STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135135	A. BUILDING _____ B. WING _____	07/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF POST FALLS	460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854

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 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 Cleaning and Disinfection of Non-Critical Patient Care Equipment, revised 3/13/20, directed staff to clean and disinfect equipment prior to storage. On 7/22/20 at 10:24 AM, CNA #1 pushed the Hoyer lift (a mobility lift device used for transfers) out of Resident #12's room. CNA #1 then left the Hoyer lift outside Resident #12's room and went to the soiled utility room. On 7/22/20 at 10:36 AM, NA #1 pushed the Hoyer lift to a vacant room where the other two Hoyer lifts were stored. NA #1 did not clean or disinfect the Hoyer lift before placing it in the storage room. On 7/22/20 at 11:42 AM, CNA #1 said she did not disinfect or clean the Hoyer lift after she used it to help transfer Resident #12 to her wheelchair. On 7/22/20 at 3:00 PM, the ICP said the Hoyer lift should have been cleaned after each use. 2. The facility's Cleaning and Disinfection of the Glucometer (a portable machine used to measure the blood glucose level) policy and procedure, revised 4/7/20, directed staff to do the following: *Clean and disinfect the glucometer prior to leaving the resident's room with commercially available Environmental Protection Agency (EPA) registered disinfectant wipes. *Wipe the entirety of the glucometer using the disinfectant wipe. *Wrap the glucometer with a clean wipe. *Place the glucometer in a disposable cup, to ensure the glucometer remained wet for the duration of time required according to the manufacturer recommendation. A plastic container of Sani-Cloth wipes, with a red top, included directions for disinfection. The directions stated a three-minute contact time (the total amount of time that it takes to inactivate all the microorganisms listed on the product label) was required. On 7/22/20 at 11:17 AM, RN #1, while wearing gloves, took a wipe from the Sani-Cloth container and wiped the glucometer outside Resident #11's room. RN #1 then placed the glucometer on top of the PPE cart located outside Resident #11's room. There was no barrier between the glucometer and the PPE cart. RN #1 removed her gloves and performed hand hygiene. RN #1 then picked up the glucometer and walked toward the medication cart. RN #1 placed the glucometer on top of the medication cart. There was no barrier between the glucometer and the medication cart. RN #1 then took another wipe and wiped the glucometer and placed the glucometer back on the top of the medication cart with no barrier between the glucometer and the medication cart. RN #1 then opened the medication cart and placed the glucometer in the top drawer of the medication cart. On 7/22/20 at 12:15 PM, RN #1 said she did not put a barrier between the glucometer and the PPE cart, and the glucometer and medication cart after she used a Sani-Cloth wipe. RN #1 said she was not sure what kind of barrier she was going to use. RN #1 said the facility had both Sani-Cloth wipes with a purple top and a red top and she was not sure which one she used to wipe the glucometer. RN #1 said she knew the red top Sani-Cloth had a three-minute contact time. RN #1 said she placed the glucometer back in the medication cart and she did not think she followed the three-minute contact time when she wiped the glucometer with a Sani-Cloth wipe. On 7/22/20 at 3:00 PM, the ICP said there should be a barrier when staff put the glucometer on any surfaces. The ICP said the barrier could be a paper towel or an empty cup. The ICP also said she expected the staff to follow the Sani-Cloth manufacturer's recommendations for the contact time in cleaning the equipment. 3. The facility's Hand Hygiene for Residents policy, dated 4/16/20, directed staff to encourage and assist residents to perform hand hygiene prior to eating or drinking. This policy was not followed. On 7/22/20 from 11:45 AM to 12:34 PM, lunch trays in the 100 and 200 hallways were being served to residents. a. The following was observed in the 100 hall: - At 11:45 AM, RNA #1 delivered and set up Resident #1's meal for him on his tray table in his room. RNA #1 did not offer hand hygiene to Resident #1 prior to eating his lunch. - At 11:58 AM, NA #2 delivered and set up Resident #2's meal for her on her tray table in her room. NA #2 did not offer hand hygiene to Resident #2 prior to eating her lunch. - At 12:10 PM, NA #2 delivered and set up Resident #3's meal for him on his tray table in his room. NA #2 did not offer hand hygiene to Resident #3 prior to eating his lunch. - At 12:16 PM, RN #2 delivered and set up Resident #4's meal for her on her tray table in her room. RN #2 did not offer hand hygiene to Resident #4 prior to eating her lunch. - At 12:19 PM, NA #2 delivered and set up Resident #5's meal for her on her tray table in her room. NA #2 did not offer hand hygiene to Resident #5 prior to eating her lunch. - At 12:22 PM, NA #2 delivered and set up Resident #6's meal for her on her tray table in her room. NA #2 did not offer hand hygiene to Resident #6 prior to eating her lunch. At 12:24 PM, the DON delivered and set up Resident #7's meal for her on her tray table in her room. The DON did not offer hand hygiene to Resident #7 prior to eating her lunch. On 7/22/20 at 11:50 AM, Resident #1 said he was blind in one eye, had difficulty seeing with his other eye and needed assistance from staff to set up his meals. Resident #1 said staff did not offer to assist him with hand hygiene before his meals. On 7/22/20 at 12:07 PM, Resident #2 said staff did not always offer her hand hygiene before meals. On 7/22/20 at 12:30 PM, Resident #3 said staff did not offer him to hand hygiene before meals. He said he would like the staff to offer him the chance to perform hand hygiene before eating. On 7/22/20 at 12:35 PM, Resident #6 said staff did not offer her hand hygiene before her lunch was served. On 7/22/20 at 12:38 PM, NA #2 said she had not offered residents hand hygiene when she delivered their meal trays. On 7/22/20 at 2:00 PM, RNA #1 said she did not offer Resident #1 hand hygiene prior to his lunch. She said she had not been offering residents hand hygiene for over a month because residents' trays no longer came with hand sanitizing wipes on them. RNA #1 said she thought the wipes were supplied by the dietary department. On 7/22/20 at 3:00 PM, the DON said she did not offer Resident #7 hand hygiene prior to her lunch and said she should have. On 7/22/20 at 3:00 PM, the ICP said she expected staff to offer residents hand hygiene before every meal. b. The following was observed in the 200 hall: - On 7/22/20 at 12:28 PM, CNA #2 delivered Resident #8's food tray. CNA #2 removed the hot plate cover and set up the tray for Resident #8. CNA #2 then asked Resident #8 if there was anything else she needed, Resident #8 said no. CNA #2 then left Resident #8's room. CNA #2 did not offer Resident #8 hand hygiene before eating her meal. - On 7/22/20 at 12:30 PM, CNA #2 delivered Resident #9's food tray and placed it on Resident #9's overbed table and left the room. CNA #2 did not offer Resident #9 hand hygiene before eating his meal. On 7/22/20 at 12:42 PM, CNA #2 said she did not offer Resident #8 and Resident #9 hand hygiene before eating their meals. CNA #2 said she usually offered residents hand hygiene after she assisted them to use the restroom or when their hands were soiled. On 7/22/20 at 12:34 PM, the DON delivered Resident #10's food tray. The DON removed the hot plate cover and set up the tray for Resident #10. The DON then asked Resident #10 if there was anything she needed, Resident #10 said she was okay. The DON then left Resident #10's room. The DON did not offer Resident #10 hand hygiene before eating her meal. On 7/22/20 at 2:35 PM, Resident #8 said she was not offered hand hygiene before eating her meals. On 7/22/20 at 3:00 PM, the DON said she did not offer Resident #10 hand hygiene before eating her meal. The DON said hand hygiene should be offered to the residents before and after eating their meals.

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