STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135058	A. BUILDING _____ B. WING _____	**07/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOOD SAMARITAN SOCIETY - SILVER WOOD VILLAGE	**405 WEST SEVENTH STREET SILVERTON, ID 83867**

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** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 failure created the potential for negative outcomes by exposing residents to the risk of infection and cross-contamination including COVID-19. Findings include: 1. The facility's Nursing Care Equipment and Supplies policy, dated 12/1/15, directed staff to dispose of supplies that are soiled or suspected to be unsafe. The facility's Oxygen Administration policy, dated 10/1/17, directed staff to store nasal cannulas in a plastic bag when not in use. These policies were not followed. Resident #1 was readmitted to the facility on [DATE], with multiple diagnoses, including shortness of breath and [MEDICAL CONDITION]. Resident #1's physician's orders [REDACTED]. On 7/21/20 from 9:00 AM to 9:15 AM, Resident #1 was observed in the dayroom in his wheelchair wearing a NC. He took off his NC and placed it in his wheelchair with the NC prongs wedged between his seat cushion and his left pant leg. At 9:10 AM, Resident #1 then picked up the tubing and it fell to the floor. The NC prongs and 6 inches of O2 tubing was on the floor to the left side of his wheelchair. At 9:15 AM, the Activity Director picked up the NC tubing and prongs and placed it between Resident #1's back and his wheelchair. The Activity Director then performed hand hygiene and assisted Resident #1 by placing the NC prongs back in his nose with the tubing on his face and over his ears. The Activity Director did not disinfect or replace the O2 tubing after it was on the floor. On 7/21/20 at 9:22 AM and 2:00 PM, the Activity Director said he picked up Resident #1's O2 tubing off the floor and placed the tubing behind the resident's back because there was no plastic bag to store the O2 tubing in. He said he then put the NC back onto Resident #1. The Activity Director said he thought he could place the NC back on Resident #1 because he did not realize the NC prongs had touched the floor. He said if the NC prongs were on the floor, he would let the nurse know to replace the tubing. On 7/21/20 at 2:25 PM, the ICP said the NC tubing and prongs should have been discarded if they touched the floor. She said she expected staff to place O2 tubing in plastic bags when not in use. 2. The facility's Environmental Cleaning Principles policy and procedure, dated 3/2016, stated high touch areas (surfaces with high probability of contact with skin such as handles on equipment) were cleaned frequently in between resident contact with the equipment. This policy was not followed. On 7/21/20 at 1:33 PM, CNA #1 exited Resident #2 and Resident #3's room with the Hoyer lift (a mobility lift used for transfers and entered Resident #4's room. CNA #1 then left the Hoyer lift inside Resident #4's room. On 7/21/20 at 1:37 PM, Resident #4, in his power wheelchair, entered his room followed by CNA #1 and CNA #2. CNA #1 then closed the door to Resident #4's room. On 7/21/20 at 1:43 PM, CNA #1 said she did not clean the Hoyer lift after she and CNA #2 used it to transfer Resident #2 to his bed. CNA #1 said she should have wiped the Hoyer lift with disinfectant wipes before they used it to transfer Resident #4. On 7/21/20 at 2:15 PM, the ICP said the Hoyer lift should have been wiped down with Sani-wipes (a disinfectant wipe) after each use.

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