STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135042	A. BUILDING _____ B. WING _____	10/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LACROSSE HEALTH & REHABILITATION CENTER	**210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814**

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, interview and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the transmission of communicable diseases, including COVID-19 and infections. COVID-19 is an infectious disease by a new virus causing respiratory illness with symptoms including cough, fever, new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death. Specifically: 1. Failed to change gloves and perform hand hygiene to prevent cross contamination when moving from dirty to clean tasks during incontinence care for 1 of 1 resident (R) (R1) observed for incontinence care. 2. Failed to perform hand hygiene after doffing (removing) used isolation gown as part of transmission based precautions (TBP) on COVID-19 unit before donning (putting on) new isolation gown for 1 of 1 Certified Nursing Assistant (CNA)1 observed doffing and donning gown. 3. Failed to clean and disinfect high touch items in resident rooms on the COVID-19 unit for 3 of 3 resident room (R3, R4, R5) cleaning observations. 4. Failed to ensure operating fans in laundry area were clean for 2 of 2 fans observed. These failures increased the risk for the spread of infection and its associated discomfort and decline in physical condition. Findings include: During an interview on 10/21/20 at 8:10 AM Director of Nursing (DON) and Infection Preventionist (IP) stated that the facility census was 59. The facility's 200/300 hall had 26 residents who were previously COVID-19 positive and were recovered and 100 hall had 8 residents; of which some were recovering. The 100 hall was the facility's COVID-19 unit. The facility did not have any resident presumed positive or under investigation. Facility had sufficient inventory of PPE (personal protective equipment) although was running low on N95 masks and all staff were required to wear full PPE comprised of mask (N95 on COVID unit and KN95 on non-COVID unit), eye protection, gown and gloves. Full PPE use started on 9/11/20 when facility had first COVID-19 positive case. Review of Centers of Disease Control and Prevention (CDC) cases and deaths by county, https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/county-map.html, dated 10/14/20, accessed 10/20/20, showed Kootenai County (the county where the facility was located) had 12.6 percent positivity rate indicating a high level of community COVID-19 activity/red zone positivity classification. Review of facility's listing of residents COVID-19 positive results, untitled and undated, showed columns for date, resident (name), and 20 days (from date of positive result and TBP could be discontinued). The most recent resident who tested positive for COVID-19 was R2. R2 tested positive for COVID-19 on 10/20/20. *Incontinence care: Review of R1's record showed the facility admitted the resident on 6/29/20 with [DIAGNOSES REDACTED]. R1's Minimum Data Set (MDS-assessment tool), dated 10/6/20, showed the resident was cognitively intact and had total dependence for toileting and had frequent incontinence of both bladder and bowel. Review of R1's care plan showed Activities of Daily Living Self Care Performance Deficit including toilet use: is primarily incontinent of B(owel) and B(ladder). Requires dependent assistance with incontinence care and bed pan as needed/requested with start date of 8/11/20. In addition, care plan showed (functional) bladder incontinence r/t (related to) [MEDICAL CONDITION], debility, weakness, constipation, acute infection, use of daily diuretics, [MEDICAL CONDITIONS] with start date of 6/29/20. Observations on 10/21/20 at 10:20 AM showed Certified Nursing Assistant (CNA)1, with assistance from Rehabilitation staff (RS)1, provide incontinence care for R1. CNA1 wore gloves and opened resident's brief and used wipes to clean resident and then asked resident to turn towards RS1. CNA1 obtained additional wipes and wiped resident's buttocks with brown smear of stool appearing on wipes. CNA1 continued cleaning with several additional wipes and then removed and discarded brief. Brief appeared saturated, heavier and darker in color. Wearing the same pair of gloves, CNA1 touched resident's draw sheet on the bed and straightened out and repositioned draw sheet and then obtained new clean brief, opened brief and placed under the resident. Resident was then turned towards CNA1 with brief repositioned. Using the same pair of gloves, CNA1 picked up and put away container of wipes and then bagged trash, then rolled resident onto her back and fastened brief closed. Using the same pair of gloves, CNA1 repositioned resident's gown. CNA1 then removed gloves and washed hands. During an interview on 10/21/20 at 10/49 AM CNA1 stated that resident did have some urine in her brief as resident dribbles urine. CNA1 stated that she should have changed her gloves after touching the soiled brief and before touching clean brief and finishing incontinence care. When asked if CNA1 was taught to perform hand hygiene after removing gloves when going from dirty to clean tasks during incontinence care, CNA1 shook her head and said, no, I do hand hygiene at the beginning and end of pericare. CNA1 stated that hand hygiene is not done after glove change between incontinence care. During an interview on 10/21/20 at 1:00 PM with IP and Resident Care Manager (RCM)1 who was the previous IP, IP and RCM1 stated staff should change their gloves and perform hand hygiene after removing gloves when moving from dirty to clean tasks during incontinence care. Review of the facility's policy titled, Hand Washing/Hand Hygiene, revised August 2019, showed use of an alcohol-based hand rub (ABHR) for several situations including after contact with bodily fluids, before moving from a contaminated body site to a clean body site during resident care and after removing gloves. The Center for Disease Control and Prevention, Guidelines for Hand Hygiene in Healthcare Settings, dated October 2002, showed hand hygiene is required regardless of whether gloves are used or changed. Failure to remove gloves after patient contact or between dirty and clean body-site care on the same patient must be regarded as nonadherence to hand-hygiene recommendations. During an interview on 10/22/20 between 7:41 AM and 8:17 AM DON stated that CNA1 should have absolutely changed her glove after dirty task and before clean task during incontinence care and hand hygiene is done after gloves is removed. *Gown: Observation on 10/21/20 at 2:44 PM on the COVID-19 100 Hall showed CNA2 wearing N95 mask, eye protection, and thin blue plastic gown. Two holes (about 2x3 inches each) were observed on the front chest area of CNA2's gown. CNA2 was overheard stating that she needed to change her gown. CNA2 was not wearing gloves and removed her gown and rolled it into a ball and discarded it. CNA2 did not perform hand hygiene. CNA2 then opened isolation cart drawer and obtained new clean gown despite not performing hand hygiene and placed gown over her head and pulled her arms through the gown sleeves. CNA2 then performed hand hygiene with wall-mounted ABHR and fastened gown ties. During interview on 10/21/20 at 2:45 PM CNA2 stated that the gowns are really thin and rip often, sometimes the gowns rip in the back when she is trying to get around a wheelchair but this time there were ripped holes in the front of the gown from wire hangers when she was carrying a load of clothing. When asked about the sequence of doffing and donning isolation gown and step for hand hygiene, CNA2 nodded her head and stated that she forgot and should have completed hand hygiene after removing used gown and before touching and donning new gown but didn't do this. She stated that she did remember to use hand hygiene before fully completing the donning process. During an interview on 10/21/20 at 3:20 PM after observation was shared, DON stated that hand hygiene should have been done after doffing gown and before donning new gown. During an interview on 10/22/20 between 7:41 AM and 8:17 AM DON stated that facility's policy for donning and doffing sequence and when hand hygiene is used is consistent with and adopted from CDC's guidelines and mentioned CDC's donning and doffing PPE instructions posted throughout the facility. Review of CDC's Using Personal Protective Equipment (PPE), https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html, updated Aug. 19, 2020, accessed 10/22/20, showed the sequence for taking off (doffing) PPE gown was to remove gown then perform hand hygiene. The sequence

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) for putting on (donning) PPE gear was to identify and gather proper PPE to don, perform hand hygiene using hand sanitizer and then put on isolation gown. *Cleaning and disinfection of high-touch items: Observation on 10/21/20 at 1:00 PM showed Housekeeper (HK)1 in 100 Hall COVID unit wearing full PPE and cleaning room shared by R4 and R5. HK1 entered room and sprayed peroxide disinfectant and cleaner onto R4's overbed table, then sprayed R5's overbed and walked to hand sink in residents' room and sprayed hand sink and then toilet. HK1 sprayed the window sill in the room. HK1 then wiped all sprayed surfaces with a cloth. HK then observed sweeping and mopping floor surfaces in R4 and R5's room and bagged trashed and placed wet floor sign near door entrance. R4 and R5 beds were in the low position without side rails. HK1 was not observed to clean and disinfect resident's call light, overbed light pull cord, light switch or room or bathroom door knobs. HK1 was observed to enter R3's room on the 100 Hall COVID unit and spoke with R3 for a few minutes and again sprayed peroxide disinfectant and cleaner onto R3's overbed table; about half of resident's overbed table was covered with personal items. R3 laid on a specialty mattress without bed rails. R3's lights above her head were on. HK1 again sprayed hand sink and toilet and wiped down these sprayed surfaces with a cloth after several seconds. HK1 was not observed to clean and disinfect resident's call light, overbed light pull cord, light switch or room or bathroom door knobs. During an interview on 10/21/20 at about 2:30 PM HK1 stated that daily resident room cleaning did not include cleaning and disinfecting resident call light, overbed light pull cord or room light switch. HK1 stated that these items are cleaned during monthly deep cleaning or when resident leaves room, when asked if this was terminal cleaning, HK1 nodded head. HK1 further stated that sometimes he can't see where the resident call light is when the resident is in bed and doesn't want to ask to resident about it. When asked if who is responsible for daily cleaning of resident call light or overbed light pull cord, HK1 stated nursing. HK1 stated that sometimes he cleans and wipes down bed side rails, sometimes and he does and sometimes he does not. HK1 stated that he will clean and disinfect room door knobs when he wipes down the hallway hand railing but did not address how or when bathroom door knobs or room light switches are cleaned and disinfected. HK1 was observed to spray peroxide disinfectant and cleaner on room door knobs and hallway railing. During an interview on 10/21/20 at 1:30PM and 1:44PM CNA2 stated that she usually works 100 hall and knows the residents well. CNA2 stated that R4 doesn't use her call light and usually calls out for help instead. CNA2 stated that R5 uses her call light. CNA2 stated that R3 uses her call light for assistance, water, repositioning and doesn't pull overbed light pull cord and instead resident directs staff to pull cord to turn light on or off. CNA2 stated that housekeeping cleans the call lights and light pull cords in the resident's rooms and she has never been asked or aware that this nursing should be doing this instead. During an interview on 10/21/20 at 3:20 PM DON stated that housekeeping is responsible for cleaning resident call lights and light pull cords and other high touch surfaces in the resident rooms. During concurrent interview and record review on 10/22/20 at 7:07 AM Laundry/Housekeeping Supervisor (EVS) manager stated that HK should be cleaning resident's call light and light pull cord and light switches daily because they are high contact items and this should be done for all rooms, both COVID and non-COVID. When asked for written policy, checklist or documentation directing HK staff to clean high touch items in resident rooms and listing of high touch items, EVS manager looked through several drawers and folders and provided document titled, Healthcare Services Group, Inc. (facility contracted provider) Housekeeping In-Service: 5-step daily patient room cleaning, dated 1/1/2000, which showed horizontal surfaces-disinfected. Using a solution of properly diluted germicide, sanitize all horizontal surfaces. As you enter the room, work clockwise around the room hitting all surfaces. Table tops, headboards, window sills, chairs-should all be done. The document did not specifically show cleaning of high-touch surfaces or define types of high-touch surfaces such as call lights, door knobs, light switches, light pull cord, or tv remote control. Review of CDC's Preparing for COVID-19 in Nursing Homes, https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, updated 6/25/20, accessed 10/26/20, showed Develop a schedule for regular cleaning and disinfection of shared equipment, frequently touched surfaces in resident rooms and common areas. Ensure EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment disinfect surfaces that might be contaminated with [DIAGNOSES REDACTED]-CoV-2 (virus that causes COVID-19). During an interview on 10/22/20 between 7:41 AM and 8:17 AM DON nodded head that high touch items in resident's rooms should be cleaned and disinfected. *Dirty fans: During concurrent observation and interview on 10/21/20 at 10:00 AM showed laundry area with separate room and door with several barrels of dirty linen and clothing. Outside room with barrels was a separate area with two washers and then another area with dryers and large table in the center of the room. Laundry staff (LS)1 stated that dirty linen and clothing went from dirty area to washer and then dryers. Observed across of the two washers in a space about 10-15 feet in length was a rack made of white [MEDICATION NAME] chloride (PVC) tubing where several pillow cases laid and linen was shown. Box fans were present and blowing air on both sides of the PVC rack. The grill of both box fans were thick with black dust and debris with multiple black strings about half to 2 inches hanging from the grill and blowing in the air. The entire grill of one of the fan was covered with black dust and debris. When shown the fan, LS1 stated it was very dirty and stated that it looked like the fans had not been cleaned in at least three months, maybe longer. LS1 stated that she worked in the facility for the past two years and has never cleaned fans, called anyone to clean fans and she has never been told to check fans if they need to be cleaned. During an interview on 10/21/20 at about 10:00 AM EVS manager was shown fans in laundry room and stated that it was very dirty and confirmed there was not a process or schedule for cleaning the fans. EVS manager stated that LS1 and LS clean the laundry room every day but obviously that didn't include cleaning the fan. EVS manager stated that the fans will be cleaned immediately. During an interview on 10/22/20 at 7:07 AM to 7:30 AM EVS manager stated that wet clean laundry is removed from the washers and then placed in container and moved to the dryers. EVS manager confirmed that wet clean laundry is exposed to dirty air and environment when dirty fans were located. EVS manager stated that PVC rack is used to dry pillow cases, mop heads and other items that can't go into the dryer. EVS manager stated that there was no policy, process, or scheduled for cleaning the fans but one would be developed. During an interview on 10/22/20 between 7:41 AM and 8:17 AM DON stated that fans should be clean and not dirty in the laundry and especially in areas where clean laundry is present.
F 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	Based on interview and record review, the facility failed to inform residents, their representatives and families of new COVID-19 cases and weekly updates of COVID-19 status including cumulative updates of COVID-19 in the facility. This failure deprived residents, their representatives or families from having the opportunity to choose whether they wanted to move forward with the COVID-19 management plan being proposed by the facility and being informed of the extent of COVID-19 cases in the facility. This failure affected all 59 residents in the facility. Findings include: During an interview on 10/21/20 at 8:10 AM Director of Nursing (DON) and Infection Preventionist (IP) stated that the facility census was 59. The facility's 200/300 hall had 26 residents who were previously COVID-19 positive and were recovered and 100 hall had 8 residents; of which some were recovering. The 100 hall was the facility's COVID-19 unit. Full PPE use started on 9/11/20 when facility had first COVID-19 positive case. Review of facility's listing of residents COVID-19 positive results, untitled and undated, showed columns for date, resident (name), and 20 days (from date of positive result and TBP could be discontinued) and separate document listing staff COVID-19 positive results, untitled and undated, showed columns for employee name, job title, date of onset/results, and return to work/working. Review of resident and staff COVID-19 results showed the first resident tested positive on 9/11/20. That same week, 2 staff tested positive. By 9/18/20, a week later, 27 additional residents and 8 staff were positive. By 9/25/20, 14 additional residents and 8 staff were positive. By 10/2/20, 7 additional residents and 6 staff were positive. By 10/9/20, 0 residents and 6 additional staff were positive. By 10/16/20, an additional resident and two staff were positive. During an interview on 10/21/20 at 11:00 AM when asked how residents and resident representatives, family members are informed of facility's new COVID-19 cases, cumulative COVID-19 updates and mitigating actions to prevent or contain COVID-19, such as via mailed letter, email, recorded phone message, website, Administrator stated that multiple letters have been sent to families. Administrator also stated that individual family members are informed/notified when their resident tests positive but when asked how about the process for notification/communication for facility wide COVID-19 cumulative updates, Administrator stated that letters are sent. During concurrent interview and record review on 10/21/20 at 12:05 PM Administrator provided two letters from Administrator on facility's letter head. The first letter was dated 9/11/20 with salutation, Dear Family Members and showed Our current COVID-19 preventive and infectious disease measures are allowing us to monitor all staff and residents for any signs and symptoms of COVID-19, and manage any cases that may arise. To that end, the Centers for Medicare and Medicaid Services (CMS) has recently established Long-Term Care (LTC) Facility Testing Requirements for Staff and Residents. While staff testing will be of a weekly or monthly frequency that will be triggered by the facility's respective county positivity rate during the prior week; routine testing of asymptomatic residents, is not recommended . The document did not communicate

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F 0885 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 2) that the facility had positive COVID residents or staff. The second letter dated 9/25/20, with salutation Dear Residents and Family Members described the facility's testing/ monitoring plans, grouping or cohorting actions and visitation policies. Administrator and surveyor reviewed both letters and Administrator confirmed neither letter provided information or notification of COVID positive residents and staff, did not include cumulative updates of the number of COVID positive residents and staff and were not provided on a weekly basis. The facility has had residents and staff test positive for COVID-19 during the past six weeks and therefore six letters were expected, however only two letters were sent. When asked if there were any other method or venue for communicating this information, Administrator stated, no. Administrator stated that she spoke with others on the team who confirmed residents/representatives/family members have not been provided this information. Administrator further stated that the facility or corporation did not have a written policy outlining COVID-19 reporting requirements to residents/representatives/families. Review of facility's website on 10/20/20 did not show facility's COVID-19 cumulative update for residents and staff. During an interview on 10/22/20 between 7:41 AM and 8:17 AM DON stated that individual residents and/or resident representatives are notified when their individual COVID test results were positive and when providing consent for COVID testing but these communications did not include the facility's cumulative number of COVID cases on a weekly basis.