DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WJHB12

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: LTC0053

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **035099**
2. STATE VENDOR OR MEDICAID NO.
(L2) **835118**

3. NAME AND ADDRESS OF FACILITY
(L3) **SAPPHIRE OF TUCSON NURSING AND REHAB, LLC**
(L4) **2900 EAST MILBER STREET**
(L5) **TUCSON, AZ** (L6) **85714**

4. TYPE OF ACTION: **9** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. LTC PERIOD OF CERTIFICATION
From (a):
To (b):

12. Total Facility Beds **240** (L18)
13. Total Certified Beds **240** (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
__ 5. Life Safety Code __ 9. Beds/Room

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	240			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): **YES** (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
On 12/09/20 an infection control survey was conducted at the facility and the facility was found to be out of compliance with state and federal regulation. On 1/29/21 an offsite revisit was conducted and the facility was found to be back in compliance with state and federal regulation.

17. SURVEYOR SIGNATURE
for Rebecca Jacobson, Surveyor
Date: 01/29/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL
Date: 01/29/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
__ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
00000 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

January 29, 2021

Receipt Of This Notice Is Presumed To Be 01/29/2021
Important Notice - Please Read Carefully

Brian Balliet, Administrator
Sapphire Of Tucson Nursing And Rehab, Llc
2900 East Milber Street
Tucson, AZ 85714

Dear Mr. Balliet:

On January 29, 2021, an offsite revisit was conducted for your facility by the Arizona Department of Public Health, Licensing, and Certification Bureau, to determine if your facility was in compliance with federal requirements at the time of the focused infection control survey #WJHB12.

The enclosed Center for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS 2567), documents that no deficiencies of participation requirements were identified during this revisit. The plan of correction was accepted for the Federal citations.

Enclosed is the **Federal Post-Certification Revisit Report**, please retain a copy for your files. If we can be of further assistance, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Sindy Fan

LTC Customer Service Representative IV

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Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
035099 Y1	A. Building B. Wing Y2	1/29/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SAPPHIRE OF TUCSON NURSING AND REHAB, LLC	2900 EAST MILBER STREET TUCSON, AZ 85714

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 01/29/2021	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) mc	DATE 1/29/21	SIGNATURE OF SURVEYOR [signature]	DATE 1/29/21
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/9/2020	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

December 24, 2020

Receipt Of This Notice Is Presumed To Be -12/24/2020
Important Notice - Please Read Carefully
NO HARD COPY TO FOLLOW

Brian Balliet, Administrator
Sapphire Of Tucson Nursing And Rehab, Llc
2900 East Milber Street
Tucson, AZ 85714

Dear Mr. Balliet:

On **December 9, 2020**, an Infection Control COVID-19 Focused Survey was conducted at your facility by the Department of Health Services, Bureau of Long Term Care to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was not in substantial compliance with the most serious deficiency cited below:

- F880 - S/S: E - §483.80 Infection Control

The finding(s) from the survey is enclosed with this letter on from CMS-2567. Also enclosed is a list of the "resident identifiers" used in writing the statement of Deficiencies. The "resident identifiers" will enable you to identify any specific residents referred to in the CMS 2567.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

PLAN OF CORRECTION

A Plan of Correction (PoC) for the deficiencies must be submitted by **January 3, 2021**. You must include all pages of the Statement of Deficiencies when submitting your PoC. Failure to submit an acceptable PoC by **January 3, 2021** may result in the imposition of additional remedies.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice, on both a temporary and permanent basis, including the date the correction will be accomplished;

- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,

- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and the title, or position, of the person responsible for implementing/monitoring the corrective action.

- The signature and date you approve the Plan of Correction on the first page.

- Any copies of monitoring audits being done up to your Allegation of Compliance date

Your properly signed PoC constitutes your credible allegation of compliance. We may accept the Plan of Correction and presume compliance until substantiated by a revisit or other means.

The POC must be signed and dated by an official facility representative. Please send your POC by email to the following:

Ltc.licensing@azdhs.gov
SUBJECT LINE: the name of your facility and POC

SUMMARY OF ENFORCEMENT REMEDIES

Imposition of Discretionary Denial of Payment for New Admissions (DDPNA):

Payment will be denied for all NEW Medicare and Medicaid admissions, beginning February 7, 2021, in accordance with the statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal regulations at 42 CFR §488.417. CMS will notify your Medicare payer the date the denial of payment begins. DDPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated. [*You may not bill new Medicare/Medicaid residents or their responsible parties for services normally covered by Medicare, Medicaid or Medicare Managed Care Organizations during DDPNA.]*

Directed Plan of Correction (DPOC)

In accordance with Federal regulations at 42 CFR §483.424, a Directed Plan of Correction is imposed on the facility. In accordance with 42 CFR §488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. The effective date is not the deadline for completion of the DPOC. However, the State Agency will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice. Please send all documentation to ADHS at the following:

Diane Eckles, Bureau Chief
Email: Diane.eckles@azdhs.gov

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567. Please see the attached instructions for detailed guidance.

Elements of an Effective DPOC:

- The corrective action to be implemented and an appropriate infection prevention and intervention plan consistent with the requirement of §483.80 for the affected identified in the deficiency.
- Governing Body
- Specific staff involved in implementing the corrective action (such as the Staff Development Coordinator, Infection Preventionist, Nursing Home Administrator, Director of Nursing, and Medical Director)
- Systemic changes and actions that need to be taken
- Monitoring of approaches to ensure infections are controlled going forward.
- Plan of Correction Completion date with 30 days of survey exit date.

Elements of an Effective Root Cause Analysis (RCA):

- Identify the root cause resulting in the facilities Failure. This includes asking the Who, What, Where, When and Why questions which can be done by conduction internal investigations.
- Develop solutions and systemic changes that need to be taken to address the root cause.
- Implement the solution.

TERMINATION PROVISION

If your facility has not attained substantial compliance by 06/09/2021, your Medicare and Medicaid participation will be terminated effective with that date. This action is mandated by the ACT at § § 1819(h) and 1919(h) and Federal regulations at 42 CFR § 488.456 and § 489.53.

We are required to provide the general public with notice of an impending termination and will publish a notice prior to the effective date of termination. If termination goes into effect, you may take steps to come into compliance with the Federal requirement for long term care facilities and reapply to establish your facility's eligibility to participate as a provider of services under Title XV111 of the Social Security Act. Should you seek re-entry into the Medicare program, the Federal regulation at 42 CFR § 489.57 will apply.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, an explanation of why you are disputing those deficiencies along with supporting information that shows that the facility was in compliance at the time of the survey to Diane Eckles, Bureau Chief, Bureau of Long Term Care, Diane.eckles@azdhs.gov. This request must be sent during the same 10 days you have for submitting a PoC for the cited deficiencies.

An informal dispute resolution process will not delay the effective date of any enforcement action.
Please note: Facilities requesting an Informal Dispute Resolution must submit separate requests, one for State deficiencies cited and one for Federal deficiencies cited, if applicable.

FILING AN APPEAL

If you disagree with the determination to impose remedies made on the basis of noncompliance identified at the survey, you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 CFR §498.40, et. seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than 60 days from the date of receipt of this letter.

We request that you provide and electronic copy of the request for appeal to ROEnforcements@cms.hhs.gov SUBJECT LINE: Appeal ATTN: Sahana Sanyal and to the CMS Regional Chief Counsel Femi.Johnson@hhs.gov and the Bureau of Long Term Care Licensing.

If you elect to dispute deficiencies through the Informal Dispute Resolution (IDR) process this will not extend the 60-day period to file your appeal before the Departmental Appeals Board. Filing an appeal will not stop the imposition of any enforcement remedy.

If you experience problems with, or have questions about DAB e-File, please contact e-file System Support at OSDABImmediateOffice@hhs.gov about using the DAB e-file System, please visit https://dab.efile.hhs.gov/login?locale=en

ALLEGATION OF COMPLIANCE

Your properly signed Plan of Correction constitutes your credible allegation of compliance. We may accept the Plan of Correction and presume compliance until substantiated by a revisit or other means. If, upon the subsequent revisit, your facility has not achieved substantial compliance, a civil money penalty may be imposed by the CMS Regional Office or State Medicaid Agency beginning on December 9, 2020 and continuing until substantial compliance is achieved. The CMS Regional Office or State Medicaid Agency may also impose additional remedies at that time if appropriate.

Retain a copy of the PoC for your files. If the PoC is not received by this Office by **January 3, 2021**, licensure and/or recertification may be denied. **Plans of correction sent by fax will not be accepted.** If you have any questions concerning the instructions contained in this letter, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

DE:mm

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035099	A. BUILDING _____ B. WING _____	12/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAPPHIRE OF TUCSON NURSING AND REHAB, LLC	2900 EAST MILBER STREET TUCSON, AZ 85714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 1 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, facility documentation, facility policies, and review of the Centers for Disease Control (CDC) recommendations, the facility failed to ensure that infection control standards were followed. The	F 880	Facility Infection Preventionist is re-inservicing all personnel in the proper use of PPE, including donning, doffing, and disposal, as well as hand hygiene. CMS QSEP training module will be re-assigned to individuals requiring repeat instruction. Infection Preventionist and Director of Nursing establishing clean and dirty areas in the COVID-19 positive unit, including definitive areas to don/doff PPE, and appropriate use of PPE in the breakroom. Staff training in the above. The Housekeeping Manager has removed large trash cans from the hallway. Staff training in disposal of garbage and covering receptacles. Infection Preventionist re-training all-staff on the proper screening process when entering the facility. Infection Preventionist re-training screeners to review each screening log for proper completion and the protocols when a staff member does not fill in the temperature and/or their temperature is out of range. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and the title, or position, of the person responsible for implementing/monitoring the corrective action?**	

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F 880	Continued From page 2 deficient practice could result in the spread of infection, including COVID-19, to residents and staff. Findings include: -Regarding signage in the COVID-19 positive unit: An observation of the entrance to the COVID-19 unit was conducted on December 9, 2020 at 10:55 a.m. There was a plastic sheet separating the unit from the rest of the facility and the central nursing station. There was one sign observed posted outside of the unit informing visitors to the unit to see the nurse before entering. There was no other signage indicating that this was a COVID-19 unit or what PPE was required to enter the unit. On December 9, 2020 at 12:35 p.m., an interview was conducted with the facility's Infection Preventionist (IP/staff #42) and the DON (staff #37). The DON stated the sign posted on the COVID-19 unit entrance should have instructions on PPE requirements for staff entering the unit printed on the back of the sign. She stated the front office staff made the copies and did not copy it double sided. The facility's COVID-19 infection control policy noted that the facility will follow and implement guidelines in accordance with CDC guidance. The CDC's guidance for responding to COVID-19 in Nursing Homes, updated April 30, 2020, includes that facilities should place signage at the entrance to the COVID-19 care unit that instructs staff they must wear eye protection and an N95 or	F 880	Infection Preventionist and Director of Nursing, or IDT member will audit appropriate Infection Control signage weekly x 12 weeks. The results of the audits will be reported to the QAPI Committee. After 12 weeks of monitoring, and all expectations are met, monitoring will be reduced to monthly. After 3 consecutive months of sustained compliance, the QAPI committee may approve discontinuing monitoring. Infection Preventionist and Director of Nursing, or IDT member will audit appropriate use of PPE, including the proper location of donning and doffing of PPE weekly x 12 weeks. The results of the audits will be reported to the QAPI Committee. After 12 weeks of monitoring, and all expectations are met, monitoring will be reduced to monthly. After 3 consecutive months of sustained compliance, the QAPI committee may approve discontinuing monitoring. Infection Preventionist and Director of Nursing, or IDT member will monitor to ensure trash is covered weekly x 12 weeks. The results of the audits will be reported to the QAPI Committee. After 12 weeks of monitoring, and all expectations are met, monitoring will be reduced to monthly. After 3 consecutive months of sustained compliance, the QAPI committee may approve discontinuing monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAPPHIRE OF TUCSON NURSING AND REHAB, LLC	2900 EAST MILBER STREET TUCSON, AZ 85714

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F 880	Continued From page 3 higher-level respirator (or facemask if a respirator is not available) at all times while on the unit. The guidance included that gowns and gloves should be added when entering resident rooms. -Regarding donning and doffing of PPE in the COVID-19 positive unit: An interview was conducted on December 9, 2020 at 9:15 a.m. with the DON (staff #37) and the administrator (staff #22). The DON stated the facility has a dedicated COVID-19 unit and that staff working on that unit are wearing full PPE including a full body protective suit, an N95 facemask, and goggles or a face shield at all times. The DON said that they don a surgical mask, gown, and gloves when entering a resident room. An observation was conducted of the entrance to the COVID-19 unit on December 9, 2020 at 10:57 a.m. There was a plastic sheet separating the unit from the rest of the facility and the central nursing station and a sign that said to see the nurse before entering. When past the plastic sheet, there was a cart containing PPE. Also there was an employee breakroom that was beyond the plastic sheet separator, but before the closed door entrance to the hall leading to resident rooms. Continued observation of this area revealed that multiple staff left the resident room area of the COVID-19 unit, opened the door, and entered the employee break room. The staff were wearing full body protective suits, N95 facemasks, and face shields or goggles when they exited the resident room area and upon entering the break room. Once inside the break room, multiple staff were	F 880	Infection Preventionist and Director of Nursing, or IDT member will conduct on-going monitoring of screening logs to ensure staff compliance weekly x 12 weeks. The results of the audits will be reported to the QAPI Committee. After 12 weeks of monitoring, and all expectations are met, monitoring will be reduced to monthly. After 3 consecutive months of sustained compliance, the QAPI committee may approve discontinuing monitoring. Any staff found to be non-compliant with any of the above, will receive ad-hoc, documented training regarding the non-compliant issue.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 4	F 880		

observed sitting at tables. Some of them had removed their facemasks and were eating. One staff member was observed in the room wearing only a facemask and no other PPE. Another staff member was observed exiting the breakroom wearing a disposable gown, N95 mask, and goggles. This staff member then entered the COVID-19 resident room area.

At 11:15 a.m., observations of the COVID-19 unit, the entrance to the unit, and the employee breakroom revealed no obvious signs of an area to doff PPE. Also, there was no clear distinction as to which parts of the unit required full PPE and which parts of the unit did not require full PPE. There was no garbage can or soiled linen container near the exit of the unit to doff PPE.

An interview was conducted with a Licensed Practical Nurse (LPN/staff #17) on December 9, 2020 at 11:15 a.m. She stated that she is working on the COVID-19 unit on this date. She said that she receives PPE for the shift when she first signs in after being screened. She stated that she is provided with a full body protective suit, an N95 mask, and goggles or a face shield, and multiple surgical masks. She stated that she removes her PPE when she goes on her break and she does this in the employee break room. She stated that she will keep her full body suit on for the entire time she is in the facility, but will take off the N95 mask and face shield while on her break. She said that all the staff working on the COVID-19 unit takes breaks in the same break room. When asked where a visitor, provider, or surveyor is to doff their PPE, she said there is a garbage can and linen container at the end of the hall near the exit. She tried to point it out, but there was no garbage or linen container in the hall. She said

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SAPPHIRE OF TUCSON NURSING AND REHAB, LLC	2900 EAST MILBER STREET TUCSON, AZ 85714

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F 880	Continued From page 5 that someone must have moved it. She stated that the surveyor could doff in the break room since there is a garbage can in the room. An observation of the COVID-19 employee break room was conducted at 11:20 a.m. on December 9, 2020. There were three employees in the break room at the time. One employee was sitting at a table eating. She was not wearing any PPE. Another employee was at a separate table and was wearing a full body protective suit, N95 mask, surgical mask, and goggles, and a third employee was sitting at a desk working on a computer and was wearing a surgical mask. The employee in full PPE provided the surveyor with a garbage can to doff the PPE worn in the COVID-19 unit and stated someone would put a garbage can near the door. On December 9, 2020 at 12:35 pm, an interview was conducted with the facility's IP (staff #42) and the DON (staff #37). They stated that there should be a garbage can at the exit of the COVID-19 unit for doffing PPE. They stated it was likely moved down the hallway by a staff member and that it should not have been moved. They said that the staff doff their PPE in the breakroom prior to exiting the facility. They said that in regards to the breakroom, some staff remain in full PPE and others do not. Some staff want to be in the full body suit all day and others prefer a gown. The facility's COVID-19 infection control policy noted that the facility will follow and implement guidelines in accordance with CDC guidance. The CDC's guidance for responding to COVID-19 in nursing homes, updated April 30, 2020,	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035099	A. BUILDING _____ B. WING _____	12/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAPPHIRE OF TUCSON NURSING AND REHAB, LLC	2900 EAST MILBER STREET TUCSON, AZ 85714

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F 880	Continued From page 6 includes that facilities should place signage at the entrance to the COVID-19 care unit that instructs staff they must wear eye protection and an N95 or higher-level respirator (or facemask if a respirator is not available) at all times while on the unit. The guidance included that gowns and gloves should be added when entering resident rooms. The CDC's guidance got preparing for COVID-19 in nursing homes, updated November 20, 2020 includes that facilities should consider designating a space for COVID-19 positive residents. This could be a dedicated floor or wing of the facility that can be used to cohort resident with COVID-19. The guidance included that when providing care for these residents, staff should wear all PPE including isolation gowns, N95 respirators (or facemask if N95s are not available), eye protection, and gloves. -Regarding disposal of trash: An observation was conducted on December 9, 2020 at 10:19 a.m. of the second floor wing near rooms 222-242. A large uncovered trash can was next to a medication cart and outside of room 226. It was noted the trash can was full with empty food receptacles and other trash. An additional large uncovered trash can was found next to another medication cart further down the hall. An observation was conducted on December 9, 2020 at 11:00 a.m. on the COVID-19 unit near rooms 201-221, where an uncovered trash bin full of discarded trash and electronics was found in the hall outside room 211.	F 880		

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F 880	Continued From page 7 An interview was conducted on December 9, 2020 at 12:35 p.m. with the administrator (Staff #22), DON (Staff #37), and the IP (Staff #42). The DON stated resident rooms have small uncovered trash cans for resident personal use but the trash cans in other areas should be covered and emptied when full. The facility's COVID-19 infection control policy noted that the facility will follow and implement guidelines in accordance with CDC guidance. The CDC, Interim Infection Prevention and Control Recommendations for Healthcare Personal During the Coronavirus Disease 2019 (COVID-19) Pandemic guidance, dated November 4, 2020, states management of laundry, food service utensils, and medical waste should be performed in accordance with routine procedures. -Regarding staff screening: Review of the staff screening logs from October 29, 2020 through December 2, 2020 revealed 23 staff screening logs with no temperature documented. An interview was conducted on December 9, 2020 at 12:15 p.m. with Screener/Assistant Administrator (Staff #11) who discussed the screening process for staff and visitors. She stated staff and visitors are required to wash or sanitize hands before entering the building, then they walk across a sanitizing mat before approaching the screening desk. She said that at the desk, the screener will take the employee or visitor's temperature. She said that the visitor or employee will complete the screening log by	F 880		

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F 880	Continued From page 8 writing in the temperature and completing the screening questions. She stated the screener will watch the employee or visitor complete the forms to ensure they are filled out completely. An interview was conducted on December 9, 2020 at 12:35 p.m. with the administrator (staff #22), the DON (staff #37) and the IP (staff #42). The DON stated employees complete the temperature screening log and it is the screener's responsibility to ensure the employee fills out the temperature log and screening questions completely. The IP stated she reviews the temperature and screening logs daily and a weekly audit is performed. The DON said that staff may have been distracted while completing the screening log as they may have been trying to get to the time clock to clock in before being considered late for their shift and therefore may have neglected to document their temperature. Review of the facility COVID-19 infection control policy revealed that all employees are to be screened daily before they work in the facility. The policy included that screening must include a temperature check and screening for signs and symptoms of COVID-19. Review of CDC guidance for preparing for COVID-19 in nursing homes, updated November 20, 2020, revealed that facilities should evaluate and manage staff including screening them at the beginning of their shifts for fever and symptoms of COVID-19. This includes actively taking their temperatures and document absence of any symptoms consistent with COVID-19.	F 880		

January 3, 2021

Ms. Diane Eckles, Bureau Chief
Bureau of Long-Term Care Licensing
Arizona Department of Health Services
150 North 18th Avenue, Suite 440
Phoenix, AZ 85007-3247

Dear Ms. Eckles:

Enclosed please find the Statements of Deficiencies with the corresponding Plans of Correction and root cause analysis for the citation received in the December 9, 2020 infection control survey conducted at Sapphire of Tucson Nursing & Rehabilitation. Included are the Statements of Deficiencies and the Plans of Correction for the F-Tag and the Y-Tag cited in the Survey, as well as the root cause analysis.

Please accept these Plans of Correction as the credible allegation of substantial compliance.

Please contact me with any questions.

Sincerely,

Brian Balliet, LNHA

Brian Balliet, LNHA
Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	INITIAL COMMENTS A focused infection control survey was conducted on December 9, 2020. The following deficiency was cited:	F 000	"This Plan of Correction is submitted to meet requirements established by Federal and State law. This Plan of Correction constitutes this facility's demonstration of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency existed or that one was correctly cited."	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880	F880 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice, on both a temporary and permanent basis, including the date the correction will be accomplished?** Zero residents were found to have been affected by the alleged deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the deficient practice. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Facility Administrator posted the required COVID-19 identifying information outside of the COVID-19 positive unit.	1/29/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robin Ballett, LNHA | TITLE: ADMINISTRATOR | (X6) DATE: 1/3/2021

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.

Supplemental

Inservice Infection control/COVID unit

Covering Linen and trash off the unit

Double bags ISO linen and trash

All trash cans need to have lids.

Blue bags iso

Cleaning of equipment (vitals machines/carts/glucometers)

Coming on and off the COVID unit limited exposure

NEW PUI isolation signs

PPE requirements for all units

Donn and Doff of PPE

COVID unit procedures

New Signs on COVID unit

Screening process form and temps and reporting to nursing if symptoms

Daily Trash and Infection Control Signage Audit

Do all the Trash cans have secure lids?

Date	A1 Hall	Shower Room	B1 Hall	Shower Room	C1 Hall	Shower Room	A2 Hall COVID	Shower Room	B2 Hall	Shower Room	C2 Hall	Shower Room
1/18/21	Ø in hall lids	✓	Ø in hall	✓	Shut down Construction ↓	↓	✓	✓	Ø in hall	✓	Ø in hall	✓
1/19/21	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓
1/20/21	✓	✓	✓	✓			✓	✓	Corrected	✓	✓	✓
1/21/21	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓

Are all appropriate signs in front of the COVID unit and PUI rooms?

Date	A1	B1	C1	A2 COVID	B2	C2	Comments
1/18/21	✓	✓	Shut down Construction ↓	✓	✓	✓	✓
1/19/21	✓	✓		✓	✓	✓	✓
1/20/21	ISO removed	✓		New sign added	✓	✓	added new sign to COVID
1/21/21	✓	✓		New sign added	✓	✓	add new sign to COVID

1/20/21 - COVID Added PPE PIC to transition door
1/21/21 - COVID Added Breakroom sign

Daily Trash and Infection Control Signage Audit

Do all the Trash cans have secure lids?

Date	A1 Hall	Shower Room	B1 Hall	Shower Room	C1 Hall	Shower Room	A2 Hall	Shower Room	B2 Hall	Shower Room	C2 Hall	Shower Room
1/25/21 1/26/21	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓

Are all appropriate signs in front of the COVID unit and PUI rooms?

Date	A1	B1	C1	A2	B2	C2	Comments
1/25/21 1/26/21	added sign	added sign	✓	1/2 cases updated due to [illegible] unit	✓	updated N[illegible]	needed to fix [illegible] cases signs

Temp and Screening Desk Screening audit

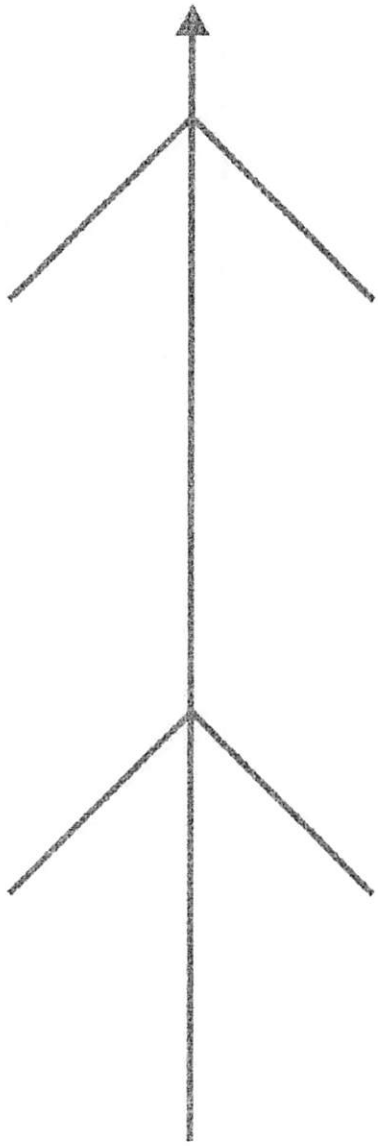
Date	Temp Logs complete	Sign and symptoms logs reviewed	Comments or corrections made
1/21	✓ [illegible]	✓ [illegible]	Ø corrections
1/22	✓ [illegible]	✓ [illegible]	all correct
1/23	✓ [illegible]	✓ [illegible]	good
1/24	✓ [illegible]	✓ [illegible]	↓
1/25	✓ [illegible]	✓ [illegible]	↓
1/26	✓ [illegible]	✓ [illegible]	↓

Telligen QI Connect™

Partnering to improve health outcomes through relationships and data

Problem Statement:

Failure to properly wear PPE by staff in the COVID unit and lack of signage for the Unit on and off of it



Environmental

Signage outside of unit and inside unit .

Staff/People

New Employees

New Nursing Managers

PPE fatigue

Covid fatigue

Equipment/Supplies

No issue

Rules/Policies/Procedures

Guidelines Always changing staff believes

Poor Understanding of clean to dirty and

Nursing home name: Sapphire of Tucson

CMS Certification Number (CCN): 035099

For additional information completing the RCA:
http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Whiteboard16.aspx

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.

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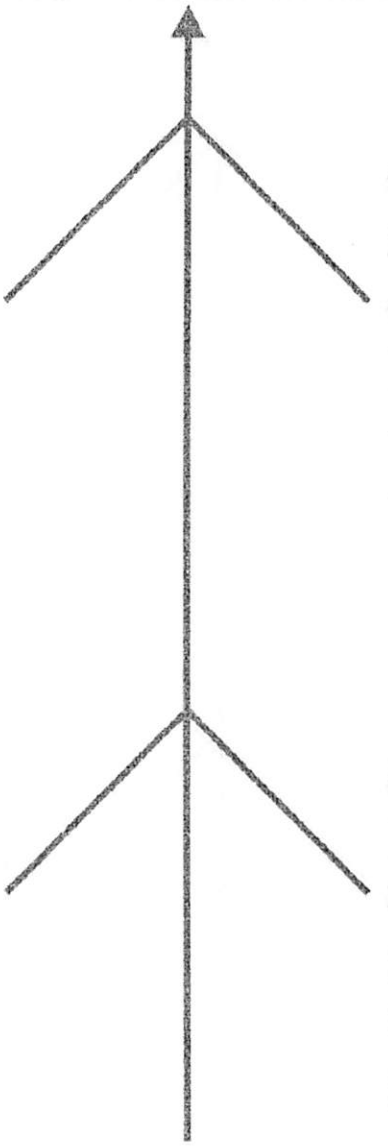
Telligen QI Connect™

Partnering to improve health outcomes through relationships and data

Problem Statement:

Failure to properly cover trash receptacles



Environmental

Uncovered trash receptacle

Staff/People

New Employees

New Nursing Managers

COVID fatigue

Equipment/Supplies

No issue

Rules/Policies/Procedures

Poor understanding of trash disposal pro

Nursing home name: Sapphire of Tucson

CMS Certification Number (CCN): 035099

For additional information completing the RCA:
http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Whiteboard16.aspx

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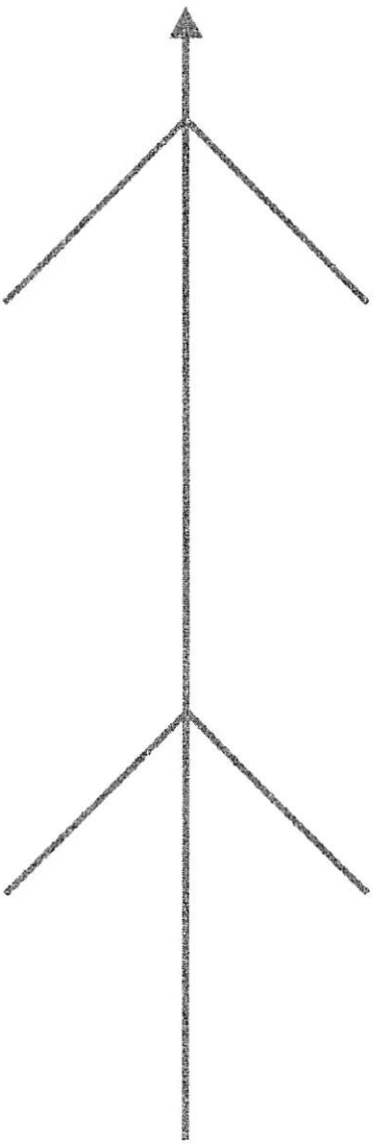
Telligen QI Connect™

Partnering to improve health outcomes through relationships and data

Problem Statement:

Failure to properly complete screening logs



Environmental

No issue

Staff/People

New Employees

COVID fatigue

Equipment/Supplies

No issue

Rules/Policies/Procedures

Poor understanding of screening process

Nursing home name: Sapphire of Tucson

CMS Certification Number (CCN): 035099

For additional information completing the RCA:
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PREVENTION WORKS!

Mandatory Infection Control meeting for ALL STAFF

YOU MUST ATTEND ONE OF THE IN-SERVICES

Agenda

- PPE required when in the facility. A2 (COVID) and all other halls
- Signage required on PUI/COVID POSITIVE
- COVID Unit PPE requirements in the breakroom, Donning and doffing area of the COVID unit.
- Proper handling of trash and proper trash cans that are acceptable on the units.
- COIVD Resource Binder what is it and where can we find it.

Tuesday 1/12/21- 12PM and 3PM in the Multiple Purpose Room/Conference room

Wednesday 1/13/21 at 6:30AM, 12PM and 5:30PM in the Multiple Purpose Room/Conference room

Thursday 1/14/21 at 6:30AM, 12PM, and 3PM in the Multiple Purpose Room/Conference room

SAPPHIRE
OF TUCSON

Stop!!!

Please See Nurse Before Entering!

Turn over for PPE required to enter this room.

SAPPHIRE
OF TUCSON

PUI (Person Under Investigation)

Instruct visitors to wash hands when entering and leaving room.

Required personal protective equipment and instructions for other departments listed below.

DUE TO COVID-19 IF VITAL MACHINES GO INTO ROOMS, CLEAN MACHINES BETWEEN EVERY PATIENT.

- ✓ **Stop sign on door.**
- ✓ **Confined to room to include therapy, activities, and dining.**
- ✓ **N95 or KN95 Mask, surgical mask over N95 or KN95, Gown, Shield or goggles, Gloves REQUIRED while in room when providing care.**
- ✓ **Wash hands with soap and water**
- ✓ **Hand hygiene (may use hand sanitizer)**
- ✓ **Housekeeping must wear N95 or KN95 Mask, surgical mask over N95 or KN95, Gown, Shield or goggles, and gloves.**
- ✓ **REMINDER- CLEAN SHIELD/GOGGLES WHEN DONE IN ROOM**

SAPPHIRE
OF TUCSON

Stop!!!

Please See Nurse Before Entering!

Turn over for PPE required to enter this room.

SAPPHIRE
OF TUCSON

COVID-19 Positive

Required personal protective equipment and instructions for other departments below.

DUE TO COVID-19 IF VITAL MACHINES GO INTO ROOMS, CLEAN MACHINES BETWEEN EVERY PATIENT.

- ✓ **Stop sign on door.**
- ✓ **Keep door closed.**
- ✓ **Confined to room to include therapy, activities, and dining.**
- ✓ **N95 or KN95 Mask, surgical mask over N95 or KN95, gown, gloves, and shield/goggles are REQUIRED while in the room.**
- ✓ **Gloves always required when providing care.**
- ✓ **Remember to wash hands with soap and water as appropriate.**
- ✓ **Housekeeping must wear N95 or KN95 Mask, surgical mask over KN95, gown, gloves, and shield/goggles REQUIRED while cleaning room.**

COVID UNIT WHAT DO YOU DO!

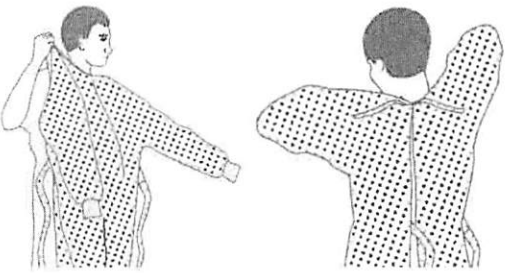
- Hang gowns on the wall in the breakroom when in the breakroom.
- Write your name with dry erase on the card hanging above the hook to identify your PPE for the day
- Masks are to be always worn when NOT eating or drinking.
- Maintain 6ft distance when in brake room.
- Gowns are to be thrown in laundry to be washed at the end of your shift (WE DO NOT REUSE THEM. YOU NEED A NEW GOWN EACH SHIFT)
- Store shield or goggles in a bag at the end of the shift (CLEAN THEM FIRST)
- Dispose of all garbage on the unit!
- Double bag all trash and linen!

SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

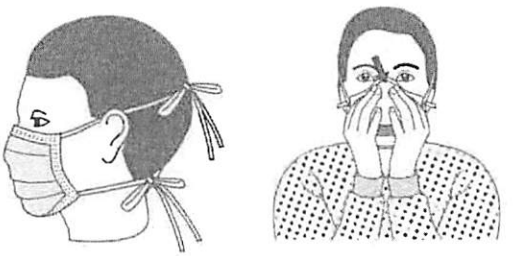
1. GOWN

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist



2. MASK OR RESPIRATOR

- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator

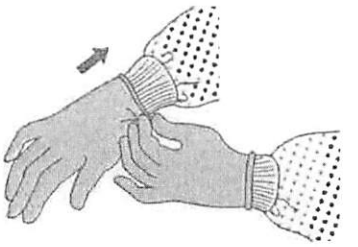


3. GOGGLES OR FACE SHIELD

- Place over face and eyes and adjust to fit

4. GLOVES

- Extend to cover wrist of isolation gown



USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION

- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene

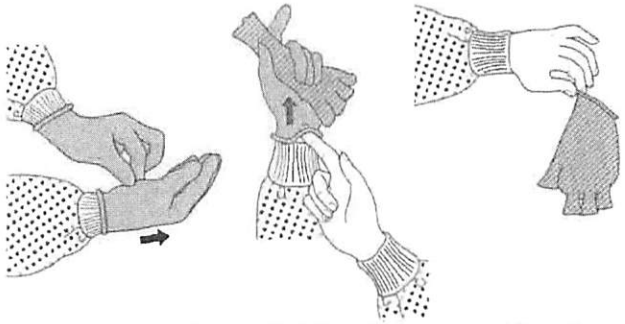
CDC

HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 1

There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. Here is one example. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GLOVES

- Outside of gloves are contaminated!
- If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Using a gloved hand, grasp the palm area of the other gloved hand and peel off first glove
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove
- Discard gloves in a waste container

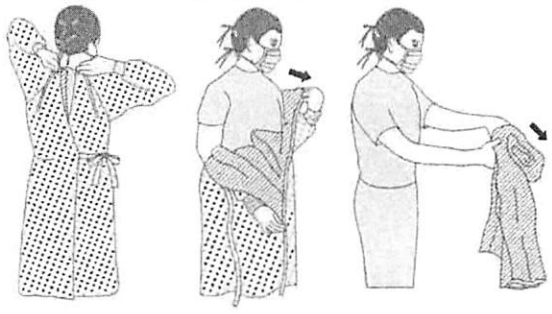


2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band or ear pieces
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

3. GOWN

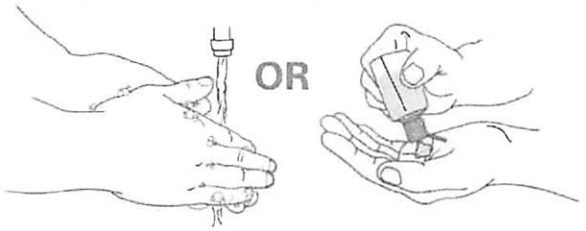
- Gown front and sleeves are contaminated!
- If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Unfasten gown ties, taking care that sleeves don't contact your body when reaching for ties
- Pull gown away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard in a waste container



4. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container

5. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



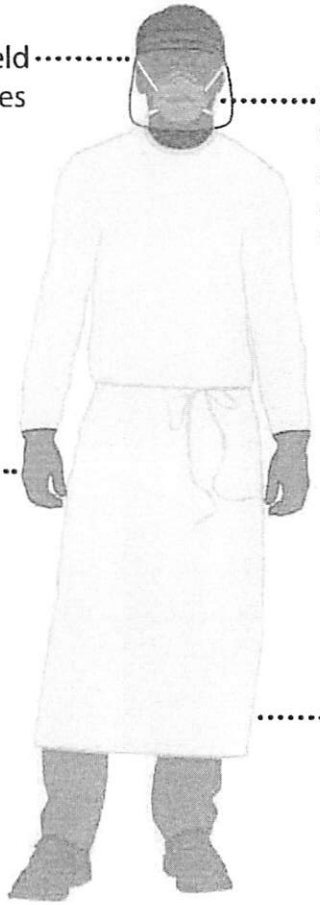
PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

CDC

CS250673-F

COVID-19 Personal Protective Equipment (PPE) for Healthcare Personnel

Preferred PPE – Use N95 or Higher Respirator



Face shield or goggles

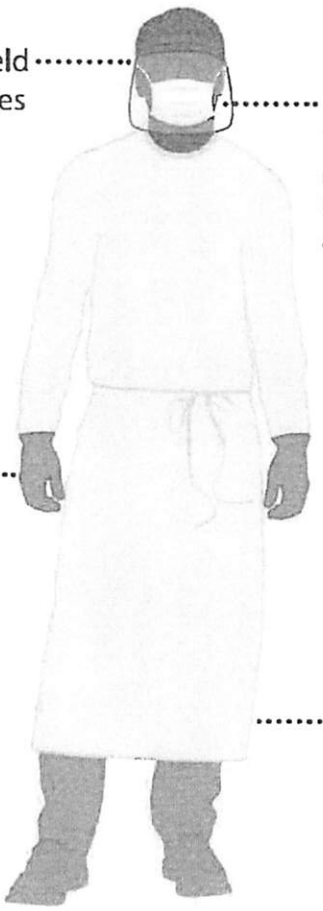
N95 or higher respirator

When respirators are not available, use the best available alternative, like a facemask.

One pair of clean, non-sterile gloves

Isolation gown

Acceptable Alternative PPE – Use Facemask



Face shield or goggles

Facemask

N95 or higher respirators are preferred but facemasks are an acceptable alternative.

One pair of clean, non-sterile gloves

Isolation gown

CDC

cdc.gov/COVID19

CS 315838-C 03/23/2020

Infection Prevention and Control Manual
Leadership Strategies for Preparation and Response (COVID-19)

Coronavirus-(COVID-19)

The following tools are designed as a framework for facility leadership to assess their current status as it relates to preparation and response to COVID-19. It is important to note that leaders need to align their plan with federal, state, and public health department guidelines.

COVID-19 Proactive Preparation Planning

Items to Review	Yes	No	N/A	Comments
1. Trustworthy Resources Utilized to Develop Plan • CDC, WHO, APIC, CMS, etc.	✓			Checked often by ICP Admin
2. Complete the following: a. CMS COVID-19 (Revised)Focused Survey for Nursing Homes: https://www.cms.gov/files/document/qso-20-38-nh.pdf b. CDC Coronavirus Disease 2019 (COVID-19) Preparedness Checklist for Nursing Homes and Other Long-Term Care Settings: https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf c. CDC Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp/assessment-tool-nursing-homes.pdf				
3. Review current Emergency Preparedness Plan and Pandemic Plan to identify • Pandemic Response • Leadership (Identify and define authority) • Contact Names and Numbers ▪ Facility Leadership o Administrator o DON o Infection Preventionist (assign and educate) o Nurse Managers o Dietary Manager o Housekeeping Manager o Social Service Manager o Environmental Services o Recreational Therapy ▪ Medical Director ▪ Pharmacy Consultant ▪ Local and State Public Health Contacts ▪ Hospital Partner Contacts ▪ Pharmacy ▪ Medical Supply • Prepare a list of essential positions necessary for day-to-day operations • Prepare a list of essential functions for emergency management of care • Review business interruption protocols and review with	✓			COVID is discussed daily with all management staff - any new updates. Employee in-service

Infection Prevention and Control Manual
Leadership Strategies for Preparation and Response (COVID-19)

leadership team members				
4. Complete plan to review facility abilities and capabilities to receive COVID-19 patients in accordance with CDC, CMS and public health requirements	✓			we have. COVID unit done at beginning
5. Set up a meeting to collaborate with local hospital partners	✓			
6. Encourage a meeting with post-acute care colleagues on collabortive efforts in the event of a Pandemic	✓			
7. Meet with pharmacy and pharmacy consultant to identify pharmaceutical needs	✓			
8. Meet with Medical Equipment suppliers to identify and prepare for needs to include: o Personal Protective Equipment o Hand Hygiene Supplies o Oxygen o Resident care supply needs based upon unique resident population	✓			
9. Meet with supplier of disinfectants and cleaners to prepare for needs	✓			Continue to order as we can
10. Meet with food suppliers to identify and prepare for food needs	✓			disposable all
11. Familiarize clinical leadership team with testing protocols as established by State and/or Local Public Health o Contact Public Health for contact numbers and questions	✓			2x week
12. Review signage and positing requirements per P&P	✓			updated
13. Review and re-educate on visitor screening protocols and visitor restriction policies (i.e. visitors, end of life care, health care workers)	✓			done, multiple
14. Review and identify staff deployment (i.e. consistent assignment)	✓			done as much as can to meet needs
15. Review facility sick leave policies and revise as necessary to encourage ill staff to remain home o Educate Staff on sick leave policy o Educate staff on COVID-19 exposure protocols	✓			
16. Re-train all employees on Infection Prevention and Control o Hand Hygiene o PPE o *Remind employees not to touch their face* o COVID-19 o Respiratory Hygiene/Cough Etiquette	✓			
17. Prepare facility communications for residents, resident representatives, families and visitors a. https://www.cms.gov/files/document/qso-20-29-nh.pdf	✓			website
18. Develop a plan for prioritizing resources o Educate Team	✓			Continued with changes
19. Meet with local transport agencies to collaborate on a plan for safe transport if necessary			✓	done with COVID transport
20. Complete the "Healthcare Professional Preparedness Checklist for Transport and Arrival of Patients With Confirmed or Possible COVID-19" from CDC: https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp-preparedness-checklist.pdf				

This resource was developed utilizing information from CDC and CMS. Providers are reminded to review state and local specific information for any variance to national guidance

Infection Prevention and Control Manual
Infection Preventionist Surveillance Audit
COVID-19 Pandemic

Infection Preventionist Surveillance - COVID-19 Audit

Surveillance	YES	NO	COMMENTS
Employee Monitoring			
1. Employee screening is completed prior to all staff entering the nursing units. (Temperature and symptom check is documented)	✓		all temps done on the records
2. Symptomatic employees are added to the employee line list	✓		error positives + symptoms
Resident Monitoring			
1. Resident Symptom Evaluation is completed for each resident on all shifts and documented on Resident Symptom Evaluation			
2. The Room Log is completed with documentation for any individual entering the room of a resident with Suspected of Confirmed COVID-19	N/A		→
3. Symptomatic residents are added to the facility line list			Line list continued to get fixed
Visitor Monitoring			
1. Only end-of-life/compassionate care visitors are permitted in the facility	✓		non this week
2. Visitor is screened for fever and signs/symptoms using the Visitor Symptom Evaluation form	✓		
Personal Protective Equipment			
1. PPE supply is replenished in the isolation carts	✓		
2. Masks are available for visitors at the entrance for end-of-life/compassionate care visitors	✓		
Comments			

Employee _____ **Date** 1/4/2021

Evaluator Paula Glaser LPN **Date** 1/4/2021

Infection Prevention and Control Manual
Infection Preventionist Surveillance Audit
COVID-19 Pandemic

Infection Preventionist Surveillance - COVID-19 Audit

Surveillance	YES	NO	COMMENTS
Employee Monitoring			
1. Employee screening is completed prior to all staff entering the nursing units. (Temperature and symptom check is documented)	✓		
2. Symptomatic employees are added to the employee line list	✓		
Resident Monitoring			
1. Resident Symptom Evaluation is completed for each resident on all shifts and documented on Resident Symptom Evaluation			IC checks daily + COC daily
2. The Room Log is completed with documentation for any individual entering the room of a resident with Suspected of Confirmed COVID-19	NA		→
3. Symptomatic residents are added to the facility line list	✓		~~that~~ still updating from last IC Nurse
Visitor Monitoring			
1. Only end-of-life/compassionate care visitors are permitted in the facility	NA		non this week
2. Visitor is screened for fever and signs/symptoms using the Visitor Symptom Evaluation form	✓		
Personal Protective Equipment			
1. PPE supply is replenished in the isolation carts	✓		
2. Masks are available for visitors at the entrance for end-of-life/compassionate care visitors	✓		
Comments			

Employee _____ **Date** 1/8/21

Evaluator Carolyn Glover LPN **Date** 1/8/21

Infection Prevention and Control Manual
Infection Preventionist Surveillance Audit
COVID-19 Pandemic

Infection Preventionist Surveillance - COVID-19 Audit

Surveillance	YES	NO	COMMENTS
Employee Monitoring			
1. Employee screening is completed prior to all staff entering the nursing units. (Temperature and symptom check is documented)	✓		
2. Symptomatic employees are added to the employee line list	✓		done with admin.
Resident Monitoring			
1. Resident Symptom Evaluation is completed for each resident on all shifts and documented on Resident Symptom Evaluation			IC Nurse does daily
2. The Room Log is completed with documentation for any individual entering the room of a resident with Suspected of Confirmed COVID-19	NA		→
3. Symptomatic residents are added to the facility line list			Continuing to update
Visitor Monitoring			
1. Only end-of-life/compassionate care visitors are permitted in the facility	✓		
2. Visitor is screened for fever and signs/symptoms using the Visitor Symptom Evaluation form	✓		
Personal Protective Equipment			
1. PPE supply is replenished in the isolation carts	✓		
2. Masks are available for visitors at the entrance for end-of-life/compassionate care visitors	✓		
Comments			

Employee _____ **Date** 1/11/21

Evaluator Charlene LPN **Date** 1/11/21

F880

Infection Prevention and Control Manual
Interim Hand Hygiene Audit- COVID-19 Pandemic

Exhibit #1

Hand Hygiene Audit – COVID-19

PROCEDURE	YES	NO	COMMENTS
Preparation			
1. Alcohol-Based Hand Rub Dispensers are located at facility entrances adequately replenished	✓		
2. Alcohol-Based Hand Rub is accessible in all resident-care areas	✓		
3. Soap dispensers are adequately replenished and available	✓		
4. Disposable hand towels are replenished and available	✓		
Hand Hygiene with alcohol-based hand rub (60-95% ethanol/isopropanol)			
1. Applies adequate product and vigorously rubs hands together, covering all aspects of hands	✓		
Hand Hygiene with soap and water			
1. Wets hand with clean, running water, , rinses soap off hands,	✓		
2. Applies soap and rubs hands together for at least 20 seconds covering all surfaces of hands and fingers	✓		
3. Dries with clean paper towel,	✓		
4. Turns off faucet using disposable towel.		✓	reminder to use new Paper towel
Additional Observations			
1. Performs hand hygiene with soap and water when hands are visibly soiled	✓		washing hands before leaving Pt room
2. Performs hand hygiene prior to donning gloves and PPE	✓		used hand sant. on PPE
3. Performs hand hygiene before performing personal cares	✓		after sanitizer did not touch wall straight to PPE
4. Performs hand hygiene after performing personal cares and removing gloves	✓		
5. Performs hand hygiene after handling soiled items and removing gloves	✓		
6. Performs hand hygiene before handling resident food			Needed to remind staff
7. Performs hand hygiene before handing resident care devices	✓		
8. Performs hand hygiene between dirty and clean procedures	✓		
9. Performs hand hygiene after touching face, facemask, goggles or face shield	N/A		

Infection Prevention and Control Manual
Interim Hand Hygiene Audit- COVID-19 Pandemic

Comments			
Observed Staff through out day and provided reminder to Staff on spot education continues.			

Employee _____ **Date** _____

Evaluator Sarah Glenn LPN **Date** 1/4/21

References and Resources:

- Centers for Disease Control and Prevention. Hand Hygiene in Healthcare Settings. Healthcare Providers. Clean Hands Count for Healthcare Providers. January 31, 2020 : https://www.cdc.gov/handhygiene/providers/index.html
- Centers for Medicare and Medicaid Services. State Operations Manual. Appendix PP – Guidance to Surveyors for Long Term Care Facilities. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf
- Centers for Disease Control and Prevention; Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/downloads/A_FS_HCP_COVID19_PPE.pdf
- Centers for Medicare & Medicaid Services. COVID-19 Long Term Care Facility Guidance. April 2, 2020. https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf
- Centers for Medicare & Medicaid Services, QSO-20-14-NH. Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED) March 13, 2020: https://www.cms.gov/files/document/3-13-2020-nursing-home-guidance-covid-19.pdf
- Centers for Medicare and Medicaid Services. Prioritization of Survey Activities. QSO-20-20-ALL https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0
- Centers for Medicare and Medicaid Services. Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes. QSO-20-29. May 6, 2020: https://www.cms.gov/files/document/qso-20-29-nh.pdf
- Centers for Medicare and Medicaid Services. COVID-19 Survey Activities, CARES Act Funding, Enhanced Enforcement for Infection Control deficiencies, and Quality Improvement Activities in Nursing Homes. QSO-20-31-All. June 1, 2020: https://www.cms.gov/files/document/qso-20-31-all.pdf

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Infection Prevention and Control Manual
Interim Hand Hygiene Audit- COVID-19 Pandemic

Exhibit #1

Hand Hygiene Audit – COVID-19

PROCEDURE	YES	NO	COMMENTS
Preparation			
1. Alcohol-Based Hand Rub Dispensers are located at facility entrances adequately replenished	✓		
2. Alcohol-Based Hand Rub is accessible in all resident-care areas	✓		need another on COVID Break room
3. Soap dispensers are adequately replenished and available	✓		
4. Disposable hand towels are replenished and available	✓		
Hand Hygiene with alcohol-based hand rub (60-95% ethanol or isopropyl)			
1. Applies adequate product and vigorously rubs hands together, covering all aspects of hands	✓		
Hand Hygiene with soap and water			
1. Wets hand with clean, running water, , rinses soap off hands,	✓		
2. Applies soap and rubs hands together for at least 20 seconds covering all surfaces of hands and fingers		✓	15 seconds asked to rewash made sing happy Birthday.
3. Dries with clean paper towel,	✓		
4. Turns off faucet using disposable towel.		✓	need to remind them
Additional Observations			
1. Performs hand hygiene with soap and water when hands are visibly soiled	✓		
2. Performs hand hygiene prior to donning gloves and PPE	✓		
3. Performs hand hygiene before performing personal cares	✓		done before + after entered room
4. Performs hand hygiene after performing personal cares and removing gloves	✓		
5. Performs hand hygiene after handling soiled items and removing gloves	✓		
6. Performs hand hygiene before handling resident food	✓		
7. Performs hand hygiene before handing resident care devices	✓		watched cna clean between residents
8. Performs hand hygiene between dirty and clean procedures	✓		
9. Performs hand hygiene after touching face, facemask, goggles or face shield	N/A		———

This resource was developed utilizing information from CDC and CMS.
Providers are reminded to review state and local specific information for any variance to national guidance
This document is for general informational purposes only. It does not represent legal advice nor relied upon as supporting documentation or advice with CMS or other regulatory entities.

Infection Prevention and Control Manual
Interim Hand Hygiene Audit- COVID-19 Pandemic

Employee _____ **Date** _____

Evaluator Carolyn Green (CPC) **Date** 1/8/21

References and Resources:

- Centers for Disease Control and Prevention. Hand Hygiene in Healthcare Settings. Healthcare Providers. Clean Hands Count for Healthcare Providers. January 31, 2020 : https://www.cdc.gov/handhygiene/providers/index.html
- Centers for Medicare and Medicaid Services. State Operations Manual. Appendix PP – Guidance to Surveyors for Long Term Care Facilities. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf
- Centers for Disease Control and Prevention; Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/downloads/A_FS_HCP_COVID19_PPE.pdf
- Centers for Medicare & Medicaid Services. COVID-19 Long Term Care Facility Guidance. April 2, 2020. https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf
- Centers for Medicare & Medicaid Services. QSO-20-14-NH. Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED) March 13, 2020: https://www.cms.gov/files/document/3-13-2020-nursing-home-guidance-covid-19.pdf
- Centers for Medicare and Medicaid Services. Prioritization of Survey Activities. QSO-20-20-ALL https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0
- Centers for Medicare and Medicaid Services. Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes. QSO-20-29. May 6, 2020: https://www.cms.gov/files/document/qso-20-29-nh.pdf
- Centers for Medicare and Medicaid Services. COVID-19 Survey Activities, CARES Act Funding, Enhanced Enforcement for Infection Control deficiencies, and Quality Improvement Activities in Nursing Homes. QSO-20-31-All. June 1, 2020: https://www.cms.gov/files/document/qso-20-31-all.pdf

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Infection Prevention and Control Manual
Interim Hand Hygiene Audit- COVID-19 Pandemic

Exhibit B-1

Hand Hygiene Audit – COVID-19

PROCEDURE	YES	NO	COMMENTS
[illegible]			
1. Alcohol-Based Hand Rub Dispensers are located at facility entrances adequately replenished	✓		
2. Alcohol-Based Hand Rub is accessible in all resident-care areas	✓		
3. Soap dispensers are adequately replenished and available	✓		
4. Disposable hand towels are replenished and available	✓		
Hand Hygiene with alcohol-based hand rub (60-95% ethanol or isopropyl)			
1. Applies adequate product and vigorously rubs hands together, covering all aspects of hands	✓		
Hand Hygiene with soap and water			
1. Wets hand with clean, running water, , rinses soap off hands,	✓		
2. Applies soap and rubs hands together for at least 20 seconds covering all surfaces of hands and fingers	✓		
3. Dries with clean paper towel,	✓		
4. Turns off faucet using disposable towel.	✓		
Additional Observations [illegible]			
1. Performs hand hygiene with soap and water when hands are visibly soiled	✓		
2. Performs hand hygiene prior to donning gloves and PPE	✓		used hand sanitizer
3. Performs hand hygiene before performing personal cares	✓		
4. Performs hand hygiene after performing personal cares and removing gloves	✓		
5. Performs hand hygiene after handling soiled items and removing gloves	✓		
6. Performs hand hygiene before handling resident food	N/A		
7. Performs hand hygiene before handing resident care devices	✓		
8. Performs hand hygiene between dirty and clean procedures	✓		
9. Performs hand hygiene after touching face, facemask, goggles or face shield	✓		

This resource was developed utilizing information from CDC and CMS.
Providers are reminded to review state and local specific information for any variance to national guidance

Infection Prevention and Control Manual
Interim Hand Hygiene Audit- COVID-19 Pandemic

Observation			

Employee _____ **Date** _____

Evaluator Carmen Glover **Date** 7/11/20

References and Resources:

- Centers for Disease Control and Prevention. Hand Hygiene in Healthcare Settings. Healthcare Providers. Clean Hands Count for Healthcare Providers. January 31, 2020 : https://www.cdc.gov/handhygiene/providers/index.html
- Centers for Medicare and Medicaid Services. State Operations Manual. Appendix PP – Guidance to Surveyors for Long Term Care Facilities. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf
- Centers for Disease Control and Prevention; Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/downloads/A_FS_HCP_COVID19_PPE.pdf
- Centers for Medicare & Medicaid Services. COVID-19 Long Term Care Facility Guidance. April 2, 2020. https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf
- Centers for Medicare & Medicaid Services, QSO-20-14-NH. Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED) March 13, 2020: https://www.cms.gov/files/document/3-13-2020-nursing-home-guidance-covid-19.pdf
- Centers for Medicare and Medicaid Services. Prioritization of Survey Activities. QSO-20-20-ALL https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0
- Centers for Medicare and Medicaid Services. Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes. QSO-20-29. May 6, 2020: https://www.cms.gov/files/document/qso-20-29-nh.pdf
- Centers for Medicare and Medicaid Services. COVID-19 Survey Activities, CARES Act Funding, Enhanced Enforcement for Infection Control deficiencies, and Quality Improvement Activities in Nursing Homes. QSO-20-31-All. June 1, 2020: https://www.cms.gov/files/document/qso-20-31-all.pdf

Infection Prevention and Control Manual
Interim Personal Protective Equipment (PPE) Audit- COVID-19 Pandemic

Personal Protective Equipment (PPE) - COVID-19 Audit

PROCEDURE	YES	NO	COMMENTS
All facility staff are wearing face covering (no cloth masks)	✓		
All facility staff are wearing PPE consistent with current guidance and COVID-19 status in facility	✓		
Preparation			
1. Determine and assemble appropriate PPE	✓		
2. Perform Hand Hygiene	✓		
Donning of Personal Protective Equipment			
1. Gown is donned first and tied at waist and neck	✓		COVID unit observ.
2. Don mask or ~~N95~~ respirator KN95	✓		
3. Secure nosepiece with both hands	✓		
4. Secure elastic bands or ties securely	✓		
5. Mask or N95 fits snug to face and below chin	✓		
6. Goggles or face shield is donned	✓		
7. Hand Hygiene is performed	✓		
8. Gloves extend to cover wrist of gown	✓		Put on during Pt care
Removal of Personal Protective Equipment			
Gloves			
1. Grasps outside of glove with opposite gloved hand and peels off	✓		
2. Holds removed glove in gloved hand	✓		
3. Slides fingers of ungloved hand under remaining glove at wrist	✓		
4. Peels glove off over first glove	✓		
5. Discards gloves in waste container	✓		reminder to wash hands
Gown			
1. Unfasten ties	✓		
2. Pulls away from neck and shoulders, touching inside of gown only	✓		
3. Turn gown inside out	✓		
4. Folds or rolls into a bundle and discards a. Disposable gowns: Discards in waste receptacle b. Reusable/cloth gowns: c. Places in soiled laundry receptacle	✓		
Exits Room after Glove/Gown Removal	✓		
Performs Hand Hygiene	✓		Used hand sanitizer
Goggles/Face Shield			
1. Removes goggles/face shield using care to pull away from face not to touch front of shield or goggles	✓		needed reminder to clean shield

Infection Prevention and Control Manual
Interim Personal Protective Equipment (PPE) Audit- COVID-19 Pandemic

Mask or Respirator			
1. Grasps bottom, then top ties or elastics and removes	✓		
2. Does not touch the front of the mask or respirator (contaminated)	✓		
3. Disposes of properly	✓		
5. The employee used the proper technique and order to don and removed PPE	✓		
6. PPE was removed at doorway or anteroom	✓		
7. Perform Hand Hygiene	✓		
Other			
1. Residents who leave facility for medical appointments (i.e. dialysis, chemotherapy) wear masks outside of room	✓		Have to remind some of the
2. Residents who are discharged/transported outside of facility wear a mask	✓		
Comments			

Employee _____ **Date** _____

Evaluator Deedra Glover **Date** 1/4/21

References

- Centers for Disease Control and Prevention: Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/downloads/A_FS_HCP_COVID19_PPE.pdf
- Centers for Medicare & Medicaid Services. COVID-19 Long Term Care Facility Guidance. April 2, 2020. https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf
- Centers for Medicare & Medicaid Services. QSO-20-14-NH. Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED). March 13, 2020: https://www.cms.gov/files/document/3-13-2020-nursing-home-guidance-covid-19.pdf
- Centers for Medicare & Medicaid Services. Prioritization of Survey Activities. QSO-20-20-ALL https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0
- Centers for Medicare & Medicaid Services. QSO-20-29-NH. May 6, 2020: Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes, May 6, 2020: https://www.cms.gov/files/document/qso-20-29-nh.pdf

Infection Prevention and Control Manual
Interim Personal Protective Equipment (PPE) Audit- COVID-19 Pandemic

Personal Protective Equipment (PPE) - COVID-19 Audit

PROCEDURE	YES	NO	COMMENTS
All facility staff are wearing face covering (no cloth masks)	✓		
All facility staff are wearing PPE consistent with current guidance and COVID-19 status in facility	✓		
Preparation			
1. Determine and assemble appropriate PPE	✓		
2. Perform Hand Hygiene	✓		
Donning of Personal Protective Equipment			
1. Gown is donned first and tied at waist and neck	✓		PCE Room A1
2. Don mask or N95 respirator KN95	✓		
3. Secure nosepiece with both hands	✓		
4. Secure elastic bands or ties securely	✓		
5. Mask or N95 fits snug to face and below chin	✓		
6. Goggles or face shield is donned	✓		face shield
7. Hand Hygiene is performed	✓		
8. Gloves extend to cover wrist of gown	✓		only done with pt care
Removal of Personal Protective Equipment			
Gloves			
1. Grasps outside of glove with opposite gloved hand and peels off	✓		
2. Holds removed glove in gloved hand	✓		
3. Slides fingers of ungloved hand under remaining glove at wrist	✓		
4. Peels glove off over first glove	✓		
5. Discards gloves in waste container	✓		
Gown			
1. Unfasten ties		✓	Needed reminder for ties
2. Pulls away from neck and shoulders, touching inside of gown only	✓		
3. Turn gown inside out	✓		
4. Folds or rolls into a bundle and discards a. Disposable gowns: Discards in waste receptacle b. Reusable/cloth gowns: c. Places in soiled laundry receptacle	✓		
Exits Room after Glove/Gown Removal	✓		
Performs Hand Hygiene	✓		Hand sanitizer
Goggles/Face Shield			
1. Removes goggles/face shield using care to pull away from face not to touch front of shield or goggles	✓		

Infection Prevention and Control Manual
Interim Personal Protective Equipment (PPE) Audit- COVID-19 Pandemic

Mask or Respirator			
1. Grasps bottom, then top ties or elastics and removes	✓		
2. Does not touch the front of the mask or respirator (contaminated)	✓		
3. Disposes of properly	✓		
5. The employee used the proper technique and order to don and removed PPE	✓		
6. PPE was removed at doorway or anteroom	✓		
7. Perform Hand Hygiene	✓		Hand Sanitizer
Other			
1. Residents who leave facility for medical appointments (i.e. dialysis, chemotherapy) wear masks outside of room	✓		need to remind transport company X 1
2. Residents who are discharged/transported outside of facility wear a mask	✓		
Comments			

Employee _____ **Date** _____

Evaluator Carolyn Glover LPN **Date** 1/8/21

References

- Centers for Disease Control and Prevention: Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/downloads/A_FS_HCP_COVID19_PPE.pdf
- Centers for Medicare & Medicaid Services. COVID-19 Long Term Care Facility Guidance. April 2, 2020. https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf
- Centers for Medicare & Medicaid Services. QSO-20-14-NH. Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED). March 13, 2020: https://www.cms.gov/files/document/3-13-2020-nursing-home-guidance-covid-19.pdf
- Centers for Medicare & Medicaid Services. Prioritization of Survey Activities. QSO-20-20-ALL https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0
- Centers for Medicare & Medicaid Services. QSO-20-29-NH. May 6, 2020: Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes, May 6, 2020: https://www.cms.gov/files/document/qso-20-29-nh.pdf

Infection Prevention and Control Manual
Interim Personal Protective Equipment (PPE) Audit- COVID-19 Pandemic

Personal Protective Equipment (PPE) - COVID-19 Audit

PROCEDURE	YES	NO	COMMENTS
All facility staff are wearing face covering (no cloth masks)	✓		
All facility staff are wearing PPE consistent with current guidance and COVID-19 status in facility	✓		
Preparation			
1. Determine and assemble appropriate PPE	✓		
2. Perform Hand Hygiene	✓		
Donning of Personal Protective Equipment			
1. Gown is donned first and tied at waist and neck	✓		PUI Room C2
2. Don mask or N95 respirator	✓		
3. Secure nosepiece with both hands	✓		
4. Secure elastic bands or ties securely	✓		
5. Mask or N95 fits snug to face and below chin	✓		
6. Goggles or face shield is donned	✓		
7. Hand Hygiene is performed	✓		
8. Gloves extend to cover wrist of gown	✓		
Removal of Personal Protective Equipment			
Gloves			
1. Grasps outside of glove with opposite gloved hand and peels off	✓		
2. Holds removed glove in gloved hand	✓		
3. Slides fingers of ungloved hand under remaining glove at wrist	✓		
4. Peels glove off over first glove	✓		
5. Discards gloves in waste container	✓		
Gown			
1. Unfasten ties	✓		
2. Pulls away from neck and shoulders, touching inside of gown only	✓		
3. Turn gown inside out	✓		
4. Folds or rolls into a bundle and discards a. Disposable gowns: Discards in waste receptacle b. Reusable/cloth gowns: c. Places in soiled laundry receptacle	✓		
Exits Room after Glove/Gown Removal	✓		
Performs Hand Hygiene	✓		Hand Sanitizer
Goggles/Face Shield			
1. Removes goggles/face shield using care to pull away from face not to touch front of shield or goggles	✓		

Infection Prevention and Control Manual
Interim Personal Protective Equipment (PPE)
Audit- COVID-19 Pandemic

Mask or Respirator			
1. Grasps bottom, then top ties or elastics and removes	✓		
2. Does not touch the front of the mask or respirator (contaminated)	✓		
3. Disposes of properly	✓		
5. The employee used the proper technique and order to don and removed PPE	✓		
6. PPE was removed at doorway or anteroom	✓		
7. Perform Hand Hygiene	✓		
Other			
1. Residents who leave facility for medical appointments (i.e. dialysis, chemotherapy) wear masks outside of room	✓		
2. Residents who are discharged/transported outside of facility wear a mask	✓		
Comments			
Education with recp. & screened to verbal give mask to transport			

Employee _____ **Date** _____

Evaluator Carolyn Glover **Date** 1/11/21

References

- Centers for Disease Control and Prevention: Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/downloads/A_FS_HCP_COVID19_PPE.pdf
- Centers for Medicare & Medicaid Services. COVID-19 Long Term Care Facility Guidance. April 2, 2020. https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf
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- Centers for Medicare & Medicaid Services. Prioritization of Survey Activities. QSO-20-20-ALL https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0
- Centers for Medicare & Medicaid Services. QSO-20-29-NH. May 6, 2020: Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes, May 6, 2020: https://www.cms.gov/files/document/qso-20-29-nh.pdf