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 _____	**05/11/2020**

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 -** Many	**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 develop and implement infection control policy and procedures such as hand hygiene and failed to implement Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention guidelines and practices to prepare for the ongoing COVID-19 pandemic to include social distancing. This failure placed residents in the facility at risk for exposure to and potential for illness with COVID-19. Findings include: During the entrance interview on 5/6/20 at 9:15 AM, the administrator and DNS (Director of Nursing Services) reported the facility was COVID?free. The administrator reported no residents or staff tested positive for or currently had symptoms consistent with COVID-19 illness. The administrator said the facility suspended visitors, communal dining and group activities during the pandemic. Communal Dining and cough etiquette During observation of the lunch meal on 5/6/20 from 12:25 PM to 12:50 PM on Appaloosa Way (300 hall) eleven residents came independently or were assisted to the Appaloosa Way Dining Room. The dining room had six small tables approximately 3 feet square with a slightly larger table positioned separate from the other tables. Several residents sat briefly at the separate table. The residents were seated two to a table and directly across from each other. A smaller room across from room [ROOM NUMBER] had two tables pushed together with one end against the wall and a separate small table. One resident sat at the end of the table, one resident sat about four feet away on the side of the table, and one resident sat at the separate table. Licensed Nurse LN1 said the small room was the assisted dining room for residents who needed a lot of help to eat. When asked about the separate table in the main dining room, LN1 said it was a gathering place where residents liked to sit throughout the day. The facility did not offer, assist, or provide hand hygiene to the residents prior to the meal. During the meal, resident R7 passed a drink cup and food from her plate to R8 who sat an arm's length away, across the table. R8 accepted and ate the food. No staff intervened. Licensed Nurse LN1 was in and out of the dining room during the meal. When asked about communal dining, LN1 said staff try to seat residents across the table from each other. When asked why the staff did not ensure social distancing of six feet as per CDC guidelines. LN1 said some residents have dysphagia (difficulty swallowing) or diet restrictions and need to be watched closely and some residents need assistance with feeding. During the observation, staff assisted only one resident, R9. Review of 4 meal tickets revealed all four had general diets with no restrictions and no precautions. R9 sat at the separate table and was noted coughing in the dining room. R9 did not practice cough etiquette such as covering her mouth with a tissue or her sleeve when coughing. R9 frequently touched her face and arms. Dining room staff did not direct R9 away from the dining room when she was coughing and staff did not offer facial tissue. Staff did not offer or assist R9 with hand hygiene before or after the meal or when she was coughing. In an interview on 5/6/20 at 1:00 PM the facility ICP (Infection Control Preventionist) was informed of the observation of R9's coughing in the dining room in the presence of 10 other residents. ICP said the cough was new for her, really new. When asked whether the facility considered a new cough as a potential sign of COVID?19 infection and whether R9 should be in a common area with a new cough; ICP said R9 had developmental delay with low cognitive functioning. ICP said R9 been self?isolating thinking people made fun of her so ICP hated to isolate R9 to her room. ICP said R9 was not capable to comply with cough etiquette. ICP said R9's temperature was 97.6 with no other symptoms and R9 would be evaluated by a speech therapist for possible aspiration (food or drinks in lungs) which may cause cough. Regarding residents eating in the communal dining room, ICP said staff have to keep an eye on some residents who might choke. ICP said some residents have their daily routines and prefer the dining room for meals, so maybe we need to get some longer tables. ICP said she was not aware that social distancing was not maintained in the dining rooms. ICP said it was an expectation that staff ensure social distancing for residents and provide hand hygiene when indicated such as before and after meals, and after coughing or using facial tissue. Group Activity- Smoking Observation of a supervised smoking session on 5/6/20 at 4:30 PM revealed the staff did not ensure social distancing during the activity. The smoking session was held outdoors on a covered patio. The smoking area had three tables. Two 3-foot?round tables were positioned approximately four feet apart. Five randomly observed residents RO1, RO2, RO3, RO4 and RO5 participated in the smoking activity. RO1, RO2, and RO3 sat at one round table, RO4 sat at the nearby table, and RO5 sat alone at the distant table. RO1, RO2, and RO3 sat elbow to elbow only inches apart. At 4:35 PM the Administrator came to the smoking area. When asked about social distancing during smoking, the Administrator said Yes it is required. The administrator immediately moved the residents apart and instructed staff on social distancing. Glove change and hand hygiene On 5/6/20 at 2:00 PM nursing assistants NAC1 and NAC2 used alcohol gel for hand hygiene and donned gloves. NAC1 and NAC 2 used the mechanical lift to move R7 from the wheelchair to the bed, NAC2 wore gloves and removed the incontinent brief. NAC2 used moistened cloths to clean R7 of a large bowel movement then without changing gloves rolled R7 from side to side to remove the lift sling which was under the resident. While still wearing the soiled gloves NAC2 put a clean brief on R7 and pulled up the sheet and blankets. NAC2 then removed the soiled gloves but did not wash or sanitize her hands. NAC2 positioned the oxygen nasal cannula on R7's face, placed the nurse call bell in R7's hand and used the bed control to raise the head of the bed. NAC2 held R7's hand and soothed the resident at completion of care. NAC2 did not wash hands and used alcohol hand gel for the first time when exiting the room. The observations were reported to the ICP on 5/6/20 at 2:30 PM. The ICP sid NAC2 should have removed gloves and washed hands after cleaning bowel movement and before moving to another part of the body or handling clean linen, the bed contro, or touching the resident. ICP said staff are all educated that they must perform hand hygiene when removing gloves.

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