| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135075 | A. BUILDING _____ B. WING _____ | 08/26/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| VALLEY VISTA CARE CENTER OF ST MARIES | 820 ELM STREET ST MARIES, ID 83861 |

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<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, policy review, nationally recognized standards of practice, and staff interview, it was determined the facility failed to ensure infection control prevention practices were consistently 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. Staff working in the facility did not consistently don (put on) the correct PPE in the COVID-19 positive unit, in the unit that housed residents with signs and symptoms of COVID-19, and in the unit that housed residents with possible exposure to COVID-19. a. The facility's guidance for Infection Prevention and Control for COVID-19, revised 6/5/20, stated staff should wear a gown, gloves, eye protection, and a respirator mask for the care of all residents when there was a facility outbreak. This guidance was not followed. i. On 8/25/20 at 1:45 PM, the outside doors to the facility's COVID-19 positive unit had two signs on the door. One sign directed staff to wear full PPE, including a respirator mask, face shield or goggles, a gown, and gloves. A second sign stated, Staff Respirators and face shield/goggles are to be warn (sic) at all times except while eating. Gowns and gloves are to be worn when entering patient rooms. CNA #2 admitted the surveyor into the COVID-19 unit through the locked doors and followed the surveyor into the unit. All three resident rooms' doors were closed and there were no residents or other staff in the common area of the unit. CNA #2 had on a respirator mask, goggles, and scrubs. She did not wear a gown or gloves. At 1:53 PM, CNA #2 then performed hand hygiene outside of Resident #9's room and donned a gown and gloves and went into Resident #9's room. At 1:55 PM, CNA #2 doffed (took off) her gown and gloves and performed hand hygiene just inside Resident #9's room. She then picked up Resident #9's meal tray with her bare hands, left the room and placed the tray on a cart in the common area of the COVID-19 unit and performed hand hygiene. CNA #2 did not don a gown or gloves. She then took a large plastic covering and placed it over the tray cart and wheeled it to the plastic barrier that separated the COVID-19 positive unit from the rest of the building. She then unzipped the barrier, moved the cart out of the unit and zipped the barrier closed, and performed hand hygiene. At 2:03 PM, CNA #2 was seated at the nurses' station charting on an electronic device with bare hands and was not wearing a gown. On 8/25/20 at 2:05 PM, CNA #2 said she wore a gown and gloves when in residents' rooms or when with a resident who tested positive for COVID-19. She said she thought she only had to wear a gown and gloves in the COVID-19 unit common area when residents were also in the common area. On 8/25/20 at 2:55 PM, the DON said she expected staff to wear full PPE, including a gown and gloves, while in the COVID-19 positive unit. She said the sign on the outside of the COVID-19 unit door was intended to remind staff not to wear a gown and gloves in the COVID-19 unit staff breakroom. ii. On 8/25/20 from 9:53 AM to 11:35 AM, the following was observed on the facility's unit with residents who were potentially exposed to COVID-19. * At 11:30 AM, LPN #1 delivered and set up Resident #6's meal on her tray table in her room. LPN #1 did not don a gown prior to entering the room. * At 11:34 AM, LPN #1 delivered and set up Resident #7's meal tray on his tray table in his room. LPN #1 did not don a gown prior to entering the room. * At 11:35 AM, CNA #5 delivered and set up Resident #9's meal on her tray table in her room. CNA #5 did not don a gown prior to entering the room. On 8/25/20 at 11:40 AM and 2:55 PM, the DON said staff were to wear gowns when delivering meal trays. b. The facility's Transmission-Based Precautions policy, revised 10/2018, stated personal eyeglasses should not be considered adequate protective eye protection This policy was not followed. i. On 8/25/20 at 1:56 PM, CNA #1 was observed in the COVID/Pink hall which included rooms #216 through #219. CNA #1 said the hallway had 3 residents who exhibited symptoms of COVID-19, and she thought they were on droplet precautions. CNA #1 said the 3 residents in the COVID/Pink hall had negative test results for COVID-19, and they were under observation for 7 more days. Two male residents were sitting in the hallway, and CNA #1 spoke to them. CNA #1 was wearing PPE which included a gown, gloves, a respirator mask, and she was wearing personal eyeglasses. CNA #1 said staff who worked in that hallway should wear a gown, gloves, and facemask. CNA #1 said staff were wearing a face shield when working in that area up until 2 days ago, but she was told it was no longer necessary to wear a face shield. On 8/25/20 at 3:00 PM, the DON said staff should wear eye protection when working in the COVID/Pink hall where residents who were suspected of having COVID-19 resided. ii. On 8/25/20 at 9:40 AM, the DON said room [ROOM NUMBER] through room [ROOM NUMBER] had residents who were potentially exposed to individuals who tested positive for COVID-19. On 8/25/20 from 9:53 to 11:35 AM, the following was observed on the unit: * At 9:53 AM, CNA #4 wheeled Resident #1 from the hallway into her room. CNA #4 had on a respirator mask and personal eyeglasses. She put on a gown and gloves and assisted Resident #1 into her room and closed the dor. CNA #4 did not put on eye protection. * At 9:57 AM and 10:05 AM, CNA #3 went into Resident #2's room. CNA #3 wore personal eyeglasses. She was not wearing a face shield or goggles for eye protection. On 8/25/20 at 10:30 AM, CNA #3 said she did not wear eye protection when going into residents' rooms on the unit. She said she was told her personal eyeglasses offered enough protection. On 8/25/20 at 11:22 AM, CNA #4 said she did not wear eye protection when going into residents' rooms on the unit. She said she was told her personal eyeglasses offered enough protection. On 8/25/20 at 11:40 AM and 2:55 PM, the DON said personal eyeglasses were not appropriate eye protection and she expected staff to wear goggles or face shields when on the potentially exposed unit. 2. The facility's guidance for Infection Prevention and Control for COVID-19, revised 6/5/20, stated signs indicating appropriate precautions were to be placed outside of resident rooms. The facility's policy for Categories of Transmission-Based Precautions, revised 10/2018, stated: * When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precaution. * The signage informs the staff of the type of CDC precaution(s), instructions for use of PPE, and/or instruction to see a nurse before entering the room. This guidance was not followed. On 8/25/20 at 9:40 AM, the DON said rooms #220 through #239 were occupied by residents who were potentially exposed to individuals who tested positive for COVID-19. On 8/25/20 at 9:45 AM, the unit had a door which was closed with a sign on it directing staff how to don and doff PPE. There was no signage on the door instructing staff when and what PPE to wear while on the unit. The resident room doors #220 to #239 did not have signage outside the rooms instructing staff when and what PPE to wear. On 8/25/20 at 11:00 AM, LPN #1 said there were no precaution signs on the unit doors or on the residents' room doors. LPN #1 said the residents on the unit were probably on contact precautions but said she was not sure. On 8/25/20 at 11:22 AM, CNA #4 said she did not know what precautions staff were to take, except to wear a gown when providing direct care for the residents, like using the toilet or changing incontinent briefs. On 8/24/20 at 11:40 AM and 2:55 PM, the DON said staff should be following COVID precautions for the potentially exposed unit. She said that meant droplet precautions with eye protection and a respirator mask. The DON said there was no signage and there should be a precaution sign for the unit to inform staff what PPE to wear. 3. The facility's policy for Handwashing/Hand Hygiene, revised 8/2019, documented hand hygiene should be performed using alcohol-based hand rub or soap and water after contact with objects in the immediate vicinity of the resident, after removing gloves, and before and after entering isolation settings. A document provided by the facility, undated, had instructions for how to safely remove PPE. The document stated the following: * The outside of goggles or face shield are contaminated. If hands become contaminated, immediately wash your hands or use alcohol-based hand sanitizer. * The front of |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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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>the mask/respirator is contaminated. If hands become contaminated, immediately wash your hands or use alcohol-based hand sanitizer. This policy and guidance were not followed. Examples include: a. On 8/25/20 from 9:57 AM to 10:22 AM and 10:32 to 10:38 AM, Housekeeper #1 was observed cleaning 3 resident rooms in the facility's unit with residents who were potentially exposed to COVID-19. At 9:57 AM, Housekeeper #1 was in Resident #2's room and was wearing a gown, gloves, goggles, and a respirator mask. At 9:59 am, she came out of the room with a used rag she had just used to clean the toilet. Housekeeper #1 then disposed of the rag and doffed her gloves. She did not perform hand hygiene. Housekeeper #1 then donned new gloves and took a new wet rag and wiped surfaces in the room. Housekeeper #1 then disposed of the rag and doffed her gloves. She did not perform hand hygiene. Housekeeper #1 then donned new gloves and swept and mopped the room floor. At 10:08 AM, Housekeeper #1 doffed her gloves and performed hand hygiene. She then dropped her goggles on the floor and picked them up and placed them on her cart. She then put on a new pair of goggles adjusted her hair, moved her cart to Resident #3 and Resident #4s' room, picked up a wet floor sign and placed it outside of Residents #3 and Resident #4s' room.<br>Housekeeper #1 then donned new gloves without performing hand hygiene before putting on the new gloves. At 10:11 AM, Housekeeper #1 removed Residents #3 and Resident #4s' garbage from the garbage cans and placed new plastic liners in the garbage cans. She then took a new wet rag and wiped down the paper towel dispenser, wheelchair and walker handles, the window seal, and 2 transfer poles. At 10:22 AM, she doffed her gloves and her gown and performed hand hygiene. At 10:32 AM, Housekeeper #1 pushed her cart with bare hands to Resident #5's room. She adjusted her goggles and her facemask with her hands. She did not perform hand hygiene. She then donned new gloves. Housekeeper #1 then took a new wet rag and wiped down surfaces in Resident #5's room. She then disposed of the rag and doffed her gloves. She did not perform hand hygiene. Housekeeper #1 then donned new gloves. She took a new wet rag and wiped the counter and sink. On 8/25/20 at 10:40 AM, Housekeeper #1 said she did not perform hand hygiene after removing her gloves until she was finished cleaning each room. She said she did not know she was not supposed to touch her mask. b. On 8/25/20 at 1:56 PM, CNA #1 was observed in the hallway that included rooms #216 through #219. CNA #1 said the hallway had 3 residents who exhibited symptoms of COVID-19, and she thought they were on droplet precautions. CNA #1 said the 3 residents had negative test results for COVID-19, and they were under observation for 7 more days. CNA #1 was wearing PPE which included a gown, gloves, and respirator mask. CNA #1 removed her gloves and gown and hung the gown on the door of the employee breakroom. CNA #1 then exited the hall to go outside. She did not perform hand hygiene after she removed her PPE. On 8/25/20 at 2:15 PM, CNA #1 said she forgot to wash her hands after she removed her PPE. On 8/25/20 at 3:00 PM, the DON said staff should perform hand hygiene after removing PPE and after touching their masks and goggles. |