STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135133	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IDAHO STATE VETERANS HOME - LEWISTON	821 21ST 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 -** Immediate jeopardy **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 fully implement its COVID-19 prevention plan. The facility failed to ensure infection control standards related to hand hygiene and use of personal protective equipment were implemented and maintained for 8 of 49 residents (R1, R6, R8, R9, R11, R14, R15, and R16). The facility failed to implement appropriate transmission-based precautions during the 14-day period following admission for R1 who admitted with unknown COVID-19 status. The deficient infection control practices placed all residents residing on 3 of 3 halls (North, East, and West) at risk at risk for exposure to and potential for infection with COVID-19 which constituted immediate jeopardy. The facility administration was informed of the immediate Jeopardy on 6/18/20 at 3:05 PM. Findings include: Transmission-based precautions and PPE use During the entrance interview on 6/18/20 at 9:00 AM the Home Administrator (HA) reported all current residents tested negative for COVID-19 and all employees tested negative with re-testing scheduled every two weeks. HA reported this nursing home remained COVID-free but at least two other nursing homes in the community had experienced COVID-19 outbreaks accounting for over 50 cases with some deaths attributed to COVID-19. HA designated the facility Infection Preventionist (IP) and/or the facility Occupational RN-Infection Control Specialist (ICS) to provide facility infection control information. ICS accompanied on initial observations on 6/18/20 at 10:20 AM. ICS said the West Wing (W hall) was the isolation designated hall in the event residents tested positive for COVID-19. A sign posted on resident room W2 door indicated: STOP, Contact Precautions, Please see nurse before entering. The sign did not indicate what personal protective equipment (PPE) or measures were needed to enter the room. When asked what the sign meant ICS said she was new to the building having started a week ago so she did not know specifically what the facility contact precautions were. ICS left briefly and returned with a new sign for room W2. The sign said contact precautions: *perform hand hygiene before enter and before leaving room. *Wear gloves when entering room or cubicle and when touching patient's intact skin, surfaces, or articles in close proximity. *Wear gown when entering room or cubicle and whenever anticipating that clothing will touch patient items or potentially contaminated environmental surfaces. *Use patient dedicated or single-use disposable shared equipment (B/P cuff, thermometer) between patients. ICS said R1 in room W2, admitted from the local hospital on [DATE] and was on contact precautions for 14 days. ICS said new admissions were kept on precautions for 14 days because they may have been exposed to COVID-19 prior to admission and symptoms may not show for up to 14 days. ICS said all residents were tested for COVID-19 on the day of admission, on day 7, and on day 14 and must be negative for COVID-19 after 14 days for precautions to be discontinued. A sign on room E2 indicated Contact Precautions. ISC reported R13 in Room E2 required precautions for 14 days because R13 was a new admission. A sign on room E3 indicated droplet precautions were required. ISC said R8 (in room E3) spiked a fever above 100 degrees Fahrenheit yesterday (6/17/20) and appeared red and flushed (possible symptoms of COVID) so droplet precautions were required for R8 and for R8's roommate (R9) pending the result of a COVID-19 test. Review of the admission nursing note dated 6/17/20 at 5:46 PM indicated Resident R1 came to the facility at 2:14 PM from the local hospital where he was admitted due to increased shortness of breath and fatigue. R1 had [DIAGNOSES REDACTED]. The note indicated R1 resided in room W2 and required 4 liters of continuous oxygen to keep his oxygen saturation (O2 sat) above 90%. (normal O2 sat is 98-100%). Observation conducted on 6/18/20 at 10:39 AM revealed Licensed Nurse LN1 entered room W2 wearing a facemask (surgical mask) then donned a gown and gloves. Surveyor (wearing an N95 mask/respirator) continued observation from the doorway of room W2 with the door open just enough to see into the entire room. R1 sat in a wheelchair facing the door, he wore a facemask with tubing attached to a nebulizer machine. (Nebulizers turn liquid medications into fine inhaled droplets (mist) that the person can inhale through a mask or mouthpiece) LN1 removed the nebulizer mask and explained the resident required two different nebulizer treatments 10 minutes apart so she needed to wait a few minutes to start the second treatment. LN1 rearranged the room to accommodate R1's personal electronic devices. LN 1 prepared the nebulizer with medicated solution, applied the nebulizer mask to R1 and turned on the nebulizer machine. The mask immediately began emitting a mist and R1 coughed. LN1 leaned over to within 12-18 inches of R1's face and adjusted R1's mask several times. The mist (droplets) was visible in LN1's face and around her head. LN1 did not wear eye protection. At 10:51 AM LN1 pinched the top of her surgical mask and pushed it up. LN1 did not perform hand hygiene and proceeded to handle resident supplies in the room. LN1's gown was not tied and exposed her hips and upper torso as it fell down with movement. R1 coughed several times producing sputum which he spit into tissues. LN1 took the tissues with her gloved hands. LN1 stood next to R1 and held the tissues until the coughing stopped then discarded the tissues. LN1 did not change gloves or perform hand hygiene after she discarded the sputum-soiled tissues. LN1 leaned close to R1 to talk to him and she again touched her facemask while wearing the soiled gloves. Upon completion of the treatment, LN1 removed the nebulizer mask and placed oxygen on R1. LN1 removed the soiled gloves and washed her hands as she left the room. ICS was interviewed following the above observation. ICS confirmed the nebulizer treatment was an aerosol generating procedure (AGP). When asked the rationale to require contact precautions while providing care to R1, but not special droplet precautions with appropriate PPE for aerosol generating procedures, ICS said she initially questioned the level of precautions. ICS said she thought special droplet precautions were indicated but was told it was the facility policy so she did not make changes. Signage on the door indicated special droplet precautions were required for resident room E3. The sign directed; *only essential personnel *clean hands when enter and when leave room *wear N95 or higher for aerosolizing procedures *eye protection *gown and glove at the door. The signage directed the order to doff (remove) PPE: 1. Gloves 2.gown 3.wash or gel hands 4.mask and eye cover 5. Wash or gel hands (even if gloves used). A caddy (shelf unit) hung on the outside of the door and had compartments that held gowns, masks, face shields, and gloves. Observation on 6/18/20 at 11:40 revealed licensed nurse LN2 exited room E3. LN2 removed the gown, then gloves, and finally the facemask with attached eye shield and discarded them in the room. LN2 did not remove the PPE in the order directed on the posted sign. LN2 did not perform hand hygiene after removing gown (step 3) and did not perform hand hygiene after removing the PPE (step 5). LN2 went directly from E3 to the medication cart carrying a glucometer (hand-held device used to measure the level of glucose in the blood). LN2 placed the glucometer on the medication cart then performed hand hygiene. When asked if the glucometer was used for other residents, he said yes it was but he cleans it first with Sani-Wipes (disinfectant wipes). LN2 wiped the glucometer with the Sani-Wipes and placed it back on the medication cart. LN2 but did not wipe the surface of the medication cart and did not place a barrier to separate the sanitized glucometer from the medication cart surface. In an interview on 6/18/20 at 11:42 AM LN2 said he was the charge nurse for the E Hall. When asked about a brown paper bag containing a facemask and shield labeled JH and dated 6/18/20 in the isolation supply caddy, LN2 said he did not know but maybe they were saving it to re-use it. LN2 said he did not re-use PPE supplies. Regarding donning and doffing PPE, LN2 said he followed the directions posted on each door. At 11:50 AM nursing assistants NAC 2 and NAC3 prepared to enter room E3. NAC3 removed a facemask she wore and placed it in the PPE supply caddy. The facemask was not folded properly (outside of mask folded inside) to prevent contamination, was not placed in a paper bag, and no barrier was placed to protect the isolation supply caddy from contamination by the mask. NAC3 properly donned PPE and entered room E3. The CDC

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135133	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IDAHO STATE VETERANS HOME - LEWISTON	821 21ST 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 -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) website at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html included instruction regarding extended use of facemasks: Implement extended use of facemasks. Extended use of facemasks is the practice of wearing the same facemask for repeated close contact encounters with several different patients, without removing the facemask between patient encounters. *The facemask should be removed and discarded if soiled, damaged, or hard to breathe through. *HCP must take care not to touch their facemask. If they touch or adjust their facemask they must immediately perform hand hygiene. *Facemask removal and replacement be done in a careful and deliberate manner. Facemasks should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. *The folded mask can be stored between uses in a clean sealable paper bag or breathable container. At 11:56 AM LN2 donned PPE to enter room E3. LN2 did not perform hand hygiene; LN2 donned the gown then the gloves and finally the facemask with attached eye shield. LN2 did not follow the posted instructions which read: PPE: put on in this order 1. Wash or gel hands (even if gloves are used) 2. Gown 3. Mask and eye cover. 4. Gloves. Upon exiting room E3 NAC3 retrieved the facemask from the PPE supply caddy and put it on. NAC3 wiped the face shield with disinfectant wipes then folded the attached mask and put it in the paper bag on the door caddy. NAC3 did not fold the mask properly to prevent contamination for re-use. NAC2 placed the facemask and shield she used in a paper bag and placed the paper bag on an open box of gloves that sat on top of the paper towel dispenser in room E3. Hand hygiene and gloves Observation conducted on 10:15 AM revealed NAC1 pushed Resident R6 from near resident room N12 on North Hall to the common (dining) area. NAC1 patted R6's shoulder and touched the wheelchair handles, wheelchair arms, and the bare skin of R6's forearms. Without performing hand hygiene, NAC1 proceeded to open cupboards in the dining room in search of a clothing protector. NAC1 opened the door on the nurse station and handled her microphone to speak to another staff. NAC1 walked half way down North Hall to the snack cart and obtained a snack for R6. NAC1 did not wash hands or use ABHR (alcohol-based hand rub) and did not offer R6 the opportunity to wash or sanitize his hands when NAC1 served R6 an individual package of chips to be eaten with fingers. NAC1 went directly from the dining area to the snack cart without performing hand hygiene, put on gloves, and continued to deliver snacks. While standing at the snack cart, NAC1 adjusted her facemask. Using both hands, NAC1 held the mask at the lower edge near her mouth and pulled the bottom of the mask down over her chin. NAC1 did not perform hand hygiene after touching her facemask. NAC1 did not perform hand hygiene prior to entering R11's room to provide a snack. R11 dropped the plastic spoon on the floor and picked it up. NAC1 obtained a clean spoon from the snack cart and re-entered R11's room. NAC1 took the soiled spoon in her hand and discarded it. NAC1 went to the sink and turned on the water. NAC1 was observed to pass her fingers into and immediately out of the stream of water for a total of 1-2 seconds. NAC1 did not use soap and did not wash her hands according to facility policy after handling the contaminated spoon. NAC1 entered room N9 without hand hygiene and then went directly into room N5. While in room [ROOM NUMBER] NAC1 moved the walker, touched her facemask, and touched the bed linen. NAC1 went from room [ROOM NUMBER] to the snack cart and put on gloves without first performing hand hygiene. NAC1 continued to deliver snacks. The findings were shared with ICS who stated staff should perform hand hygiene by washing with soap and water or using ABHR before entering and when leaving a resident room, and before handling food. ICS said staff should not touch the facemask and must immediately perform hand hygiene if the facemask is touched. ICS said she was surprised because NAC1 said all staff were educated on handwashing technique and expectations. ICS said NAC1 did not wash hands as the facility instructed. ICS provided the facility policy titled HAND HYGIENE with a review date of 11/19 and a policy titled USING GLOVES reviewed 08/19. The Hand Hygiene policy stated: All personnel working in the facility are required to wash their hands before and after resident contact, before and after performing any procedure, after sneezing or blowing nose, after using the toilet, before handling food, and when hands become visibly soiled. Alcohol Based Hand Rub (ABHR) may be used unless: 1.Potential of Actual contact with bodily fluids. 2. If hands are visibly soiled. The Procedure listed 14 steps for handwashing that included; 4.Wet hands and wrists thoroughly under running water. 6 .Apply a small amount of soap or antiseptic, lathering thoroughly. 7. Wash hand using plenty of lather and friction for at least 20 seconds. The Using Gloves policy stated the purpose: To provide guidelines for the use of gloves for resident and employee protection. 1.f. Non-sterile gloves should be used primarily to prevent the contamination of the employee's hands when providing treatment or services to the resident and when cleaning contaminated surfaces. 1.g. Wash hands after removing gloves. Gloves do not replace hand washing. During an interview with ICS, IP and DNS on 6/18/20 at 1:15 PM surveyor discussed observations and findings regarding transmission-based precautions for R1 with unknown COVID-19 status, the level of PPE protection for staff who performed aerosol generating procedures (nebulizer treatments) with R1, and general breeches in infection control related to hand hygiene and PPE use. ICS confirmed the facility utilized the Centers for Disease Control (CDC) as a reference source for infection control concerns. The CDC website at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html included a section: Preparing for COVID-19 in Nursing Homes that included the following: Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown. Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. Testing at the end of this period can be considered to increase certainty that the resident is not infected. ISC, IP, and the DNS stated all staff were trained regarding hand hygiene and PPE use and the observed infection control breeches did not meet facility expectations and were not acceptable. Regarding the COVID-19 status of R1, ISC said the facility tested all residents at admission but she was not sure if a COVID-19 test was sent out yet for R1. ISC said the facility had to wait for the lab to bring a test kit to the facility before a specimen could be collected. ISC said she did not know if a test kit was requested. IP said it took a couple of days to get the result back once the specimen was collected and sent out to the laboratory. When asked about the rationale why the facility required contact precautions and not special droplet/contact precautions to ensure eye protection during aerosolizing procedures until R1's COVID status was known, ISC said the hospital would have tested R1. Review of hospital records revealed no COVID-19 test. The DNS confirmed with the hospital that no COVID test was performed. ISC said she was confident R1's symptoms of cough and shortness of breath were not COVID related because he had a [MEDICAL CONDITION] [DIAGNOSES REDACTED]. The World Health Organization and CDC websites indicate a person may be pre-symptomatic (before symptoms show) but infectious and able to spread COVID-19 virus and in some cases persons with COVID-19 may have no symptoms. In these instances reliance on symptom screening alone may fail to detect COVID-19. After discussion, ISC, DNS, and IP confirmed that R1's COVID status was unknown and further acknowledged that R1 could potentially have COVID-19 in addition to his underlying condition of [MEDICAL CONDITION] or may have COVID-19 without showing symptoms. ICS and IP concurred that symptoms of COVID-19 may not be evident for 14 days after exposure and R1 and new admissions and re-admissions should be on special droplet/contact precautions for a minimum of 14-days after admission to the nursing home to prevent introduction and spread of COVID-19 in the nursing home. On 6/18/20 at 3:05 PM the facility (home) administrator (HA) and Director of Nursing (DNS) were verbally informed the findings related to infection control placed all residents in the facility at risk for exposure to and potential for infection with COVID-19 which constituted immediate jeopardy. The facility was provided written documentation of the immediate jeopardy via email to the nursing home administrator on 6/18/20 at 9:00 PM. On 6/19/20 at 9:30 AM, HA presented a plan to remove the immediacy. The plan included immediate placement of R1 on COVID-19 droplet precautions with communication to staff, posting of proper signage for droplet precautions and procedures for donning and doffing PPE. The facility revised the procedures for new admissions to include review and approval by the infection preventionist prior to acceptance for admission, COVID-19 testing procedures, and appropriate transmission-based precautions. The plan included inservice for all staff regarding droplet precautions and 1 on 1 inservice with employees as indicated. On 6/19/20 observations, interviews, record review to include facility policies and training documentationc onducted on site at the facility from 9:20 AM through 2:30 PM validated effective implementation of the removal plan. On 6/19/20 at 1:30 PM the facility administrator was informed the immediacy was removed.