STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135103	A. BUILDING _____ B. WING _____	**09/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRESTIGE CARE & REHABILITATION - THE ORCHARDS	**1014 BURRELL AVENUE LEWISTON, ID 83501**

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 prevent the spread of COVID-19 and other infectious diseases. This failure placed all staff on the COVID + at risk of contracting COVID-19 and/or other infections. Findings include: 1. The CDC website, accessed on 9/11/20, included a document dated 5/22/20, titled Responding to Coronavirus in Nursing Homes. The document stated healthcare providers must wear eye protection and an N95 or higher-level respirator at all times while on the COVID-19 positive unit. This guidance was not followed. On 9/9/20 from 1:35 PM to 2:40 PM, observations were conducted of facility staff on the facility's COVID-19 positive unit, as follows: * At 1:35 PM and 1:40 PM, LPN #1 was in the COVID-19 unit hallway and at the nurses' station with an N95 mask on and no eye protection. * At 1:40 PM, RN #2 was at the COVID-19 unit nurses' station with an N95 mask on and no eye protection. * At 1:45 PM, CNA #2 was at the COVID-19 unit hallway with an N95 mask on and no eye protection. * At 2:03 PM, CNA #3 was at the COVID-19 unit hallway with an N95 mask on and no eye protection. On 9/9/20 at 1:35 PM, LPN #1 said staff wore N95 masks at all times in the COVID-19 unit and donned (put on) eye protection, gowns, and gloves before going into residents' rooms or when providing resident care. On 9/9/20 at 2:10 PM, CNA #3 said staff wore N95 masks at all times in the COVID-19 unit and donned eye protection, gowns, and gloves before going into residents' rooms. On 9/9/20 at 2:20 PM, RN #2 said staff wore N95 masks at all times in the COVID-19 unit and donned eye protection, gowns, and gloves before going into residents' rooms. On 9/9/20 at 2:20 PM, CNA #2 said staff wore N95 masks at all times in the COVID-19 unit and donned eye protection, gowns, and gloves before going into residents' rooms or when providing resident care. On 9/9/20 at 2:50 PM, the DON, with the Administrator present, said the COVID-19 unit was under droplet precautions and staff were expected to wear N95 masks while on the unit. The DON said she thought staff only had to wear eye protection and full PPE when in the residents' rooms or when providing resident care. The Administrator said she thought staff only needed to wear a mask in the hallway because there was no risk of encountering a splash or splatter from a resident when in the hallway, but they should wear a face shield in residents' rooms. 2. The CDC website, accessed 9/11/20, included guidance dated 4/30/20, which documented signage was to be placed at the entrance to the COVID-19 unit instructing staff they must wear eye protection and an N95 or higher-level mask at all times while on the unit. This guidance was not followed. On 9/9/20 at 1:30 PM, two surveyors entered the COVID-19 positive unit from the outside. A sign was present on the door that documented, Do Not Use This Door. There was no sign posted on the door that indicated the area was an isolation area and it was necessary to wear eye protection and an N95 or higher-level mask when entering the area. On 9/9/20 at 2:20 PM, RN #2 said there was no sign on the COVID-19 unit entrance door. On 9/9/20 at 2:50 PM, the Administrator, with the DON present, said there was not a sign on the COVID-19 unit entrance door. The Administrator said she expected staff to know what PPE they were to wear when inside that unit. The DON said there was not a sign on the COVID-19 unit entrance door. The DON said no one should enter the unit except staff who worked in the unit. 3. The CDC website, accessed 9/11/20, provided guidance that Standard Precautions were used for all patient care. The guidance further stated that PPE (including gloves) was used whenever there was possible exposure to infectious material. This guidance was not followed. a. On 9/9/20 from 2:03 PM to 2:08 PM, CNA #3 was wiping down handrails and residents' door handles in the COVID-19 positive unit with a disinfectant Sani-wipe with no gloves on. After using a Sani-wipe with her right hand, she transferred the used wipe to her left hand and cupped it there. CNA #3 then used her left hand to take out a Ziploc bag with clean wipes in it from her left pants pocket and retrieved a new wipe. She then finished wiping down more handrails and door handles with her right hand while cupping the used wipe in her left hand. CNA #3 then placed the second used wipe into her left cupped hand. She then disposed of the wipes in the nurses' station and then retrieved a new wipe from the Ziploc bag in her pocket and continued to wipe down the handrails and door handles. On 9/9/20 at 2:10 PM, CNA #3 said she had not worn gloves while wiping down the handrails and door handles on the COVID-19 positive unit. On 9/9/20 at 2:50 PM, the DON said she expected staff to wear gloves when cleaning surfaces in the COVID-19 positive unit. She said there was a potential for cross contamination when CNA #3 had cupped the used wipes in her hand and then retrieved the new wipes out of her pocket. b. On 9/9/20 at 8:33 AM, Hospitality Aide #1 was observed in the dining area and was clearing dishes from the dining tables where residents had just finished eating breakfast. Hospitality Aide #1 was not wearing gloves, and as she brought the used dishes to the bussing cart she scraped the remaining food from the plates into a receptacle on the bussing cart. Hospitality Aide #1 also poured out remaining liquid from the glasses she had cleared from the table, and she placed the used glasses, plates, and silverware into tray bins on the bussing cart with her bare hands. On 9/9/20 at 10:20 AM, Hospitality Aide #1 said the staff did not wear gloves when serving food and when bussing the tables. Hospitality Aide #1 said she did not remember who she talked to, but she asked someone about wearing gloves and that person said they did not need to wear gloves when clearing the tables. On 9/9/20 at 12:50 PM, RN #1 was observed in the dining area, and she was clearing dishes from the dining tables where residents had just finished eating lunch. RN #1 was wearing gloves as she bussed the dishes from the tables in the same manner as described above. RN #1 said she did not think it was expected for staff to wear gloves when they bussed tables, but she chose to wear gloves as her personal decision. On 9/9/20 at 12:55 PM, CNA #1 was observed bussing dishes from a tray she carried to the bussing cart. CNA #1 was not wearing gloves, and she said she just fed a resident in her room. CNA #1 said sometimes she wore gloves when she worked in the dining room, but the staff had been given different directions at different times regarding whether they were to wear gloves. On 9/9/20 at 2:53 PM, the Administrator said the facility did not have a policy for bussing tables. On 9/9/20 at 3:08 PM, the DON said staff should wear gloves when bussing dishes in the dining room.
F 0882 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	Based on record review and staff interview, it was determined the facility failed to ensure an ICP with specialized training in infection control and prevention was appointed to the facility. This failure had the potential to negatively impact all 46 residents who resided in the facility and all of the staff. This deficient practice created the potential for staff to not receive appropriate infection control prevention training and provide resident care inconsistent with current standards of practice for infection prevention and control. Findings include: On 9/9/20, the facility provided documentation that the ICP was Not Yet Certified. On 9/9/20 at 9:00 AM, the DON said the ICP was new to the role and had not completed CDC infection control training yet. On 9/9/20 at 1:20 PM, the Administrator said she thought the ICP had specialized infection control training and would look into that. On 9/9/20 at 5:02 PM, an email sent by the Administrator documented the ICP's credentials and training. The email did not document the ICP had specialized training for infection control and prevention.

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