STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135102	A. BUILDING _____ B. WING _____	**06/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNNY RIDGE	**2609 SUNNYBROOK DRIVE NAMPA, ID 83686**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** Based on observation, policy review, and staff interview, it was determined the facility failed to ensure infection control prevention practices were implemented and maintained to provide a safe and sanitary environment. This was true for 4 of 4 residents (#1, #2, #3, and #4) observed for infection control prevention practices. This failure created the potential of exposing residents to the risk of infection and cross-contamination including COVID-19. Findings include: 1. The facility's Hand Hygiene, Standard Precautions, and Personal Protective Equipment (PPE) policies, dated 11/15/19 and 9/26/19; respectively, directed staff to perform hand hygiene before and after resident care and after contact with the resident's environment. The policies directed staff to change gloves after contact with residents and/or their environment and to perform hand hygiene after removing gloves. These policies were not followed. On 6/11/20 from 9:27 AM to 10:07 AM, Physical Therapy Assistant #1 (PTA) was observed while assisting Resident #1. PTA #1 had on blue disposable gloves and used both of her gloved hands to adjust Resident #1's cloth mask, touching the front of the mask. PTA #1 then disposed of the blue gloves and underneath the disposable gloves were white cotton gloves. PTA #1 did not remove the cotton gloves and did not perform hand hygiene. PTA #1 then went into Resident #2's room to speak to her. While in the room, PTA #1 adjusted the front of her own face mask with her right cotton gloved hand and did not remove the gloves or perform hand hygiene. She then left Resident #2's room and while speaking to another staff member in the hallway, PTA #1 adjusted the front of her mask two times with her right cotton gloved hand and did not remove the gloves or perform hand hygiene. PTA #1 then walked down the hallway and stopped and adjusted Resident #3's cloth mask, who was in the hallway, touching the left front of the mask with her right cotton gloved hand. PTA #1 did not remove her white cotton gloves or perform hand hygiene. PTA #1 then walked to the West Side nurses' station and removed a set of blue disposable gloves from her right jacket pocket. She then put the blue disposable gloves on over the same white cotton gloves. PTA #1 next went into Resident #4's room and picked up his oxygen tubing and cleaned it with a sanitation wipe. PTA #1 and CNA #2 then assisted Resident #4 down the hallway with his 4-wheeled walker. PTA #1 held her right blue gloved hand on his gait belt and CNA #2 pushed his wheelchair behind him. At 9:47 AM, PTA #1 applied the wheelchair brake with her right hand so Resident #4 could sit down to rest for a minute. Then she assisted him back up to a standing position. At 9:51 AM, PTA #1 applied the brakes again and the resident rested in his wheelchair. At 9:55 AM, PTA #1 adjusted the front of her mask with her right gloved hand and then released the wheelchair brake and finished assisting him back to his room using the walker. At 9:59 AM, Resident #4 was in his room and he sat back in his wheelchair and PTA #1 grabbed the walker's handles with both hands and moved it out of the way to the side of the room. CNA #2 removed her gloves and performed hand hygiene and at the same time, Resident #4 spilled some coffee on his tray table. PTA #1 removed her disposable blue gloves and held them in her right cotton gloved cupped hand and picked up his coffee cup with the same hand by the handle while CNA #2 cleaned his tray table. PTA #1 then threw away the dirty pair of disposable blue gloves and she did not remove her white cotton gloves and did not perform hand hygiene. At 10:04 AM, PTA #1 took out a piece of folded paper from her left jacket pocket and held it with both cotton gloved hands and then placed it back in her pocket. She next took off her white cotton gloves, placed them in her left jacket pocket and then pulled out hand sanitizer out of her right jacket pocket and performed hand hygiene. PTA #1 then left the room and briefly went into another resident's room. While there she adjusted the front of her mask with her right bare hand and did not perform hand hygiene after touching her face mask. On 6/11/20 at 11:55 AM and 12:55 PM, PTA #1 said she had multiple pairs of sanitized white cotton gloves she wore due to a skin condition. She said she also used special soap because the facility's soap and hand sanitizer were rough on her skin. She said the Infection Control Preventionist (ICP) had educated her on hand hygiene practices but she did not always perform hand hygiene due to her skin condition and did not always change the cotton gloves after working with residents. On 6/11/20 at 1:15 PM, the ICP said PTA #1 was educated to perform hand hygiene between residents and to change her white cotton gloves between residents' cares. She said she expected staff to perform hand hygiene after each glove change and after they touched their masks. The ICP said staff should not store new or used gloves in their pockets due to cross contamination concerns. The ICP also said PTA #1 should not have kept the dirty disposable gloves in her hand while she held Resident #4's coffee mug. 2. The facility's Linen Handling policy and procedure, revised 3/1/18, directed staff to wash any linen dropped on the floor. On 6/11/20 at 11:00 AM, Resident #3 was sitting in her wheelchair by the East nurse's station. Resident #3 was eating fresh fruits when she dropped her small pillow on the floor. CNA #1 walked toward the nurse's station and picked-up the pillow from the floor and positioned the pillow under Resident #3's right forearm. CNA #1 did not change the pillow case on Resident #3's small pillow prior to placing it back under Resident #3's arm. On 6/11/20 at 11:17 AM, CNA #1 said she picked up Resident #3's pillow and placed it under Resident #3's right forearm. CNA #3 said I know I did not change the pillow case. On 6/11/20 at 1:40 PM, the ICP said when CNA #1 picked-up Resident #3's pillow from the floor, she should have changed the pillow case of Resident #3's pillow before giving it back to her to use.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE