

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: 135123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/24/2020
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF TREASURE VALLEY			STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH KIMBALL PLACE BOISE, ID 83704		
(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 by the Centers for Medicare & Medicaid Services (CMS) Seattle on 6/24/20. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6).</p> <p>Total residents: 80</p>	E 000			

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

TITLE

(X6) DATE

Electronically Signed

07/09/2020

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) Seattle on 6/24/20. A deficiency was cited. The survey sample, based on a resident census of 80, included 5 sampled residents and 6 non-sampled residents. The CMS Seattle team member was: Terry Aoki, RN 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)	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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		8/1/20	

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F 880	<p>Continued From page 1 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> <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (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 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 	F 880			

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F 880	<p>Continued From page 2 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 properly prevent and/or contain COVID-19. COVID-19 is an infectious disease by a new virus causing respiratory illness with symptoms of cough, fever, and in severe cases difficulty breathing that could result in severe impairment or death.</p> <p>The facility failed to establish and maintain an infection prevention and control program designed to provide a safe and sanitary environment to prevent the development and transmission of communicable diseases and infections. In addition, the facility failed to establish a system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility.</p> <p>Specifically, 1. Review of the facility's infection control logs for March 2020, April 2020 and May 2020 showed the facility failed to accurately track and trend</p>	F 880	<p>This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. The Plan of Correction does not constitute agreement by the facility that the surveyors findings constitute a deficiency and/or that the scope and severity of the deficiencies cited are correctly applied.</p> <p>F880</p> <p>Failure to completely implement Infection Control Program:</p> <p>Corrective Action: The infection control program has been reviewed and appropriate assignments have been made with clear delegation of duties to ensure the program will be implemented in full. The line listing form has been modified with all needed</p>		

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F 880	<p>Continued From page 3</p> <p>infections of the residents in the facility.</p> <p>2. Failed to wear personal protective equipment (PPE) eye protection (Housekeeper 1) when cleaning 3 of 3 resident (R) (R2, R6, R7) Special Droplet/Contact Precautions rooms on isolation unit.</p> <p>3. Failed to allow sufficient dwell time for Super Sani cloth disinfecting wipes, per manufacturer's instructions, when cleaning/disinfecting shared glucometer for 1 of 1 sampled resident (R1).</p> <p>These failures represented systemic failures which increased the risks for the spread of COVID-19 and other communicable diseases and infections amongst residents and staff.</p> <p>Findings include:</p> <p>During an interview on 6/24/20 at 8:00 AM Administrator and Director of Nursing (DON) stated that facility census was 80, facility was admitting residents and the facility had no current COVID-19 positive residents or staff.</p> <p>1. Infection control logs</p> <p>Review of facility policy, "Infection Prevention and Control Program (IPCP) and Plan", revised 7/25/19, showed "the organization-wide Infection Prevention and Control Program (IPCP) is comprehensive in that it addresses detection, prevention, and control of infections among residents and personnel. The risk of development of a healthcare-associated infection (HAI) is minimized through an organization-wide IPCP including the implementation of antibiotic stewardship activities Surveillance activities, including data collection and analysis, are used to</p>	F 880	<p>information and will be filled out completely each month. All identified infections will have the criteria validated by using the McGreer's checklist. The infection control committee will meet each month prior to the facility QAPI meeting to review data, make adjustments as needed, and ensure the program has been fully completed for the prior month.</p> <p>Identification: All residents can potentially be affected by this deficiency.</p> <p>Systemic Changes: The infection Preventionist and their partner have been fully trained on all parts of the facility infection control program. Each have been given specific assignments to ensure that the program will be fully implemented and followed up as needed. The infection control team will meet prior to QAPI meeting each month to review prior month's data. The data will be then presented monthly at the QAPI meeting.</p> <p>Monitor: The ED and DON will attend the monthly infection control meeting. The ED, DON, or designee will review line item listing to ensure it is fully completed each month during this meeting. Any missing data and or other issues that are identified will be brought to our monthly QAPI meeting and addressed as needed.</p> <p>Failure to wear PPE:</p>		

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F 880	<p>Continued From page 4</p> <p>identify infection prevention and control risks. Identify specific issues and trends usingmonthly data collection and summary report. Initiate action plans when issues and trends are identified using information from themonthly data collection."</p> <p>Review of facility's "Line Listing of Patient Infections", dated March 2020, showed resident's name, admission date, type of infection, symptoms/onset, cultures date/site/results), treatment, precautions, if infection criteria was met, and if infection was healthcare acquired infection or community acquired infection. The column for "does not meet infection criteria" was not completed for all 16 infections shown even though 12 of the 16 infections were identified as healthcare acquired infections and only 3 of the 16 infections showed the culture results with pathogen or organism identified. R8 was shown twice on March's report for pneumonia and c.diff (Clostridium difficile is a specific kind of bacterial infection that causes mild to life-threatening forms of diarrhea and colitis and typically occurs after antibiotic use, stressing the importance of using the right antibiotic based on culture results). There were no culture results for R8's pneumonia and neither the pneumonia or c.diff infection showed the date symptoms or infection occurred. R8's c.diff infection did not show if Contact Transmission Based Precautions were instituted to contain the spread of infection to others. The log failed to document if the ordered antibiotic was appropriate to treat the infection or if, and when, the infection was resolved. The March 2020 report also included a map of the facility color coded with type of infection, but there was no organism identified on the map or line listing of patient infections and therefore the facility map</p>	F 880	<p>Corrective Action: Staff are not to enter droplet precaution isolation rooms unless they have properly donned all appropriate PPE. This includes gowns, masks, eye protection, and gloves.</p> <p>Identification: All residents who are in an isolation unit or their room is under droplet precaution isolation can potentially be affected by this deficiency.</p> <p>Systemic Changes: Reeducated all housekeeping on facility policy for appropriate PPE use in a droplet precaution isolation room.</p> <p>Monitor: 1. Infection Preventionist or designee will randomly observe 5 staff members including nurses, nursing assistants, and housekeeping staff to observe they properly use and wear PPE in a droplet precaution isolation room. 2. Audits to be conducted at the following frequencies: a. Weekly for four (4) weeks b. Monthly for three (3) months 3. Findings to be reviewed and reported to QA Committee</p> <p>Inadequate dwell time:</p> <p>Corrective Action:</p>		

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F 880	<p>Continued From page 5</p> <p>was very limited to assess the potential relationship and spread of infection in the facility. Review of facility's "Healthcare-Associated Infection Summary Report by Resident Days", dated March 2020, showed it was blank without any narrative or calculation entered for "this month's infection per 1000 resident days", "specific issues or infection trends identified this month" and "actions taken relating to the specific issues or trends identified."</p> <p>Review of facility's "Line Listing of Patient Infections", dated April 2020, showed resident's name, admission date, type of infection, symptoms/onset, cultures date/site/results), treatment, precautions, if infection criteria was met, and if infection was healthcare acquired infection or community acquired infection. The column for "does not meet infection criteria" was not completed for all 17 infections shown even though 11 of the 17 infections were identified as healthcare acquired infections and none of the 17 infections showed the culture results with pathogen or organism identified. R9 was shown as having a healthcare acquired urinary tract infection and treated with antibiotic Nitrofurantoin for seven days. There were no symptoms listed, no date for when infection or symptoms occurred, no culture results or if R9 meet infection criteria. R10 was shown as having a healthcare acquired urinary tract infection and treated with two doses of antibiotic Ceftriaxone. There were no symptoms listed, no date for when infection or symptoms occurred, no culture results or if R10 meet infection criteria. The April 2020 report also included a map of the facility color coded with type of infection, but there was no organism identified on the map and line listing of patient infections and therefore the facility map was very</p>	F 880	<p>Glucometers will not be used unless properly cleaned per our infection control policy and per the manufacture's instructions. In order to ensure that the cleaning dwell time is adequate nurses have been instructed to wrap glucometer in sanitation wipe and place in plastic cup. After the sanitation wipe dwell time is met then the nurse will take and unwrap the glucometer. This will insure the glucometers will be cleaned appropriately.</p> <p>Identification: All residents with blood sugar checks can potentially be affected by this deficiency.</p> <p>Systemic Changes: Educated license nursing staff on facility procedures for proper cleaning of a glucometer machine including ensuring the glucometer is wet for the appropriate dwell time per the sanitation wipe that is being used.</p> <p>Monitor: 4. Infection Preventionist or designee to audit to observe 5 random blood sugar checks to observe proper cleaning of the glucometer. 5. Audits to be conducted at the following frequencies: a. Weekly for four (4) weeks b. Monthly for three (3) months 6. Findings to be reviewed and reported to QA Committee</p>		

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F 880	<p>Continued From page 6</p> <p>limited to assess the potential relationship and spread of infection in the facility. Facility's "Healthcare-Associated Infection Summary Report by Resident Days", was not found for April 2020.</p> <p>Review of facility's "Line Listing of Patient Infections", dated May 2020, showed resident's name, admission date, type of infection, symptoms/onset, cultures date/site/results), treatment, precautions, if infection criteria was met, and if infection was healthcare acquired infection or community acquired infection. The column for "does not meet infection criteria" was not completed for all 17 infections shown even though 12 of the 17 infections were identified as healthcare acquired infections. R11 had a healthcare acquired infection with frequency and hematuria symptoms with line drawn through a circle entered for column labeled "cultures: date/site/results", indicating culture was not obtained or culture results were not entered or known, and resident was treated with antibiotic Ciprofloxacin for 7 days, the column labeled "does not meet infection criteria" was blank with nothing entered. Although R11 was treated with antibiotics, it was unclear if the infection met criteria or if organism was susceptible or if antibiotic was appropriate treatment based on organism since a culture was not noted. Similar to report two months ago, R8 was shown on May's report as having c.diff, thereby emphasizing the importance for antibiotic stewardship; antibiotics used only when needed such as when minimum criteria for antibiotic uses is met and antibiotics use is based on culture results. The log failed to document if the ordered antibiotic was appropriate to treat the infection or if, and when, the infection was resolved. The May 2020 report</p>	F 880			

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F 880	<p>Continued From page 7</p> <p>also included a map of the facility color coded with type of infection, but there was no organism identified on the map and very minimal information on line listing of patient infections and therefore the facility map was very limited to assess the potential relationship and spread of infection in the facility. Review of facility's "Healthcare-Associated Infection Summary Report by Resident Days", dated May 2020, showed it was blank without any narrative or calculation entered for "this month's infection per 1000 resident days". Under "specific issues or infection trends identified this month" section, "no trends noted. The other infections include ear infections" was shown. It is unclear how the issues or infection trends and action required or indicated could have been determined without the organisms being consistently identified and form was incomplete with information missing.</p> <p>During an interview on 6/24/20 at 8:00 AM Administrator and Director of Nursing (DON stated that two staff were responsible for infection prevention; both took the class and were certified. One was the Staff Development Coordinator (SDC) and the other was the D-wing Unit Manager (UM).</p> <p>During an interview on 6/24/20 at 3:30 PM when asked questions about Line Listing of Patient Infections and Healthcare-Associated Infection Summary Report by Resident Days reports, SDC stated that UM was responsible for those reports.</p> <p>During an interview on 6/24/20 at 3:40 PM UM stated that SDC was responsible for Line Listing of Patient Infections and Healthcare-Associated Infection Summary Report by Resident Days reports. When informed that SDC just stated that</p>	F 880			

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F 880	<p>Continued From page 8</p> <p>UM was responsible, UM stated that she did the reports but no one wanted to take the blame. When asked to explain column on Line Listing of Patient Infections labeled "does not meet infection criteria", UM stated that she didn't know. When asked what criteria the facility used for determining if a resident had an infection or not, UM stated that she didn't know. When asked if facility used McGeer's, NHSN, or AHRQ or other criteria, UM said she didn't know but McGeer's sounded familiar. UM stated that facility former IP retired in October and she is sharing the IP role with SDC and received little training, although did take CDC TRAIN IP course. When asked how UM used line listing or summary report information to determine actions or if presence of trends or infection issues, UM stated that she didn't know. UM stated that some residents are colonized but nodded head in agreement that residents colonized can still spread infections to others.</p> <p>During exit conference on 6/24/20 at 4:30 PM with Administrator, DON and SDC, it was stated that staff has been trying hard to fulfill role vacated by retired IP. No further information was provided.</p> <p>2. Lack of eye protection</p> <p>During an interview on 6/24/20 at 8:00 AM Administrator and Director of Nursing (DON stated that new residents admitted to the facility or who go out into the community for dialysis or appointments reside on isolation units on A wing and are placed on full droplet transmission based precautions with staff wearing full personal protective equipment (PPE) such as N95 masks,</p>	F 880			

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F 880	Continued From page 9 gown, gloves and face shield. Observation on 6/24/20 at 2:20 PM showed Housekeeper (HK)1 in isolation unit on A Wing. Special Droplet/Contact Precautions sign was posted on door of each resident room door in isolation units on A Wing. The sign showed "Everyone Must: including visitors, doctors and staff, clean hands when entering and leaving the room, wear mask (fit tested N-95 or higher required when performing aerosol-generating procedures), wear eye protection (face shield or goggles), gown and glove at the door" An isolation cart and wall hooks outside the resident room doors included gowns, gloves and goggles. HK1 was observed outside R6's room. HK1 wore surgical face mask and donned new gown then entered R6's room. No eye protection, such as goggles, were worn while HK1 was in R6's room. HK1 wore gloves on hands, bagged trash, spray solution onto cloth and then used cloth to wipe down door knobs and overbed table. When wiping down overbed table, HK1 stood less than six feet away from R6. Certified Nursing Assistant (CNA)1 entered R6's room while HK1 was cleaning room. CNA1 wore mask, gown, gloves and goggles and went to talk with R6 who sat on recliner chair. CNA1 did not inform HK1 that she should be wearing goggles. HK1 continued cleaning room and then exited room and doffed gloves and gown. HK1 then donned new gown and gloves and entered R7's room. HK1 did not wear goggles while in R7's room. HK1 mopped room, cleaned toilet, wiped down door knobs, overbed table, air conditioner, window ledge, bedside table. HK1 stood within 6 feet of R7 while she wiped overbed table and bedside table. CNA1 entered R7's room with water. CNA1 wore gown, gloves, mask, and goggles and did not	F 880			

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F 880	<p>Continued From page 10</p> <p>inform HK1 that she should be wearing goggles while in R7's room. HK1 doffed PPE and then donned PPE and entered R2's room. Again, HK1 did not wear goggles in R2's room while standing less than 6 feet from resident while wiping handles of bedside table.</p> <p>During an interview on 6/24/20 at 3:00 PM when asked what PPE staff should wear when in isolation rooms on A Wing, DON stated that gown, gloves, goggles, and mask should be worn. When asked if this applies to all staff, DON stated, "yes". When asked if this applied to housekeepers, DON stated "all staff, including housekeeping." When informed of observation of HK1 entering isolation rooms on A Wing without eye protection/goggles, DON shook her head and stated that housekeepers should be wearing goggles and they have been trained, it doesn't matter what the resident's COVID status is, full PPE for droplet/standard precautions should be worn.</p> <p>During exit conference on 6/24/20 at 4:30 PM with Administrator, DON and SDC, DON stated that she spoke with Director of Environmental Services about HK not wearing goggles in isolation rooms and Director of Environmental Services stated that some staff missed the training and thought that only surgical mask was needed and didn't realize goggles needed to be worn.</p> <p>3. Inadequate dwell time</p> <p>Record review of R1's Medication Administration Record and progress notes showed resident was admitted on 12/10/19 with diagnosis including traumatic brain injury and diabetes (A disease</p>	F 880			

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F 880	<p>Continued From page 11</p> <p>that makes the person more susceptible to developing infections, as high blood sugar levels can weaken the person's immune system defenses. In addition, some diabetes-related health issues, such as nerve damage and reduced blood flow to the extremities, increase the body's vulnerability to infection.)</p> <p>Observation on 6/24/20 at 11:55 AM showed Licensed Nurse (LN)1 enter R1's room. LN1 stated that she just cleaned Optium EZ glucometer (glucometer is a blood glucose meters device that measure blood glucose levels). LN1 placed two tissues on resident's overbed table and placed glucometer on the tissue. LN1 also placed three small paper cups containing lancet, alcohol swab packet, and gauze on the overbed table. LN1 wiped resident's finger with alcohol and then pricked resident's finger. LN1 used the glucometer to check R1's blood sugar by obtaining blood from R1's finger placed in contact with the small strip on the glucometer. LN1 opened a Super Sani-Cloth large wipe packet and wiped the glucometer for approximately 15-20 seconds then placed the glucometer in medication cart. The glucometer did not remain wet for at least two minutes.</p> <p>During a concurrent interview and record review on 6/24/20 at about 12:10 PM when asked how long glucometer stayed wet after wiping with sani-cloth, LN1 stated "not very long, maybe 30 seconds". LN1 and surveyor reviewed the label of the Super Sani-Cloth packet which showed it was a germicidal disposable wipe with directions "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." LN1 stated that she did not know the</p>	F 880			

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F 880	<p>Continued From page 12</p> <p>glucometer needed to be wet for two minutes and stated that she wanted to test it. LN1 bought out glucometer and wiped it with super sani-cloth, after about 30 seconds, LN1 stated that it's dries quickly. After a minute, LN1 confirmed the glucometer was dry. LN1 showed surveyor facility policy, "Cleaning and Disinfection of Glucometer", undated, which showed "pick up glucometer from barrier and disinfect the glucometer with a Sanidex HB wipe or equivalent product that kills Hep-B and blood borne pathogens paying close attention to strip holder area to make sure you do not over saturate area and place back down on the barrier #2 to dry. Make sure that the glucometer is allowed to dry per the manufacturer's drying time." LN1 stated that the policy did not say the glucometer needed to be wet for two minutes when using the super sani-cloths. The policy directed staff to pay attention to the disinfecting wipe's drying time and not the disinfecting wipe's wet or dwell time.</p> <p>During an interview on 6/24/20 at 3:30 PM SDC stated that the facility lost a lot of glucometers because bleach destroyed the sensor but dwell time is covered during trainings. When asked if staff are expected to follow manufacturer's instructions for use of disinfecting wipes, SDC stated that staff should follow disinfectant's manufacturer's instructions to ensure disinfectant is effective.</p> <p>During Exit interview on 6/24/20 at 4:30 PM with SDC, Administrator and DON, when informed of observation with glucometer disinfecting, DON stated that staff are expected to follow manufacturer's instructions for dwell time. Review of CDC's website, at www.cdc.gov, section titled, "Infection Prevention During Blood</p>	F 880			

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

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F 880	Continued From page 13 Glucose Monitoring and Insulin Administration", showed that if the glucose meters must be shared, the device should be cleaned and disinfected after every use per the manufacturer's instructions.	F 880			