the litmus test. The IJ was abated on 7/10/2020 at 9:46 AM. Findings include: During a tour of the kitchen on 7/9/2020 at 1:35 PM, accompanied by Food Services Director (FSD) and the Dietary Services Supervisor (DSS) and the Infection Preventionist (IP), when asked what kind of dishwashing machine they used the FSD stated a low temperature machine (120 - 150 F(ahrenheit)) which requires a chlorine sanitizing solution to sanitize the dishes. At 1:40 PM, when asked to test the chlorine solution for concentration, FSD inserted a test strip for about 10 seconds into the water at the exit for the dishwashing machine. The test strip showed the concentration as less than 50 parts per million (PPM). When asked if this was ok, the FSD stated, it should be between 50 -100 ppm. Review of the Dishmachine Temperature Log (log) Form 408 where dietary staff document the wash and rinse temperature and ppm (chlorine concentration) revealed for 7/9/2020 before lunch a ppm reading of 100 PPM. When asked where on the dishmachine she tested the solution Staff 52 reached up above the garbage disposal sink to a dispenser labeled ECOLAB , indicating she tested directly from the dispenser instead of at the dishwashing machine after the sanitizer mixes with the rinse water where the dishes come out of the machine. Review of the log for July 2020 showed in the ppm column documented a chlorine concentration of between 100 and 103 ppm on every line. Staff 52 stated she was responsible to test the concentration of the sanitizer and the temperature of the water as well as document the results on the log before each dishwashing episode. When asked if this documentation was accurate Staff 52 stated, I didn't check it (before the lunch dishwashing). FSD, DSS, and the IP was present and stated they heard what Staff 52 said. FSD asked Staff 52 if she had documented the numbers on the log before lunch. Staff 52 said, Yes. When asked what part of the dishwashing machine the staff should place the test strip, FSD stated it didn't matter. When asked how she monitored that the documentation of the temperature and chlorine concentration was correct and that the staff were testing appropriately, FSD stated she did spot checks but did not have consistent routine. She said that she rarely checked the sanitizer concentration. When asked what should be done about this the FSD told the staff to stop washing the dishes in the dishwashing machine and switch to the three compartment sink to complete the dishwashing of the lunch dishes and to start re-washing all of the other dishes that had been put away. When asked how often ECOLAB came out to maintain the dishwasher and solution dispensers, FSD stated they come about monthly. She stated they had just been out on 7/6/2020. On 7/9/2020 at 2:50 PM, an Immediate Jeopardy situation was identified and the administrator was informed (See introduction). At 3:50 PM the FSD informed the surveyor that ECOLAB came out and repaired the machine. She stated it now tested at 100 ppm. Returned to the kitchen to observe dishwashing process. The staff in the kitchen at this time were the evening shift staff. Observed kitchen staff continuing to rewash the dishes in the three compartment sink. When asked if he had been trained about testing and documenting the chlorine concentration and water temperature, the evening dishwasher stated he had. He stated they were not to use the dishwashing machine to rewash the dishes. The FSD stated she would continually run the dishwashing machine for about 30 minutes to make sure it maintained the appropriate chlorine concentration and temperature. At 4 PM the administrator provided the surveyor with a corrective action plan. The plan was not accepted as it was missing several elements. The administrator stated she had spoken with the corporate registered dietitian who told her they had been having problems with this machine. When asked how long they have had problems with the machine and how often they've had to call for repairs, the FSD stated for about a year. She stated she had to call about every two to three weeks and it's usually because the chlorine solution wasn't right. She stated the machine was a high temperature machine (150 -165 F); however it wasn't maintaining the high temperature. ECOLAB installed a chlorine dispenser in April 2020. When asked</p>		

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 0812  <b>Level of harm - Immediate jeopardy</b>  <b>Residents Affected - Some</b>	<p>(continued... from page 1)</p> <p>if she was aware of the problems with machine, the Admin stated that they did not report it to her. The report these problems directly to the Vice President of Dining Services. She further stated that since the machine broke down so often the facility would consider replacing the machine. At 4:30 PM, the administrator submitted a revised corrective action plan and it was accepted. (See introduction comments) 7/9/2020 - 7/10/2020 Record review revealed the following: Review of the ECOLAB service request for 7/9/2020 at 3:11 PM, revealed that the sanitizer line popped out of the squeeze tube. The technician repaired it so the sanitizer was being delivered at the appropriate concentration. Previous ECOLAB maintenance invoices included Regular Service Call with dates of about every 2 months. The most recent was dated 7/6/2020 that revealed the dishmachine met all measures. Review of the policy and procedures (P&amp;Ps) revealed the following: P&amp;P INS 117 - Dishwashing Procedure revised 11/19/2019 read in pertinent part: Objective: Participants will understand the correct dishwashing procedures and how to record the dishmachine (sic) temperature and ppm 2. Recording of Dishmachine (sic) temperature and ppm: .Record temperatures every shift on Dishmachine (sic) Temperature log(Form 408) .Low temperature dishmachines- wash temperature is 120 - 150 F (and) final rinse temperature is 120 - 150 F . The concentration of the sanitary solution during the rinse cycle is 50 - 100 ppm with Chlorine sanitizer on low temperature dishmachines . P&amp;P INS 126 Criteria for completion of RD's Quarterly Report Sanitation for Long Term Care revised 01/15/2019 read in pertinent part: .Food Preparation Area: 23 - 24 Current Food Code Temperatures available and followed .a. Food Code Temperatures (DOC401) iv. Dishmachine (cold correct ppm .) .d. Check with those who wash pots and pans and . have them test with litmus paper for correct amount of sanitizer .i. Chlorine Sanitizer = 50 - 100 ppm- contact time 7 seconds .86 Dishmachine Temperatures recorded every shift and corrective action noted. a. Check Dishmachine temperature FORM 408 to see if wash and rinse temperatures are recorded 3xday. If it is a cold temperature dishmachine the ppm must be recorded also 3xday. B. if the dishmachine is not working properly, correct action must be noted on the dishmachine temperature form . Review of the training log indicated Staff 52 attended a training on 2/4/2020 titled How to clean and sanitize pots, pans, utensils and dishes. The training included the following directions: .Test sanitizing sink with litmus strip for proper amount of sanitizer. Test wash and rinse water for proper temperature. Record wash/rinse and PPM every shift . This training did not have specific instruction regarding where to test the sanitizer concentration for the dishwashing machine. On 7/10/2020 at 9 AM, the surveyor observed the dishwashing process and asked Staff 52 to test the chlorine sanitizer concentration. Staff 52 made two attempts to test the solution and did it incorrectly. When asked if the management had provided additional training this morning, Staff 52 stated, Yes. When asked why she had difficulty testing the chlorine concentration, Staff 52 stated, I already know how to do it The Vice President of Dining Services tested the concentration and it read 100 ppm. Interviewed five other kitchen staff and they acknowledged they had received training that morning and on 7/9/2020 and were able to perform the litmus test. The IJ was abated on 7/10/2020 at 9:46 AM.</p> <p><b>Provide and implement an infection prevention and control program.</b></p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b></p> <p>Based on observation and interview the facility failed to assure infection control and prevention techniques were followed resulting in the potential for the spread of the [DIAGNOSES REDACTED]-CoV-2 [MEDICAL CONDITION] that causes COVID19 disease to vulnerable residents and staff in the facility. Findings include: During a tour of the facility on 7/9/2020 beginning at 9:48 AM, while observing the laundry process Staff 23 came into the laundry room and washed her hands shutting off the faucet with her bare thumb. When asked about this practice, Staff 23 stated she should have used a towel to turn off the faucet. The Housekeeping Supervisor (HS) and the Infection Preventionist (IP) were present and observed the same thing. HS stated that Staff 23 re-contaminated her hand when she touched the faucet with her bare hands after washing them. On 7/9/2020 at 11:30 AM, on 4 North West Hall in the dining area accompanied by IP and ADON, Staff 38 was observed using Alcohol Based Hand Rub (ABHR) when entering the hallway where she delivered meal trays; however she did not sanitize hands between each resident's room. At 11:34 AM, on the same hall, Staff 52 was observed pushing a meal cart to deliver meals to the unit. Staff 52 had on a mask that did not cover her nose. The IP stated Staff 52 should wear the mask so it covers both the nose and mouth. During observation of 1 South East (ISE), COVID UNIT on 7/9/2020 beginning at 12:30 PM, those who enter this unit to care for residents must put on full PPE including mask, face shield/goggles, gloves and gown. The IP stated all the residents on this unit had active COVID19 disease and all were on transmission based precautions (TBP). There were eight residents on this unit At approximately 12:25 PM, Staff C-46 walked down the hall toward the exit to the hallway holding two wrist/ankle weights and a draw string bag. She stopped between room [ROOM NUMBER] and 109. When asked what she was doing Staff C-46 stated she had given therapy to a resident at the end of the hall. She stated she reused the weights between residents but had to sanitize them between each use. She used a spray bottle with Virex solution in it. She placed the drawstring bag on the floor while she sanitized the two weights. She placed the bottle of Virex on the floor and then draped the weights over the hand rail. She then picked up the drawstring bag and sprayed it with the Virex solution; again placing the bottle on the floor. When asked if the staff should put equipment on the floor, the IP stated, No and pointed to the table near the entry/exit door about 10 feet away. When asked why she put the equipment and sanitizer on the hand rail and the floor, Staff C-46 stated there was no place to set them. She started to place the contaminated Virex bottle on the clean table and was reminded it should not be placed on the clean table until it had been sanitized after being on the floor. She then again placed it on the floor. Her colleague sanitized the bottle and placed it on the table. 7/9/2020 at 12:40 PM after leaving the ISE unit, at the screening desk a person entered the building wearing PPE that was put on prior to coming into the building. The person wore a N95 mask that had an exhalation valve. When asked what the person was going to do in the building the IP stated she was a laboratory technician there to draw blood samples and collect other specimens for testing. When asked if she got close to residents, the IP stated yes. Drawing blood from a resident required the lab technician to hold the residents arm and if collecting oral swab or sputum specimens getting close to the resident's mouth. When asked about the mask, the Lab Tech stated that was mask the company provided for them. When asked if it was ok for the Lab Tech to wear the N95 mask with an exhalation valve to draw blood or collect specimens from residents, the IP and Director of nursing (DON) stated, Yes, it's a N95 mask. Referred them to the CDC and NIOSH websites indicating that N95 masks with exhalation valves do not contain droplets or prevent the spread of infectious particles being spread to residents/patients who have a medical condition or are vulnerable.</p> <p>&lt;<a href="https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirator-use-faq.html">https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirator-use-faq.html</a>&gt; and &lt;<a href="https://www.cdc.gov/niosh/nppt/topics/respirators/factsheets/resp[DIAGNOSES REDACTED].html">https://www.cdc.gov/niosh/nppt/topics/respirators/factsheets/resp[DIAGNOSES REDACTED].html</a>&gt; The valve opens to release exhaled breath and closes during inhalation so that inhaled air comes through the filter. Health care workers may wear respirators with exhalation valves unless the patient has a medical condition (such as an open wound) for which a health care worker would normally wear a surgical mask to protect the patient. Similarly, respirators with exhalation valves should not be placed on a patient to contain droplets and prevent spread of infectious particles; surgical masks are adequate for this purpose.</p>		
F 0880  <b>Level of harm - Minimal harm or potential for actual harm</b>  <b>Residents Affected - Some</b>			