| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235377 | A. BUILDING _____ B. WING _____ | 04/29/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| VALLEY VIEW CARE CENTER | 1050 FOUR MILE NW GRAND RAPIDS, MI 49544 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to maintain adequate infection control practice during a COVID-19 infection control survey. Findings include: Review of the Centers for Disease Control and Prevention website: (https://www.cdc.gov/handhygiene/providers/guideline.html) last reviewed: January 30, 2020 revealed, Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Immediately before touching a patient .Before moving from work on a soiled body site to a clean body site on the same patient .after touching a patient or the patient's immediate environment, after contact with blood, body fluids, or contaminated surfaces, immediately after glove removal. Healthcare facilities should: require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations .ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered . Review of facility policy HANDWASHING AND HAND HYGIENE revision Date: 3/13/2020 Definition: 1. Hand hygiene for each facility will follow the CDC definitions of cleaning your hands by using either handwashing (washing hands with soap and water), or antiseptic hand rub (i.e. alcohol-based hand sanitizer including foam or gel). PURPOSE: 1. To ensure appropriate hand hygiene which is essential in reducing the risk of transmission of infectious agents. GENERAL Guidelines for Hand Hygiene: To protect our residents, visitors, and staff, each facility will promote hand hygiene practices during all care activities and working in locations within the facility. Conditions which may require hand hygiene include but not limited to: Before and After applying gloves, before and after eating, after using the restroom, after contact/potential contact with blood or body fluids, secretions, mucous membranes, open skin or when the procedure requires hand hygiene . PROCEDURE: 1. Hand washing with plain or antimicrobial soap: a. Wet hands with running water. Avoid hot water. b. Apply 3-5 ml of hand washing agent and thoroughly disperse over hands. c. Vigorously rub hands together for at least 20 seconds, covering all surfaces of the hands and fingers d. Rinse hands with water and use disposable towels to dry. e. Use a clean paper towel to shut off the faucet. Review of facility DRESSING CHANGE (CLEAN) revision Date: 7/12/19, revealed, PURPOSE: 1. To protect wound. 2. To prevent irritation. 3. To prevent infection and spread of infection. 4. To promote healing. PROCEDURE: 1. Explain procedure and provide privacy. 2. Create clean field with appropriate barrier on clean over bed table and place needed supplies on barrier. 3. Place plastic bag within reach to receive soiled dressing. 4. Utilize alcohol gel unless hands are visibly soiled then you could wash hand with soap and water. DON gloves. 5. Remove soiled dressing and discard in plastic bag. 6. Dispose of gloves in plastic bag. 7. Sanitize hands and re apply gloves. 8. Cleanse wound with prescribed cleansing solution. 9. Apply prescribed medication as ordered. 10. Remove gloves and discard with any contaminated supplies in plastic bag. 11. Cleanse scissors with appropriate solution/wipe- as necessary. 12. Sanitize hands . Review of facility policy Perineal Care revision Date: 9/15/17 revealed, PURPOSE: 1. To cleanse the perineum. 2. To prevent infection and odor. 3. To maintain skin integrity . Female perineal care: 1. Wash hands and put on gloves. 2. Ask resident to separate her legs and flex knees. If she is unable to spread her legs and flex knees, the perineal area can be washed with the resident on the side with legs flexed .4. Use one gloved hand to stabilize and separate the labia, with other had wash from front to back, making sure to use a different part of the washcloth with each swipe. Change washcloths as needed to maintain a clean surface for each swipe .8. Remove gloves and wash hands . Review of Assure Platinum Blood Glucose Monitoring System User Instruction Manual unknown date, revealed, .Maintenance Cleaning & Disinfecting Guidelines: Healthcare professionals should wear gloves when cleaning the Assure Platinum meter. Wash hands after taking off gloves. Contact with blood presents a potential infection risk .suggest cleaning and disinfecting the meter between patient use. Option 1 .to use a wipe, remove from container and follow product label instructions to disinfect the meter. Take extreme care not to get liquid in the test strip and key code ports of the meter use one wipe to clean and a second wipe to disinfect . Review of Sani-Cloth Germicidal Disposable Wipe date unknown, revealed, .Directions For Use .To Disinfect .To disinfect nonfood contact surfaces only: Unfold a clean wipe and thoroughly wet surface. Allow treated surface to remain wet for a full two (2) minutes. Let air dry .Cleaning Procedure: All blood .must be thoroughly cleaned from surfaces .before disinfection by the germicidal wipe .use first germicidal wipe to remove heavy soil .Contact Time: Use second germicidal wipe to thoroughly wet surface. Allow to remain wet two (2) minutes, let air dry . Resident #101 Review of a Face Sheet revealed Resident #101 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.) and left trochanter (two bony protuberances by which muscles are attached to the upper part of the thigh bone) stage 1 (Intact skin with non-blanchable redness of a localized area usually over a bony prominence.). Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 2/14/2020, revealed a Brief Interview for Mental Status (BIMS) score was not able to be obtained due to Resident #101 being unable to complete the interview. The MDS further revealed Resident #101 was totally dependent on 2 persons for physical assistance for bed mobility (side-to-side turning and positioning while in bed) and toileting. Review of Resident #101's Care Plan revealed, Focus: SKIN MANAGEMENT . incontinence stage 4 sacrum .Revision on: 2/17/2019 .Goal: Skin will remain free from breakdown . Revision on: 03/27/2020 .Interventions . Treatments/medication as ordered Date Initiated: 08/19/2019 . During an observation and interview on 4/28/2020 at 12:10 PM, Licensed Practical Nurse (LPN) N entered Resident #101's room with supplies to perform a wound dressing change. LPN N placed a barrier on the bedside table with supplies on top of it and went into resident bathroom to wash hands with soap and water. She washed her hands for 9 seconds. Then using her feet, she pushed bathroom garbage can under the bedside table positioned to the resident's left side of bed. Resident #101's feeding pump buzzer sounded and LPN N touched buttons both hands to silence it and then used the bed controller to raise and flatten resident's bed. Using both hands, LPN N touched the air mattress control panel, pulled resident's blanket down to foot-of-bed, moved bed away from wall, and removed pillows from under Resident #101's knees. Then LPN N went between wall and resident's bed. At this time, LPN N was on resident's right side. LPN N proceeded to untapped resident's brief, and indicated she needed something from resident's cupboard. LPN N left resident's bed positioned away from the wall in a high position and walked to cupboard on the other side of the room. LPN N reached into her shirt pocket and used hand sanitizer for less than 20 seconds. When LPN N took a basin of supplies from cupboard, she threw out opened packages of gauze into garbage can under bedside table stating, Not all supplies are here and then left Resident #101's room while resident was in bed in a high position and away from the wall. Approximately 2 minutes later, LPN N returned to the doorway of Resident #101's room with the treatment cart. After using hand-sanitizer for less than 20 seconds, LPN N entered room with additional supplies and a towel. Placing the towel next to Resident #101's right foot towards the end-of-the bed, LPN N placed supplies on it. The scissors that were part of the supplies fell to the floor. LPN N picked up the scissors and went to the resident's bathroom, leaving her in her bed in a high position away from the wall. LPN N rinsed off both her hands and the scissors for 5 seconds and wrapped them in gloves and a paper towel, then placed them in her right shirt pocket. LPN N stated, If they (scissors) fall out of my pocket again they will be in something. LPN N went to Resident #101's right side, between the wall and bed, used |

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<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 1)<br>hand-sanitizer rubbing her hands for less than 20 seconds and donned clean gloves. LPN N then opened a package of rolled gauze, used the scissors she took out of her right pocket and cut opened a container of cleanser. Once opened, LPN N placed the scissors on the towel she had designated as a barrier and poured the cleanser into the package of rolled gauze. Once the container of cleanser was empty, LPN N leaned over Resident #101, touching her with her shirt and mid-torso and threw the empty container into the garbage can located on the resident's left side and still under the bedside table. LPN N then opened a single-use bottle of normal saline (NS) and poured it on 4x4 squares of gauze and opened cotton-tipped swabs. Both the 4x4s and swabs were placed on the towel barrier. LPN N donned clean gloves, again touched the feeding pump this time with her left hand and removed Resident #101's urine soaked brief. Observing the wound on Resident #101 sacrum, LPN N stated, Her (Resident #101) dressing is completely off the wound. LPN N took the dressing into her gloves she removed, leaned over the resident, and threw them into the garbage can still under the bedside table. LPN N then left Resident #101 with bed in high position and away from the wall and went into the bathroom where she washed her hands with soap and water for 5 seconds. Bringing 6 wash cloths to Resident #101's right side of the bed, LPN N placed them under the sacral wound. LPN N donned clean gloves and used 1-4x4 to clean wound. After using 1-4x4 in a single swipe around wound, LPN N removed gloves placing them on the towel she had designated as a clean barrier next to clean wound dressing supplies. Then LPN N used hand-sanitizer for less than 20 seconds and donned clean gloves. LPN N then used the top washcloth that was next to the sacral wound to pat dry the wound placing it on the designated barrier also next to the clean wound dressing supplies. With the NS soaked rolled gauze, LPN N packed it into the sacral wound with the cotton-tipped swabs. After she was done packing the wound with the gauze, LPN N took the scissors up off the barrier and cut the gauze. The scissors and used cotton-tipped swabs were placed back on the barrier next to the remaining clean wound dressing supplies. LPN N removed gloves placing them on the barrier and without performing hand hygiene, used the scissors to cut the ABD (abdominal) dressing in half, and leaned over Resident #101 to take the basin of supplies off of the bedside table and placed them on the towel barrier. Taking tape out of the basin, LPN N taped the ABD dressing over the resident's sacral wound. At this time, it was observed LPN N was wearing artificial nails that extended inch past the tips of her fingers. LPN N took a marker from her shirt pocket and used it to date and label the dressing. Without wearing gloves, LPN N put all the soiled supplies in the towel barrier and took the towel and walked away from Resident #101 leaving her bed in a high position away from the wall. After putting the soiled supplies into the garbage can under bedside table and without performing hand hygiene, LPN N touched the feeding pump and put a designated garbage bag on the foot-of-the bed next to Resident #101's left foot. At this time, it was observed Resident #101 began to urinate onto the barrier pad underneath her. Without providing Resident #101 with incontinence care, LPN N moved resident's bed up against the wall and applied the brake. Using soap and water, LPN N washed her hands for 5 seconds, donned gloves and rolled resident onto her right side. She then removed Resident #101's right trochanter soiled dressing, removed gloves and used hand sanitizer for less than 20 seconds. Leaving Resident #101 in a high positioned bed, LPN N went to the treatment cart to get normal saline and returned to resident's bedside table. Taking a marker out of shirt pocket, LPN N dated and labeled a clean dressing. Without performing hand hygiene, LPN N donned gloves, and used 1-4x4 saturated with normal saline to cleanse the trochanter wound. Without performing hand hygiene and changing gloves, LPN N left Resident #101 in a high-positioned bed and went to the closet to get a brief, cleansing wipes and a barrier pad. Wearing the same gloves LPN N use to cleanse wound, she placed the clean brief and chuck pad under the resident. LPN N then performed urinary incontinence care without spreading resident's legs apart and fully cleaning perineal area. With the same gloves used to change trochanter dressing and perform perineal care, LPN N repositioned Resident #101 in bed, placed pillows under knees and placed basin of unused supplies into resident's closet and close up garbage bag. Without performing hand hygiene, LPN N turned Resident #101's feeding pump off, used the bed controller to position resident's bed into a low position, and take a box of unused gloves to the treatment cart placing them in a drawer. LPN N stated, Hands should be washed for 20 seconds. You can sing the ABC or Birthday song twice. Hands should be washed when visibly soiled, before a sterile procedure, before or after meals, and after 3 times using hand sanitizer. Hands should also be washed during wound care and brief change. Gloves should be changed when visibly soiled. I had training on hand hygiene earlier this month. Review of facility education/training Temps, Handwashing, PPE prepared on 3/24/2020 revealed LPN N signed she had received the information on 4/4/2020. During an interview on 4/28/2020 at 2:06 PM, Director of Nursing (DON) B stated, Staff should call for help and not leave a resident alone in a bed that is in a high position. Staff would not want to leave the resident in a unsafe manner. During an interview on 4/28/2020 at 2:06 PM, Infection Preventionist/RN (IP) R stated, During wound care, the garbage can should be placed near where the nurse is working. The nurse should not lean over the resident to throw away soiled contaminated materials. Cross-contamination could happen if this is done. Nurses should not put dirty supplies on a clean barrier with clean supplies. Hand washing should be done for at least 20 seconds. It should be done when entering and leaving a resident's room, before procedures, during procedures when gloves become soiled, and going from dirty to clean areas during patient care. Hand washing should be done to prevent cross-contamination during perineal care and wound dressing change. Resident #102 Review of a Face Sheet revealed Resident #102 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 1/21/2020, revealed a Brief Interview for Mental Status (BIMS) score of 12, out of a total possible score of 15, which indicated Resident #102 was moderately cognitively impaired. Review of Resident #102's Care Plans revealed, Focus: Diabetes type 2 R/T Insulin dependence and diagnosis .Revision on: 09/22/2019 Goal: will have no complications related to diabetes .Revision on: 04/23/2020 .Interventions: Follow diabetic protocol per MD order Date Initiated: 08/19/2019 . During an observation and interview on 4/28/2020 at 11:31 AM, LPN N pulled an Assure Platinum Blood Glucose Monitoring meter (glucometer) from top drawer of 400 Hall medication cart (med cart) and placed on top without a barrier. LPN N gathered lancet, test strip, and alcohol wipe and placed supplies in a med cup. Taking one (1) Sani-Cloth wipe, LPN N wiped the glucometer for two (2) minutes. LPN N did not follow the manufacturer's recommended 2-wipe cleaning/disinfectant method and drying time before entering Resident #102's room. LPN N entered resident's room, announced she would be checking his blood glucose level. LPN N used hand-sanitizer before donning clean gloves then touched her hair with her left-gloved hand. After using the glucometer to test Resident #102's blood, LPN N removed the blood- soaked test strip from the glucometer and placed the glucometer into her right pocket and removed her gloves. No hand hygiene was performed before exiting resident room. When LPN N went back to the med cart, she took the glucometer from her right pocket, placed it on a barrier on top of med cart, used hand-sanitizer, and donned clean gloves. LPN N then took a visibly wet Sani-Cloth wipe and used it to enter the test strip port. Using the same cloth, LPN N wiped the glucometer multiple times, stating, I wipe the glucometer for 1 to 3 minutes and leave the wipe on it for a while. Then I remove the wipe and let it dry. I just use the 1 wipe to clean the glucometer. During an interview on 4/28/2020 at 11:45 AM, Registered Nurse (RN) M stated, To clean a glucometer, a nurse is to wipe it with a Sani-Cloth wipe for 2 minutes. There must be contact for 2 minutes and keep it wrapped until it dries. That will complete the sanitation process. Most med carts have 2 glucometers to speed up the process. The Sani-Cloth manufacturer recommends 2-minute contact time. A barrier must be on top of med cart and on resident bedside table for blood glucose supplies to prevent cross-contamination. During an interview on 4/28/2020 at 2:06 PM, IP R stated, Glucometer cleaning is done with Sani-cloths. They should be wiped down before and after use for 3 minutes. A barrier should be on top of the med cart to keep the glucometer clean. Shared equipment should be cleaned after each use. The lifts are being cleaned with a disinfectant. Whoever is using the equipment should clean it after use. The wipes are kept in the treatment cart and the nurse has the key. My expectation for staff is equipment should be cleaned after each use. During an observation and interview on 4/28/2020 at 12:05 PM, Certified Nursing Assistant (CNA) T was observed taking a mechanical lift (EZ Lift) from the 300 Hall shower room. CNA T stated, I am not sure if this lift is clean or if it was cleaned when it was put in the shower room. Housekeeping is to clean the lifts and equipment when put back in the shower room after use. There used to be Sani-Cloth wipes and packets but they facility ran out of them; I don't see them anymore. Housekeeping uses a cloth and a disinfecting solution to clean the equipment. I let housekeeping know when I'm done with the lifts so they can clean them. During an interview on 4/28/2020 at 12:04 PM, Housekeeping L stated, Housekeeping cleans resident equipment like lifts when we can. Housekeeping can't clean lifts and other equipment each time a CNA gets done with it. We can't do that because we are cleaning resident rooms, bathrooms, and halls. When housekeeping has time and is cleaning a shower room, we will wipe down the equipment then. During an observation and interview on 4/28/2020 at 1:17 PM, a vital sign machine was observed on 400 Hall with 3 thermometer probe covers in a plastic box next to a box of opened unused thermometer probe covers. Clinical Care Coordinator (CCC) O stated, If the probe covers are not in a box, they are to be presumed dirty. My expectations for staff are to throw them away after use. CNAs should clean equipment after each use. The |

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| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 2)<br>wipes they should be using are kept in the treatment carts or shower rooms. The CNAs must find a nurse to get the wipes to clean equipment. Observed CCC O use a glove to remove probe covers from plastic box and throw them in garbage. CCC O did not ensure the plastic box was disinfected after removing them nor was the unused box of probes disposed of. During an interview on 4/28/2020 at 2:06 PM, Nursing Home Administrator (NHA) A stated, Housekeepers cleaning schedule is more of a deep cleaning by wiping down the entire room. Housekeeping does not clean patient equipment after each use. |