STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135080	A. BUILDING _____ B. WING _____	07/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRANGEVILLE HEALTH & REHABILITATION CENTER	**410 EAST NORTH SECOND STREET GRANGEVILLE, ID 83530**

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 -** Few	**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 implement accepted infection control standards related to donning (putting on) and doffing (taking off) PPE (personal protective equipment) for residents on droplet precautions due to 14-day quarantine for residents newly admitted to the facility. This failure potentially placed residents in the facility at risk for exposure to the [MEDICAL CONDITION] and potential for facility transmission of COVID-19. Findings include: During the entrance interview on 7/22/20 at 8:45 AM, the administrator and the DNS reported the facility was COVID-free with no residents or staff tested positive for COVID-19. The administrator reported the surrounding community had no COVID spread. The facility had four residents on droplet precautions for new admission 14-day quarantine status. During observations conducted 7/22/20 at 10:45 AM on the 100 Hall resident room [ROOM NUMBER] had signage that indicated droplet + precautions. Observation revealed no PPE or supplies for droplet precautions outside the room. Nursing assistant CNA1 explained the process for room [ROOM NUMBER]. room [ROOM NUMBER] was empty and had an adjoining bathroom with room [ROOM NUMBER] so room [ROOM NUMBER] was the clean side where staff donned PPE. PPE and other supplies were in room [ROOM NUMBER]. CNA1 said staff washed hands and donned PPE in room [ROOM NUMBER] then entered room [ROOM NUMBER] through the bathroom. PPE was doffed in the room and staff exited 104 directly into the corridor. On 7/22/20 at 11:10 AM housekeeper (HK1) correctly donned PPE in room [ROOM NUMBER] and entered room [ROOM NUMBER] through the bathroom. HK1 completed the cleaning of room [ROOM NUMBER] then doffed PPE at the door and exited directly into the corridor still wearing the goggles. When HK1 reached the housekeeping cart in the corridor HK1 realized HK1 still had the goggles on. HK1 removed the goggles, took them into room [ROOM NUMBER], and placed the soiled, potentially contaminated goggles on a paper towel on the sink counter. HK1 sanitized the goggles with bleach wipes but then placed the goggles back down on the same paper towel which was contaminated when the soiled goggles were placed on it. When asked: If the goggles were not considered clean when placed on the paper towel; was the paper towel still considered clean now? HK1 replied; Oh no it's not, I will redo it. HK1 sanitized her hands and again sanitized the goggles then placed them on a clean paper towel which served as a barrier between the goggles and the sink surface. On 7/22/20 at 11:45 AM the clinical nurse manager (CNM1) was present during observation as therapy staff (TS1) donned PPE to enter resident room [ROOM NUMBER] to deliver a recliner chair. Signage indicated droplet precautions and PPE supplies were located in a movable cart in the corridor next to the door to room [ROOM NUMBER]. TS1 wore a mask and donned gown then gloves and finally a face shield. At 11:47 AM TS1 removed gloves and placed them in the trash bin in the room and immediately donned new gloves. TS1 did not wash hands or use alcohol based hand gel with glove change. TS1 wiped down the hand truck with bleach wipes then removed gloves and performed hand hygiene when exiting the room. In an interview immediately following the observation, CNM1 confirmed TS1 donned PPE in incorrect order. CNM1 said the face shield should be donned before gloves. Gloves should be donned last. Additionally CNM1 confirmed TS1 failed to perform hand hygiene with glove change. CNM1 said she provided weekly education on donning and doffing PPE. CNM1 said the education included the order to don and doff PPE and the proper use of barriers. CNM1 said TS1 and HK1 had training regarding PPE. Signage posted in the facility indicated the order to don and doff PPE. Order to don; 1. Gown 2. Mask and eye protection 3 gloves and order to doff 1. Gloves 2. Gown 3. Mask and eye protection. The posted signage was consistent with the CDC (Centers for Disease Control and Prevention) guidelines for PPE use.

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