

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: 135098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/22/2020
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1140 NORTH ALLUMBAUGH STREET BOISE, ID 83704		
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E 000	<p>Initial Comments</p> <p>A COVID-19 Focused Emergency Preparedness Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) Seattle on 6/18/20, 6/19/20 and 6/22/20. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6).</p> <p>Total residents: 71</p>	E 000			

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

TITLE

(X6) DATE

Electronically Signed

07/08/2020

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	<p>INITIAL COMMENTS</p> <p>A COVID-19 Focused Infection Control Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) Seattle on 6/18/20, 6/19/20 and 6/22/20.</p> <p>A deficiency was cited.</p> <p>The survey sample, based on a resident census of 71, included 7 sampled residents and 3 non-sampled residents.</p> <p>The CMS Seattle team member was: Terry Aoki, RN</p> <p>CMS Seattle federal surveyors can be reached at: US Department of Health and Human Services Centers for Medicare and Medicaid Services 701 Fifth Avenue Suite 1600 Region 10, mailstop 400 Seattle, WA 98104 206.615.2313 206.615.2088 (Fax)</p>	F 000			
F 880 SS=D	<p>Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§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.</p> <p>§483.80(a) Infection prevention and control program.</p>	F 880		7/11/20	

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F 880	<p>Continued From page 1</p> <p>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§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;</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>	F 880			

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F 880	<p>Continued From page 2</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 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, interview and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the transmission of communicable diseases, including COVID-19, and infections. Specifically:</p> <p>1. Failed to ensure 1 of 7 sampled residents (R1) reviewed for COVID-19 symptom monitoring had daily infection surveillance screening assessments conducted from date of readmission. There were no documented evidence of assessments conducted for 9 of 9 opportunities. No assessments on 6/9/20 to 6/17/20.</p> <p>2. Failed to perform hand hygiene between glove changes during incontinence care for 1 of 1 sampled resident (R2) observed for incontinence care.</p> <p>These failures increased the risks for delayed</p>	F 880	<p>Failed to ensure 1 of 7 sampled residents reviewed for COVID-19 symptom monitoring had daily infection surveillance screening assessments conducted from date of readmission. There was no documented evidence of assessments conducted for 9 of 9 opportunities. No assessments on 6/9/20 to 6/17/20.</p> <p>1. Corrective actions will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>-The Director of Nursing(DON) entered COVID-19 symptom monitoring orders with associated documentation tasks immediately, upon notification of deficient practice on 6/19 for resident R1.</p> <p>2. How will you identify other residents having the potential to be affected by the same deficient practice and what</p>		

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F 880	<p>Continued From page 3</p> <p>identification of COVID-19 and therefore increase the risk for spreading COVID-19 and other communicable diseases and infections amongst residents and staff.</p> <p>Findings include:</p> <p>During an interview on 6/18/20 at 8:20 AM Director of Nursing (DON) stated that facility census was 71, facility was admitting residents, and had no current known or suspected/presumed positive COVID-19 residents or staff. The DON stated that Infection Preventionist (IP) was on vacation and she would respond to any IP questions.</p> <p>1. Daily COVID-19 symptom monitoring Record review of progress notes, physician orders, Medication Administration Record (MAR) and Treatment Administration Record (TAR) and assessments showed R1 was readmitted to the facility on 6/9/20 with diagnosis including Adult Failure to Thrive and hypertension. R1 was transferred to the hospital on 6/6/20 for urosepsis (blood infection caused by infection in the urinary tract) and readmitted back to the facility on 6/9/20.</p> <p>R1 had physician orders from previous admission to "Monitor Vital Signs and record twice daily, Monitor for the following: Fever >99.0, Cough, Chest pain, Runny nose, SOB (shortness of breath), Chills, Muscle pain, Headache, Loss of smell or taste, N/V (nausea/vomiting) or diarrhea and loss of appetite, or sore throat. If source of symptoms has not yet been determined or treatment implemented, follow up with MD (medical doctor) for any positive findings, two times a day." The order and monitoring started on</p>	F 880	<p>corrective actions will be taken.</p> <p>-The DON/designee conducted a review of all resident charts to validate that COVID-19 symptom monitoring orders were in place and that associated documentation was being completed. No other residents were found to be affected by the deficient practice.</p> <p>3.What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.</p> <p>-The DON educated the IDT about COVID-19 symptom monitoring orders, documentation expectations and the use of the admission check list to validate completion of key admission tasks.</p> <p>DON educated direct care staff education on the expectation of completing documentation Q shift on symptom monitoring for new admissions.</p> <p>-The DON added COVID-19 monitoring to the batch orders for all new and re-admissions and added COVID-19 symptom monitoring order validation to the admission check list. Check lists and orders on new admissions/re-admission will be reviewed during our clinical meeting, to further validate the presence of these orders and associated documentation.</p> <p>4.Indicate how the corrective action will be monitored to ensure the corrective actions</p>		

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F 880	<p>Continued From page 4</p> <p>5/1/20 and was discontinued on 6/7/20 when resident was transferred to the hospital.</p> <p>During concurrent record review and interview on 6/18/20 at about 10:39 AM DON confirmed covid symptom monitoring assessments were not present since resident was readmitted on 6/9/20.</p> <p>During interview on 6/19/20 at 2:20 PM when asked about R1's covid symptom monitoring DON stated that every resident should be monitored for covid symptoms but the monitoring order was missed upon resident's readmission to the facility. DON stated that this will be corrected.</p> <p>Review of facility policy, "COVID-19 Pandemic Plan", undated, showed a system is implemented to monitor residents daily for symptoms of COVID-19. Information from the monitoring system is utilized to implement prevention and interventions such as isolation and cohorting.</p> <p>CDC's Preparing for COVID-19: Long-term Care Facilities, Nursing Homes, accessed 5/14/20, https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fprevent-spread-in-long-term-care-facilities.html, showed "actively monitor all residents upon admission and at least daily for fever (T >100.0 O F) and symptoms consistent with COVID-19."</p> <p>2. Failed to perform hand hygiene</p> <p>Observation on 6/18/20 at 9:28 AM showed CNA1 and CNA2 providing colostomy care to R2.</p>	F 880	<p>are effective and compliance is sustained will not recur.</p> <p>-The DON or Designee will conduct random chart audits to validate that symptom monitoring orders and documentation are being completed to facility standards. Findings will be reported to the QAPI committee monthly and as needed. Any negative trends identified will be addressed through system modification and staff education, as appropriate. These audits will be conducted 3 times per week for 30 days, twice weekly for 30 days, then once weekly for 30 days or until a lesser frequency is deemed appropriate by the QAPI committee.</p> <p>Observation on 6/18/20 showed CNA1 and CNA2 providing colostomy care to R2. CNA1 wore gloves and removed colostomy bag, removed stool from resident's skin around stoma site and then removed gloves. Without performing hand hygiene, CNA1 donned new gloves and placed new clean colostomy wafer bag on. CNA1 then fastened colostomy bag closed with clip. CNA1 wiped resident's indwelling catheter tubing and abdominal folds with same gloves. Resident was repositioned to her side while CNA1 wiped resident's buttocks and applied cream. CNA1 then removed her gloves and applied barrier cream. CNA1 again removed gloves and applied new gloves and placed briefs under resident and then</p>		

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F 880	<p>Continued From page 5</p> <p>CNA1 wore gloves and removed colostomy bag, removed stool from resident's skin around stoma site and then removed gloves. Without performing hand hygiene, CNA1 donned new gloves and placed new clean colostomy wafer and bag on. CNA1 then fastened colostomy bag closed with a clip. CNA1 wiped resident's indwelling urinary catheter tubing and abdominal folds with same gloves. Resident was repositioned to her side while CNA1 wiped resident's buttocks and applied cream. CNA1 then removed her gloves. Without performing hand hygiene, CNA1 donned new gloves and applied barrier cream. CNA1 again removed gloves and applied new gloves and placed briefs under resident and then dressed resident in pants, shirt and socks. After completing these tasks, CNA removed gloves and performed hand hygiene.</p> <p>During an interview on 6/18/20 at about 11:50 AM when informed of incontinence observation, DON stated it was the facility expectation to perform hand hygiene between glove changes, especially during incontinence care.</p> <p>Record review of R2's current physician orders and MAR showed R2 was readmitted on 12/20/19 with diagnosis including chronic obstructive pulmonary disease, diabetes, and spina bifida (birth defect where spine and spinal cord don't form properly).</p> <p>Facility policy, "Handwashing/Hand Hygiene", dated Quarter 3, 2018, showed use of an alcohol-based hand rub or soap and water for several situation including after removing gloves and before moving from a contaminated body site to a clean body site during resident care, and</p>	F 880	<p>dressed resident in pants shirt and socks. After completing these tasks, CNA removed gloves and performed hand hygiene.</p> <p>1. Corrective actions will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Education was provided to CNA1 by the DON, regarding appropriate hand hygiene practices immediately upon notification of deficient practice. Resident R2 hasn't shown any signs or symptoms of infection since 6/18/20 due to possible cross contamination.</p> <p>2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken. An audit was performed on July 1st of all residents with ostomy's during cares and all staff performed proper hand hygiene throughout the process. No other residents with ostomy's were affected by the same deficient practice.</p> <p>3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur.</p> <p>-The Director of Nursing/Designee provided Hand Hygiene Education, related to hand-washing during peri-care, colostomy care, and catheter care, on 6/30/20, to direct care staff</p>		

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F 880	Continued From page 6 after contact with bodily fluids.	F 880	<p>-The Don/Designee will complete hand hygiene competencies with all direct care staff.</p> <p>4. Indicate how the corrective action will be monitored to ensure the corrective actions are effective and compliance is sustained will not recur.</p> <p>The DON or Designee will conduct random audits to validate that hand hygiene is being performed appropriately. Findings will be reported to the QAPI committee monthly and as needed. Any negative trends identified will be addressed through system modification and staff education, as appropriate. These audits will be conducted 3 times per week for 30 days, twice weekly for 30 days, then once weekly for 30 days or until a lesser frequency is deemed appropriate by the QAPI committee.</p>		