

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/26/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135085	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2020
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - BOISE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 3115 SYCAMORE DRIVE BOISE, ID 83703		
(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	<p>Initial Comments</p> <p>A COVID-19 Focused Emergency Preparedness survey was conducted on June 16, 2020 through June 17, 2020. The facility was found to be in compliance with CFR §483.73 related to E-0024 (b)(6).</p> <p>The survey was conducted by:</p> <p>Cecilia Stockdill, RN, Team Coordinator Sallie Schwartzkopf, LCSW</p>	E 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/22/2020

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 The following deficiency was cited during a COVID-19 Focused Infection Control survey which was conducted on June 16, 2020 through June 17, 2020. The survey was conducted by: Cecilia Stockdill, RN, Team Coordinator Sallie Schwartzkopf, LCSW Survey Abbreviations: DON = Director of Nursing LPN = Licensed Practical Nurse	F 000			
F 880 SS=D	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. §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	F 880		8/3/20	

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F 880	<p>Continued From page 1</p> <p>conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of</p>	F 880			

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F 880	<p>Continued From page 2 infection.</p> <p>§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, policy review, and staff interview, it was determined the facility failed to ensure staff performed hand hygiene consistent with infection control standards and the facility's policy. This failure created the potential of exposing residents to the risk of infection from cross contamination including COVID-19. Findings include:</p> <p>The Centers for Disease Control and Prevention (CDC) website, accessed 6/17/20, documented hand hygiene should be performed immediately after removing gloves.</p> <p>The facility's policy for Hand Hygiene and Handwashing, dated 4/14/20, documented, "If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based hand rub for routinely cleaning hands." The policy stated hand hygiene should be performed; before having direct contact with residents, after having direct contact with another person's skin, after having contact with body fluids wounds or broken skin, after touching equipment or furniture near the resident/patient, after removing gloves.</p> <p>On 6/16/20 at 11:13 AM, LPN #1 was observed in the Harbor Care unit. LPN #1 was preparing oral medications at the medication cart while wearing gloves. LPN #1 then walked from the nurses' station to a male resident who was sitting at a table in the common area of the unit. LPN #1</p>	F 880	<p>General Disclaimer Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations manual.</p> <p>Hand Hygiene 1) Root Cause Analysis completed by QAPI Committee, Quality Advisor, and Clinical Specialists regarding Hand Hygiene on 7/14/20. 2) Hand Hygiene policy and procedure reviewed by the above parties on 7/14/20. Policy was last updated 4/14/2020. 3) DNS will develop additional training</p>		

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F 880	<p>Continued From page 3</p> <p>administered the oral medication to the resident, using a spoon and what appeared to be pudding. LPN #1 then walked over to a trash can on the farthest side of the unit, removed her gloves, and disposed of the medication cup, spoon, and gloves. LPN #1 did not perform hand hygiene after removing her gloves. She then walked back to the nurses' station and picked up a laptop computer from the medication cart. LPN #1 sat down at the nurses' station and started typing on the laptop computer.</p> <p>Immediately after the observation, LPN #1 said hand hygiene should be performed when hands are soiled, after feeding a resident, after returning from a break, after using the bathroom, and between contact with residents. LPN #1 said she usually wore gloves so her hands were not soiled, and she would "just put on a new pair of gloves." LPN #1 said her hands were clean when she put on the gloves and she did not touch anything, so she did not need to perform hand hygiene after she removed the gloves. LPN #1 said she did not perform hand hygiene after she administered the medication and removed her gloves.</p> <p>On 6/16/20 at 3:10 PM, the DON said hand hygiene should be performed after gloves are removed, and it was not acceptable for LPN #1 to walk away without performing hand hygiene after she removed her gloves.</p>	F 880	<p>with return demonstration for licensed and unlicensed staff using scenarios from cares provided during each shift.</p> <p>4) A post-test will be developed and administered to each licensed and unlicensed staff following the competency training and return demonstration with a required score of 90% or greater.</p> <p>6) Monthly hand washing competencies will continue with full return demonstration required for each competency.</p> <p>7) Hand hygiene will be reviewed, monitored, and addressed by the QAPI Committee.</p> <p>8) A minimum of 10 randomly selected staff members will be audited weekly for hand hygiene during the process of providing care. Randomly selected staff will include all departments and audits will include what staff members were doing at the time of audit. Audits will be conducted by the DNS, Infection Preventionist, or Care Managers.</p> <p>Date of Compliance August 3, 2020</p>		