STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135015	A. BUILDING _____ B. WING _____	**06/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PAYETTE HEALTHCARE OF CASCADIA	**1019 THIRD AVENUE SOUTH PAYETTE, ID 83661**

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.** **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 maintained to provide a safe and sanitary environment. This was true for 4 of 10 residents (#5, #6, #7, and #10) observed for infection control prevention practices. These failures created the potential of exposing residents to the risk of infection and cross contamination including COVID-19. Findings include: 1. The facility's Screening and Management of Coronavirus COVID-19 policy and procedure, dated 5/19/20, directed staff to place their newly admitted residents in quarantine precautions and to place a sign outside of the rooms indicating they were under quarantine. According to the U.S. Department of Health and Human Services, website accessed 6/23/20, quarantine is defined as separation and restriction of movement of people who may have been exposed to a contagious disease to see if they become sick. A facility in-service Transmission Based Precautions, dated 6/10/20, directed staff to post the appropriate precaution signage outside the resident's room and to place and maintain an adequate supply of appropriate PPE at the door. On 6/16/20 at 8:30 AM, during the initial tour of the facility's quarantine unit, PPE carts were observed outside the rooms of Residents #5, #6, #7, and #10. There were no signs posted outside their rooms. On 6/16/20 at 8:45 AM, NA #1 entered Resident #10's room. NA #1 wore a mask but did not don a gown or gloves when she entered Resident #10's room. On 6/16/20 at 10:38 AM, RN #1 said resident rooms in the quarantine unit with a PPE cart outside their doors were newly admitted residents whose COVID-19 test results were still pending. RN #1 said staff should wear a facial mask, gown, and gloves when they enter residents' rooms with PPE carts outside their doors. On 6/16/20 at 12:05 PM, UM #1 together with the ICP, said resident rooms in the quarantine unit with a PPE cart outside their doors were newly admitted residents whose COVID-19 test results were still pending, residents on [MEDICAL TREATMENT], or residents who had frequent medical appointments such as wound clinic visits. UM #1 said there should be a sign which stated STOP please see the nurse outside the residents' doors in the quarantine unit. UM #1 said staff entering resident rooms with a PPE cart outside their door should wear a facial mask, gown, and gloves before entering these rooms. When asked why there were no signs posted outside of the resident rooms in the quarantine unit, UM #1 said the facility had a recent change of management and all of the signs had the name of their former corporation. On 6/16/20 at 12:45 PM, NA #1 said she knew she had to wear a gown before entering Resident #10's room but there were no gowns in the PPE cart. NA #1 said she just wanted her job done and she made a poor choice. 2. The Centers for Disease Control and Prevention's website, accessed on 6/17/20, stated hand hygiene should be performed before donning PPE. On 6/16/20 at 1:45 PM, NA #1 walked toward Resident #6's room and opened the PPE cart, then took a gown out and put it on over her clothes. NA #1 then put on a pair of gloves and entered Resident #6's room. NA #1 did not perform hand hygiene before donning her PPE. On 6/16/20 at 2:00 PM, NA #1 said she did not perform hand hygiene before donning her PPE when she entered Resident #6's room because there was no hand sanitizer of top of the PPE cart. 3. A facility in-service Transmission Based Precautions, dated 6/10/20, documented isolation and quarantine interventions were to be communicated to staff through clinical alerts, communication boards, signage, and stand-up meetings. On 6/16/20 at 12:55 PM, CNA #1 stepped out of Resident #6's room carrying a food tray and placed it inside the food cart. CNA #1 was not wearing a gown when she stepped out of Resident #6's room. NA #1 was heard saying to CNA #1 I am confused now, are we supposed to wear gowns when we enter residents' rooms with a PPE cart outside their rooms? CNA #1 said she was told she did not need to wear a gown to enter residents' rooms if she was only collecting food trays. On 6/16/20 at 1:05 PM, the ICP said she was appointed as Infection Control Nurse four days ago and had recently started training the staff regarding hand hygiene and infection control and prevention practices.

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