January 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 the state requirements at the time of the focused infection control survey #WJHB12.

Enclosed is the **State Revisit Report form**, which indicates the licensee to be in substantial compliance. A copy of this form will become a part of the facility's public file. Please keep this current inspection report in the facility and available for review.

If we can be of further assistance, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Sandy Farmer
LTC Customer Service Representative IV

\sf

Enclosure

Douglas A. Ducey | Governor   Cara M. Christ MD, MS | Director
150 North 18th Avenue, Suite 440, Phoenix, AZ 85007-3247   P | 602-364-2690   F | 602-324-0993
W | azhealth.gov
Health and Wellness for all Arizonans

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
NCI-2643 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 State surveyor to show those deficiencies previously reported 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 State Survey Report (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 Y0342 Reg. # R9-10-403.C.2.e. 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) nc	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			

EVENT ID: WJHB12

STATE FORM: REVISIT REPORT (11/06)

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

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

Dear Mr. Balliet:

Thank you for the courtesy and cooperation extended to our staff during the recent Infection Control Focus Survey of your facility.

Enclosed is a statement of **STATE** deficiencies noted during the inspection of your facility on December 9, 2020. A Plan of Correction (PoC) for the deficiencies must be submitted. This plan must be both specific to the problems noted and general to the overall process involved.

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. Please be advised that your plan of correction will be available as a public document for review by interested parties.**

Please place your plan of correction in the space provided in the right column of the statement of deficiencies and return the original to this office no later than **January 3, 2021**. You must include all pages of the Statement of Deficiencies when submitting your PoC. Please ensure to retain a copy for your files. If the plan of correction is not received by this Office on or before this date, state enforcement action may be taken. 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

Informal Dispute Resolution - You have an opportunity to dispute any deficiencies or language listed on the SOD through an Informal Dispute Resolution (IDR). To dispute a deficiency or language listed on the SOD, send a written request on a separate document **due 10 days from receipt of this letter**. The written request must include documentation that shows the licensee was in compliance at the time of the inspection. The Department will review the written request and documentation provided to the Department and notify you of the Department's decision. If you have any questions, please call: Diane Eckles, Bureau Chief, Bureau of Long Term Care 150 North 18th Avenue, #440, Phoenix, Arizona 85007at (602) 364-2690.

Sincerely,

Diane Eckles
Bureau Chief

DE:mm

Enclosure

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2643	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) COMPLETE DATE
Y 000	Initial Comments An onsite focused infection control survey was conducted on December 9, 2020. The following deficiency was cited:	Y 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."	
Y 342	R9-10-403.C.2.e. Administration R9-10-403.C. An administrator shall ensure that: R9-10-403.C.2. Policies and procedures for physical health services and behavioral health services are established, documented, and implemented to protect the health and safety of a resident that: R9-10-403.C.2.e. Cover infection control; This RULE 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 establish and follow policies in regards to infection prevention and control practices to prevent the development and transmission of infection including COVID-19. 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	Y 342	**<u>Y342</u>** **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: Brian Baltut, LNHA | TITLE: ADMINISTRATOR | (X6) DATE: 1/3/2021

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Y 342	Continued From page 1 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 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	Y 342	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?** Infection Preventionist and Director of Nursing, or IDT member will audit	

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Y 342	Continued From page 2 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 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.	Y 342	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. Infection Preventionist and Director of Nursing, or IDT member will conduct on-	

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Y 342	Continued From page 3 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 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	Y 342	going monitoring of screening logs to ensure staff compliance weekly x 12 weeks. Any staff found to be non-compliant with any of the above, will receive ad-hoc, documented training regarding the non-compliant issue.	

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Y 342	Continued From page 4 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, 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	Y 342		

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Y 342	Continued From page 5 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. 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	Y 342		

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Y 342	Continued From page 6 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 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	Y 342		

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Y 342	Continued From page 7 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.	Y 342		

Notice of Inspection Rights

Facility/Agency Name: Sapphire Of Tucson Nursing And Rehab, Llc			
Address: 2900 East Milber Street		City: Tucson	Zip: 85714
Facility I.D.#: LTC0053	License #: NCI-2643	Medicare #: 035099	Date of Inspection: December 9, 2020
Survey Event ID: WJHB11			
Inspector/Team Coordinator: Rebecca Jacobson			
Accompanied By: Sallie Martinez			

BUREAU OF LONG TERM CARE LICENSING

This inspection is conducted under the authority of:

1. Arizona Revised Statutes (A.R.S.) Title 36, Chapters 1 and 4, and Arizona Administrative Code (A.A.C.), Title 9, Chapter 10. Some of the activities during the inspection may include, but are not limited to, a facility premise inspection, review and/or copying of records, including personnel records, interviews with residents/patients/clients, family and staff, and review of services offered.
2. The purpose of this inspection is to:
   - ☐ Determine compliance with health care institution requirements pursuant to the above A.R.S. and A.A.C.
   - ☐ Conduct a complaint investigation.
3. No fees are charged for this inspection.
4. An authorized representative of this facility may accompany the inspector(s) during the inspection conducted on these premises, except during any confidential interview.
5. You have the right to receive copies of any original documents taken by the inspector(s) during the inspection in those cases where the agency has authority to take original documents.
6. You and your staff have the opportunity to provide any information that would clarify an issue. Additionally, interviews with staff, family or residents/patients/clients may be conducted privately. Each person interviewed will be informed that statements made by the person may be included in the inspection report and each person whose conversations are tape or video recorded will be informed that the conversation is being tape or video recorded.
7. Upon completion of the inspection the inspector(s) will conduct an exit interview and informally disclose their findings. A Statement of Deficiencies (SOD) formally notifying you of the findings will be provided within 30 working days. You will be afforded an opportunity to submit a Plan of Correction (POC) unless the Department is considering enforcement against the license.
8. You have an opportunity to dispute any findings of non-compliance through an Informal Dispute Resolution (IDR). Details of the IDR process will be provided when the SOD is mailed to you.
9. If you have questions regarding this inspection, you may contact: Diane Eckles, Bureau Chief, at 150 N. 18th Ave., Suite 440, Phoenix, Arizona 85007-3242, Phone: (602) 364-2675, FAX: (602) 324-0993, E-Mail: Diane.Eckles@azdhs.gov. If you have an issue that you cannot resolve with the Bureau or the Division, you may contact the Office of Ombudsman-Citizens' Aide, 7878 N. 16th St., Suite 235 Phoenix AZ 85020 (602) 277-7292.
10. Your administrative hearing rights are found at A.R.S. § 41-1092 et seq., and rights relating to appeal of a final agency decision can be found in A.R.S. §12-901 et seq.

Upon entry to the premises for this inspection, the inspector(s) presented photo identification indicating that they are Arizona Department of Health Services (ADHS) employees and reviewed with me the above Notice of Inspection Rights. I have read the disclosures and am notified of my inspection and due process rights as listed. I understand that while I have the right to decline to sign this form, the ADHS representative(s) may proceed with the inspection.

[signature] 12/9/2020

Administrator/Director/Agency Representative Signature Date:

☐ Administrator/Director/Agency Representative refused to sign this form.

☐ Administrator/Director/Agency Representative or authorized on-site representative is not present.

[signature] 12/9/20

Inspector/Team Coordinator Signature: Date:

☒ Copy left with Administrator/Director/Agency Representative