STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135127	A. BUILDING _____ B. WING _____	10/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF SANDPOINT	**1125 NORTH DIVISION STREET SANDPOINT, ID 83864**

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, resident 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 Care Equipment policy, revised 3/13/20, directed staff to clean and disinfect equipment before and after each use with an approved disinfectant. The Super Sani-Cloth germicidal wipe directions for cleaning and disinfecting stated to thoroughly wet the surface and allow to air dry for two minutes. This policy and manufacturer directions were not followed. On 10/7/20 at 2:16 PM, CNA #1 was in the 100 hallway near the nurses' station with Resident #11, who was in her wheelchair. CNA #1 had a vital sign machine on wheels which included a blood pressure cuff, a thermometer, and a pulse oximeter (oxygen level monitor). CNA #1 placed the blood pressure cuff on Resident #11's right arm. CNA #1 did not disinfect the cuff before placing it on Resident #11. At 2:17 PM, CNA #1 left Resident #11 and wheeled the vital sign machine to Resident #12's room. CNA #1 placed the blood pressure cuff on Resident #12's left arm, placed the pulse oximeter on her right finger, and then used a disposable sleeve for the thermometer and took her temperature orally. CNA #1 did not disinfect the blood pressure cuff after using it with Resident #11 and prior to using it with Resident #12. CNA #1 disposed of the thermometer sleeve and wheeled the machine into the hallway. At 2:25 PM, CNA #1 used a Sani-cloth and wiped down the blood pressure cuff and the pulse oximeter. She did not disinfect the thermometer where the sleeve had been. At 2:28 PM, CNA #1 took the machine into Resident #13 and #14's room and placed the blood pressure cuff on Resident #13's left arm, placed the pulse oximeter on her right finger, and then used a disposable sleeve for the thermometer and took her temperature under her left arm. CNA #1 then disposed of the thermometer sleeve. At 2:34 PM, CNA #1 used a Sani-Cloth and wiped down the blood pressure cuff and the pulse oximeter. She did not disinfect the thermometer where the sleeve had been. One minute later, at 2:35 PM, CNA #1 placed the blood pressure cuff on Resident #14's left arm, placed the pulse oximeter on her right finger, and then used a disposable sleeve for the thermometer and took her temperature orally. CNA #1 did not allow the Sani-Cloth disinfectant solution to stay on the blood pressure cuff and pulse oximeter for two minutes before placing them on Resident #14. She then disposed of the thermometer sleeve and wheeled the machine into Resident #15's room. At 2:38 PM, CNA #1 used a Sani-Cloth and wiped down the blood pressure cuff and the pulse oximeter. She did not wipe off the thermometer where the sleeve had been. After wiping down the blood pressure cuff and the pulse oximeter with the Sani-Cloth, CNA #1 immediately placed them on Resident #15's left arm and her right finger. CNA #1 did not allow the Sani-Cloth disinfectant solution to stay on the blood pressure cuff and pulse oximeter for two minutes before placing them on Resident #15. CNA #1 used a disposable sleeve for the thermometer and took her temperature orally. She then disposed of the thermometer sleeve and wheeled the machine into the hallway. At 2:45 PM, CNA #1 was in the 100 hallway with Resident #9 who was in her wheelchair. Resident #9 requested for her vital signs to be checked. CNA #1 used a Sani-Cloth and wiped down the blood pressure cuff and the pulse oximeter. She did not wipe off the thermometer where the sleeve had been. After wiping down the blood pressure cuff and the pulse oximeter, CNA #1 immediately placed them on Resident #9's arm and finger. CNA #1 did not allow the Sani-Cloth disinfection solution to stay on the blood pressure cuff and pulse oximeter for two minutes before placing them on Resident #9. CNA #1 then used a disposable sleeve for the thermometer and took Resident #9's temperature orally. On 10/7/20 at 2:45 PM, CNA #1 said she did not disinfect the blood pressure cuff after she used it on Resident #11 and she said she should have. She said she did not think she had to wipe down the part of the thermometer where the disposable sleeve had been. CNA #1 said she did not know how long the contact time was for the Sani-Cloth wipes and said she would let equipment dry for a few seconds before placing the blood pressure cuff and pulse oximeter on residents. On 10/7/20 at 3:15 PM, the DON said staff were to disinfect the vital sign equipment between each use and expected staff to follow the contact times per the manufacturer instructions. 2. The facility's Guide to Infection Prevention and Control, Chapter 4: Standard and Transmission Based Precautions for COVID-19, undated, stated the following: * All recommended COVID-19 PPE (for transmission-based precautions) should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (goggles or a disposable face shield that covers the front and sides of the face), gloves, and a gown. * Residents with an unknown COVID-19 status were cohorted in an area designated the yellow zone and health care providers in the yellow zone wore transmission-based precautions that included eye protection. * Healthcare providers working in facilities located in areas with moderate to substantial community transmission should wear eye protection in addition to their facemask to ensure the eyes, nose and mouth are all protected from splashes and sprays of infectious material from others. This policy was not followed. On 10/7/20 at 8:40 AM, RN #3 was observed in the yellow zone. She wore a surgical mask and no protective eyewear. RN #3 stated she did not have to wear eye protection because she did not provide direct resident care. She stated the facility policy required eye protection was worn only when entering a resident's room. On 10/7/20 at 8:45 AM, six residents were in the day room eating or preparing to eat. CNA #2 was in the day room with an N95 mask on without eye protection. On 10/7/20 at 9:50 AM, CNA #2 said he forgot to put on eye protection when he arrived for work around 5:45 AM and did not wear eye protection until the residents' breakfast time. On 10/7/20 at 4:17 PM, the DON stated staff were to wear eye protection in the facility because the community transmission of COVID-19 was moderate and they had residents with active COVID-19 illness in the building. 3. The facility's Resident Hand Hygiene policy, reviewed 4/16/20, directed staff to assist residents to perform hand hygiene prior to handling or consumption of food or drink. This policy was not followed. On 10/7/20 at 10:23 AM, AA #1 offered Resident #2 popcorn while in his room. Resident #2 accepted the popcorn and AA #1 delivered it to him and did not offer hand hygiene to Resident #2 prior to eating his popcorn. On 10/7/20 at 10:43 AM, AA #1 delivered a cup of coffee and a cookie to Resident #3, who was in his room. AA #1 did not offer hand hygiene to Resident #3 prior to eating his cookie and drinking his coffee. On 10/7/20 from 12:14 PM to 12:32 PM, lunch trays in the 100 hallway were served to residents in their rooms. The following was observed: -At 12:14 PM, the Medical Record Assistant delivered and set up Resident #4's meal on her tray table in her room. The Medical Record Assistant did not offer hand hygiene to Resident #4 prior to eating her lunch. -At 12:17 PM, MDS Coordinator #1 delivered and set up Resident #2's meal on his tray table in his room. MDS Coordinator #1 did not offer hand hygiene to Resident #2 prior to eating his lunch. -At 12:18 PM, MDS Coordinator #2 delivered and set up Resident #5's meal on his tray table in his room. MDS Coordinator #2 did not offer hand hygiene to Resident #5 prior to eating his lunch. -At 12:21 PM, the Medical Record Assistant delivered and set up Resident #6's meal on her tray table in the hallway. The Medical Record Assistant did not offer hand hygiene to Resident #6 prior to eating her lunch. -At 12:24 PM, MDS Coordinator #2 delivered and set up Resident #7's meal on her tray table in the hallway. MDS Coordinator #2 did not offer hand hygiene to Resident #7 prior to eating her lunch. -At 12:26 PM, LPN #1 delivered and set up Resident #8's meal on her tray table in the hallway. LPN #1 did not offer hand hygiene to Resident #8 prior to eating her lunch. -At 12:28 PM, LPN #1 delivered and set up Resident #9's meal on her tray table in her room. LPN #1 did not offer

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 -** Some	(continued... from page 1) hand hygiene to Resident #9 prior to eating her lunch. -At 12:32 PM, the Medical Record Assistant delivered and set up Resident #10's meal on her tray table in her room. The Medical Record Assistant did not offer hand hygiene to Resident #10 prior to eating her lunch. On 10/7/20 at 12:40 PM, Resident #4 said she was not offered hand hygiene before eating her lunch. On 10/7/20 at 12:45 PM, MDS Coordinator #2 said she had not offered residents hand hygiene when she delivered the meal trays. She said she should have offered residents hand hygiene. On 10/7/20 at 12:55 PM, LPN #1 said she had not offered residents hand hygiene when she delivered the meal trays. On 10/7/20 at 1:05 PM, AA #1 said she had not offered residents hand hygiene when she delivered snacks. She said she should have offered residents hand hygiene. On 10/7/20 at 1:25 PM, the Medical Record Assistant said she had not offered residents hand hygiene when she delivered the meal trays. She said she did not know she was supposed to offer hand hygiene to the residents before their meals. On 10/7/20 at 3:15 PM, the DON said staff were expected to offer residents hand hygiene before their meals.