STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135103		**05/11/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE CARE & REHABILITATION - THE ORCHARDS	**1014 BURRELL AVENUE** **LEWISTON, ID 83501**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on May 6, 2020 at Prestige Care and Rehabilitation - The Orchards. The facility was found to be in substantial compliance with 42 CFR §483.73 related to E-0024 (b)(6). Facility resident census: 51. Resident sample 9 with 15 randomly observed residents. The CMS Team: Barbara Daggy RN, Health and LSC surveyor Federal surveyors can be reached at: US Department of Health and Human Services Centers for Medicare and Medicaid Services 701 Fifth Avenue Suite 1600 Mailstop 400 Seattle, WA 98104 206.615.2313 206.615.2088 (Fax).	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/09/2020

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 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on May 6, 2020 at Prestige Care and Rehabilitation-The Orchards with record review completed on May 11, 2020.. The facility was not in substantial compliance with 42 CFR §483.80 infection control regulations and has not fully implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Facility Resident Census 51. Resident sample 9 and 15 randomly observed residents. The CMS Team: Barbara Daggy RN, Health and LSC surveyor Federal surveyors can be reached at: US Department of Health and Human Services Centers for Medicare and Medicaid Services 701 Fifth Avenue Suite 1600 Mailstop 400 Seattle, WA 98104 206.615.2313 206.615.2088 (Fax)	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		6/25/20

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F 880	Continued From page 1 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 2 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to develop and implement infection control policy and procedures such as hand hygiene and failed to implement Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention guidelines and practices to prepare for the ongoing COVID-19 pandemic to include social distancing. This failure placed residents in the facility at risk for exposure to and potential for illness with COVID-19. Findings include: During the entrance interview on 5/6/20 at 9:15 AM, the administrator and DNS (Director of Nursing Services) reported the facility was	F 880	F880 : Communal Dining 1. The plan for implementation of corrective actions for each specific deficiency cited a. Dining room was rearranged and seating was measured with 6 foot markings on floor to not allow for tables to be misplaced during cleaning. b. Additional small table that residents had gathered at was removed. c. Residents do not sit directly across from one another. d. Assisted dining room rearranged, each assisted diner will have individual tables	

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F 880	Continued From page 3 COVID?free. The administrator reported no residents or staff tested positive for or currently had symptoms consistent with COVID-19 illness. The administrator said the facility suspended visitors, communal dining and group activities during the pandemic. Communal Dining and cough etiquette During observation of the lunch meal on 5/6/20 from 12:25 PM to 12:50 PM on Appaloosa Way (300 hall) eleven residents came independently or were assisted to the Appaloosa Way Dining Room. The dining room had six small tables approximately 3 feet square with a slightly larger table positioned separate from the other tables. Several residents sat briefly at the separate table. The residents were seated two to a table and directly across from each other. A smaller room across from room 320 had two tables pushed together with one end against the wall and a separate small table. One resident sat at the end of the table, one resident sat about four feet away on the side of the table, and one resident sat at the separate table. Licensed Nurse LN1 said the small room was the assisted dining room for residents who needed a lot of help to eat. When asked about the separate table in the main dining room, LN1 said it was a gathering place where residents liked to sit throughout the day. The facility did not offer, assist, or provide hand hygiene to the residents prior to the meal. During the meal, resident R7 passed a drink cup and food from her plate to R8 who sat an arm's length away, across the table. R8 accepted and ate the	F 880	and individual staff members assisting with dining as long as staff available. If unable to have one staff per resident appropriate hand cleansing will occur between residents. 2. Address how the facility will correct each deficiency as it relates to the individual: a. Resident evaluated for need to be in communal dining area b. Those that can be redirected or can dine unsupervised are assisted back to their rooms for dining c. Additional small table that residents had gathered at was removed. 3. Address how the facility will act to protect residents in similar situations, for each deficiency: a. Resident evaluated for need to be in communal dining area b. Those that can be redirected or can dine unsupervised are assisted back to their rooms for dining c. Additional small table that residents had gathered at was removed. d. All staff educated on 6’ marking and social distancing policy and procedure. 4. Address what measures will be put into place or systemic changes made to	

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F 880	Continued From page 4 food. No staff intervened. Licensed Nurse LN1 was in and out of the dining room during the meal. When asked about communal dining, LN1 said staff try to seat residents across the table from each other. When asked why the staff did not ensure social distancing of six feet as per CDC guidelines. LN1 said some residents have dysphagia (difficulty swallowing) or diet restrictions and need to be watched closely and some residents need assistance with feeding. During the observation, staff assisted only one resident, R9. Review of 4 meal tickets revealed all four had general diets with no restrictions and no precautions. R9 sat at the separate table and was noted coughing in the dining room. R9 did not practice cough etiquette such as covering her mouth with a tissue or her sleeve when coughing. R9 frequently touched her face and arms. Dining room staff did not direct R9 away from the dining room when she was coughing and staff did not offer facial tissue. Staff did not offer or assist R9 with hand hygiene before or after the meal or when she was coughing. In an interview on 5/6/20 at 1:00 PM the facility ICP (Infection Control Preventionist) was informed of the observation of R9's coughing in the dining room in the presence of 10 other residents. ICP said the cough was "new for her, really new". When asked whether the facility considered a new cough as a potential sign of COVID?19 infection and whether R9 should be in a common area with a new cough; ICP said R9	F 880	ensure that the problem does not recur, for each deficiency: a. Dining room was rearranged and seating was measured with 6 foot markings on floor to not allow for tables to be misplaced during cleaning. b. Additional small table that residents had gathered at was removed. 5. Indicate how the facility will monitor its performance to make sure that solutions are sustained, for each deficiency: a. Infectious Preventionist to audit dining room to assure tables are in marked areas and residents are in marked areas for 1 meal daily for 2 weeks, then 3 meals per week for 2 weeks, then 3 meals monthly for 2 months. Then will discuss with QAPI team, need to continue audit. 6. A completion date for correction for each deficiency cited: a. June 25th, 2020 7. The name and title of the person responsible for implementing acceptable corrective action, for each deficiency: a. Infectious Preventionist to be responsible for deficiency. F880 : Resident Hand Hygiene Prior to Meals in Dining Room 1. The plan for implementation of	

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F 880	Continued From page 5 had developmental delay with low cognitive functioning. ICP said R9 been self?isolating thinking people made fun of her so ICP hated to isolate R9 to her room. ICP said R9 was not capable to comply with cough etiquette. ICP said R9's temperature was 97.6 with no other symptoms and R9 would be evaluated by a speech therapist for possible aspiration (food or drinks in lungs) which may cause cough. Regarding residents eating in the communal dining room, ICP said staff have to keep an eye on some residents who might choke. ICP said "some residents have their daily routines and prefer the dining room for meals, so maybe we need to get some longer tables." ICP said she was not aware that social distancing was not maintained in the dining rooms. ICP said it was an expectation that staff ensure social distancing for residents and provide hand hygiene when indicated such as before and after meals, and after coughing or using facial tissue. Group Activity- Smoking Observation of a supervised smoking session on 5/6/20 at 4:30 PM revealed the staff did not ensure social distancing during the activity. The smoking session was held outdoors on a covered patio. The smoking area had three tables. Two 3-foot?round tables were positioned approximately four feet apart. Five randomly observed residents RO1, RO2, RO3, RO4 and RO5 participated in the smoking activity. RO1, RO2, and RO3 sat at one round table, RO4 sat at the nearby table, and RO5 sat alone at the distant table. RO1, RO2, and RO3 sat elbow to elbow only inches apart.	F 880	corrective actions for each specific deficiency cited: a. LNs, CNAs and NAs to be educated on providing hand hygiene to any resident prior to entering dining room by Infection Preventionist. 2. Address how the facility will correct each deficiency as it relates to the individual: a. LNs, CNAs and NAs to be educated on providing hand hygiene to any resident prior to entering dining room by Infection Preventionist. 3. Address how the facility will act to protect residents in similar situations, for each deficiency: a. LNs, CNAs and NAs to be educated on providing hand hygiene to any resident prior to entering dining room by Infection Preventionist. 4. Address what measures will be put into place or systemic changes made to ensure that the problem does not recur, for each deficiency: a. LNs, CNAs and NAs to be educated on providing hand hygiene to any resident prior to entering dining room by Infection Preventionist. 5. Indicate how the facility will monitor its performance to make sure that solutions are sustained, for each deficiency:	

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F 880	Continued From page 6 At 4:35 PM the Administrator came to the smoking area. When asked about social distancing during smoking, the Administrator said "Yes it is required." The administrator immediately moved the residents apart and instructed staff on social distancing. Glove change and hand hygiene On 5/6/20 at 2:00 PM nursing assistants NAC1 and NAC2 used alcohol gel for hand hygiene and donned gloves. NAC1 and NAC 2 used the mechanical lift to move R7 from the wheelchair to the bed, NAC2 wore gloves and removed the incontinent brief. NAC2 used moistened cloths to clean R7 of a large bowel movement then without changing gloves rolled R7 from side to side to remove the lift sling which was under the resident. While still wearing the soiled gloves NAC2 put a clean brief on R7 and pulled up the sheet and blankets. NAC2 then removed the soiled gloves but did not wash or sanitize her hands. NAC2 positioned the oxygen nasal cannula on R7's face, placed the nurse call bell in R7's hand and used the bed control to raise the head of the bed. NAC2 held R7's hand and soothed the resident at completion of care. NAC2 did not wash hands and used alcohol hand gel for the first time when exiting the room. The observations were reported to the ICP on 5/6/20 at 2:30 PM. The ICP sid NAC2 should have removed gloves and washed hands after cleaning bowel movement and before moving to another part of the body or handling clean linen, the bed contro, or touching the resident. ICP said	F 880	a. Infectious Preventionist to audit dining room to assure hand hygiene is followed for 1 meal daily for 2 weeks, then 3 meals per week for 2 weeks, then 3 meals monthly for 2 months. Then will discuss with QAPI team, need to continue audit. 6. A completion date for correction for each deficiency cited: a. June 25th, 2020 7. The name and title of the person responsible for implementing acceptable corrective action, for each deficiency: a. Infectious Preventionist to be responsible for deficiency. F880 : Cough Etiquette 1. The plan for implementation of corrective actions for each specific deficiency cited: a. Resident #9 assessed for ability to understand cough etiquette, as she has Down's Syndrome, she has been unable to retain cough etiquette. b. Resident #9 was started on Speech Therapy r/t cognitive ability to eat safely. 2. Address how the facility will correct each deficiency as it relates to the individual: a. Resident #9 no longer has cough.	

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F 880	Continued From page 7 staff are all educated that they must perform hand hygiene when removing gloves.	F 880	3. Address how the facility will act to protect residents in similar situations, for each deficiency: a. Residents coughing in dining room, to be removed immediately from dining room and assisted by staff members with eating. Area where resident sat will be properly cleaned. 4. Address what measures will be put into place or systemic changes made to ensure that the problem does not recur, for each deficiency: a. LNs, CNAs and NAs to be educated on providing immediate cough etiquette education to any coughing resident in dining room by Infection Preventionist. 5. Indicate how the facility will monitor its performance to make sure that solutions are sustained, for each deficiency: a. Infectious Preventionist to audit dining room to assure coughing etiquette is followed for 1 meal daily for 2 weeks, then 3 meals per week for 2 weeks, then 3 meals monthly for 2 months. Then will discuss with QAPI team, need to continue audit. 6. A completion date for correction for each deficiency cited: a. June 25th, 2020 7. The name and title of the person	

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F 880	Continued From page 8	F 880	responsible for implementing acceptable corrective action, for each deficiency: a. Infectious Preventionist to be responsible for deficiency. F880 : Group Activity - Smoking 1. The plan for implementation of corrective actions for each specific deficiency cited: a. Smoke porch was rearranged and seating was measured with 6 foot markings on concrete slab to not allow for tables to be misplaced during cleaning. b. Dependent smoke break time divided into two smaller groups to assure residents can maintain social distancing while smoking. c. Independent smokers to smoke during times that do not overlap dependent smoke break times. 2. Address how the facility will correct each deficiency as it relates to the individual: a. All smoking residents effected. i. Smoke porch was rearranged and seating was measured with 6 foot markings on concrete slab to not allow for tables to be misplaced during cleaning. ii. Dependent smoke break time divided into two smaller groups to assure	

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F 880	Continued From page 9	F 880	residents can maintain social distancing while smoking. iii. Independent smokers to smoke during times that do not overlap dependent smoke break times. 3. Address how the facility will act to protect residents in similar situations, for each deficiency: a. Smoke porch was rearranged and seating was measured with 6 foot markings on concrete slab to not allow for tables to be misplaced during cleaning. b. Dependent smoke break time divided into two smaller groups to assure residents can maintain social distancing while smoking. c. Independent smokers to smoke during times that do not overlap dependent smoke break times. 4. Address what measures will be put into place or systemic changes made to ensure that the problem does not recur, for each deficiency: a. Smoke porch was rearranged and seating was measured with 6 foot markings on concrete slab to not allow for tables to be misplaced during cleaning. b. Dependent smoke break time divided into two smaller groups to assure residents can maintain social distancing while smoking.	

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F 880	Continued From page 10	F 880	c. Independent smokers to smoke during times that do not overlap dependent smoke break times. 5. Indicate how the facility will monitor its performance to make sure that solutions are sustained, for each deficiency: a. Administrator to audit smoke break to assure social distancing is followed for 1 smoke break daily for 2 weeks, then 3 smoke breaks a week for 2 weeks, then 3 smoke breaks monthly for 2 months. Then will discuss with QAPI team, need to continue audit. 6. A completion date for correction for each deficiency cited: a. June 25th, 2020 7. The name and title of the person responsible for implementing acceptable corrective action, for each deficiency: a. Administrator to be responsible for deficiency. F880 : Glove Change and Hand Hygiene 1. The plan for implementation of corrective actions for each specific deficiency cited: a. Specific staff members re-educated on glove change and hand hygiene policy and procedure.	

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F 880	Continued From page 11	F 880	2. Address how the facility will correct each deficiency as it relates to the individual: a. LNs, CNAs and NAs to be re-educated on glove change and hand hygiene policy and procedure by Infection Preventionist. 3. Address how the facility will act to protect residents in similar situations, for each deficiency: a. LNs, CNAs and NAs to be re-educated on glove change and hand hygiene policy and procedure by Infection Preventionist. 4. Address what measures will be put into place or systemic changes made to ensure that the problem does not recur, for each deficiency: a. LNs, CNAs and NAs to be re-educated on glove change and hand hygiene policy and procedure by Infection Preventionist. 5. Indicate how the facility will monitor its performance to make sure that solutions are sustained, for each deficiency: a. Infectious Preventionist to audit LNs, CNAs and NAs during care to assure glove changes and hand hygiene is followed for 1 ADL and/or peri care daily for 2 weeks, then 3 ADLs and/or peri cares per week for 2 weeks, then 3 ADLs and/or peri cares monthly for 2 months. Then will discuss with QAPI team, need to continue audit.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135103		**05/11/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 12	F 880	6. A completion date for correction for each deficiency cited: a. June 25th, 2020 7. The name and title of the person responsible for implementing acceptable corrective action, for each deficiency: a. Infectious Preventionist to be responsible for deficiency.	