STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135075	A. BUILDING _____ B. WING _____	07/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VALLEY VISTA CARE CENTER OF ST MARIES	820 ELM STREET ST MARIES, ID 83861

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 policy, Personal Protective Equipment - Contingency and Crisis Use of Isolation Gowns (COVID-19 Outbreak), dated April 2020, stated, Extend use of isolation gowns so that same gown is worn by the same HCP when interacting with more than one resident known to be infected with the same infectious disease . This policy was not followed. On 7/14/20 at 9:32 AM, Resident #3 had 3 yellow fabric gowns hanging from individual hooks inside the room on the door. A green sign was posted on the door, which indicated Droplet Precautions were in place. On 7/14/20 at 10:10 AM, CNA #4 entered Resident #3's room and grabbed a yellow cloth gown from the inside of Resident #3's door which was hanging from the first hook on the left. When CNA #4 finished with Resident #3's cares, she returned the yellow gown to the hook where she obtained it. On 7/14/20 at 10:30 AM, CNA #6 exited Resident #3's room. Two gowns were hanging on the inside of the door and CNA #6 was wearing the same gown that CNA #4 used previously. CNA #6 said she was using the gown that was hanging on the first hook inside on the left of the door, and she was not aware the gown was previously worn by another person. CNA #6 said the gown was supposed to be labeled with a piece of tape, and staff were to use their own gown during their shift. On 7/14/20 at 1:35 PM, the DNS said the isolation gowns were reusable, and when staff removed the gown they should fold it from the outside in and hang it up on the door. The DNS said only one person should wear the gown, and it was not intended for multiple people to wear the same gown. The DNS said each employee should choose where to hang their gown on the door, the gown should be sent to the laundry at the end of their shift, and each gown was good for 100 washes. 2. The facility's Handwashing/Hand Hygiene policy, dated August 2019, stated all personnel should follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors, including before and after direct contact with residents, and after contact with objects in the immediate vicinity of the resident. The facility's Standard Precautions policy, dated July 2020, stated standard precautions applied to the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. The policy stated: * Hand hygiene referred to handwashing with soap or the use of alcohol-based hand rub (ABHR), which did not require access to water. * Hand hygiene was performed with ABHR or soap and water before and after contact with the resident, and after contact with items in the resident's room. On 7/14/20 at 11:15 AM, CNA #1 was observed holding a soiled linen bag in her left hand while assisting Resident #1 to her seat in the East Wing common area. CNA #1 had her right hand on Resident #1's back and belt. While walking to the seat, CNA #1 passed the soiled linen bag to CNA #2 who took it into the soiled linen room. After seating Resident #1, CNA #1 rolled two side tables in front of two chairs in preparation for lunch service by grasping the tops of the tables. CNA #1 did not perform hand hygiene prior to touching the tables and after holding Resident #1 by her clothing. CNA #1 then assisted CNA #3 by grasping Resident #2 under her left arm and sliding Resident #2 up in her reclining wheelchair. CNA #1 then performed hand hygiene. On 7/14/20 at 11:50 AM, CNA #1 said after assisting a resident with personal cares, the CNAs took the soiled linen bag to the soiled linen room and washed their hands with soap and water thoroughly. CNA #1 stated she should have performed hand hygiene prior to touching residents and dining tables. On 7/14/20 at 1:30 PM, the DNS said the protocol for handling soiled linen after assisting a resident with personal cares required a CNA to place the soiled linens in a bag and take it to the soiled linen room, and then perform hand hygiene. The DNS said it was not acceptable for staff to touch residents or items after handling a soiled linen bag. 3. The facility's policy for Personal Protective Equipment-Using Gowns, revised September 2010, stated staff were to untie the back of the gown when removing it. A document provided from the facility, titled How to Safely Remove PPE, undated, directed staff to unfasten the gown ties when removing the gown, and to be careful to avoid contact with the sleeves of the gown. This policy and guidance was not followed. On 7/14/20 at 10:10 AM, CNA #4 was in the hall assisting Resident #3 who was in her wheelchair. Resident #3 had a sign on her door indicating she was on Droplet Precautions, which requires face masks and gloves were worn when entering the room, and a gown and goggles should be worn if there was risk of spraying respiratory secretions. CNA #4 grabbed a yellow cloth gown from the inside of Resident #3's door which was hanging from the first hook on the left. The gown was tied at the top, and CNA #4 put it on by pulling it over her head. On 7/14/20 at 10:13 AM, CNA #4 opened the door to Resident #3's room and removed the gown by pulling it over her head. She returned the gown to the hook, performed hand hygiene, and exited the room. On 7/15/20 at 8:45 AM, CNA #4 said she did not untie the gown. CNA #4 said the reusable gown had the ties fastened so it could be hung up. CNA #4 said staff were not trained to leave the gown tied and pull it over their head.

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