

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: 135056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2020
NAME OF PROVIDER OR SUPPLIER LINCOLN COUNTY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 511 EAST FOURTH STREET SHOSHONE, ID 83352		
(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 July 1, 2020 through July 2, 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

07/15/2020

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 July 1, 2020 through July 2, 2020. The survey was conducted by: Cecilia Stockdill, RN, Team Coordinator Sallie Schwartzkopf, LCSW Survey Abbreviations: CDC = Centers for Disease Control and Prevention CNA = Certified Nursing Assistant DNS = Director of Nursing Services LPN = Licensed Practical Nurse	F 000			
F 880 SS=E	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	F 880		7/17/20	

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F 880	<p>Continued From page 1</p> <p>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> <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>	F 880			

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F 880	<p>Continued From page 2</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, policy review, and staff interview, it was determined the facility failed to ensure infection control prevention practices were consistently implemented 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:</p> <p>1. The CDC website, accessed 7/6/20, documented hand hygiene should be performed immediately after glove removal.</p> <p>The facility's policy for Transmission Based Precautions (Isolation)/Glove Use, dated 10/2017, directed staff to wash their hands after removing gloves.</p> <p>On 7/1/20 at 3:31 PM, Resident #2 was wheeled into one of the shared bathrooms by a staff member. At 3:35 PM, Resident #1 turned on the bathroom call light, and at 3:36 PM LPN #1 entered the restroom and assisted Resident #1 off the toilet. LPN #1 wheeled Resident #1 back to her room, then she walked down the hall to the nurse's station. At 3:39 PM, LPN #1 returned to the bathroom wearing gloves and holding a</p>	F 880	<p>F880 The facility must establish and maintain an infection prevention and control program designed to promote a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infection. Individual residents: Resident #1 and #2 were not affected, by this practice. Identify Residents in Similar Situations: This has the potential to affect 23 of 32 residents. Nine of residents are totally incontinent and do not have the physical capability to use the toilet or commode. Clinical team monitored for respiratory concerns, with the respiratory screens of residents for three days to insure no one was affected by this practice. No residents were affected. Systemic changes measures to prevent: LPN #1 was disciplined on failure to follow CDC guidelines and policy for Hand Hygiene. 1. All staff in-services on proper hand hygiene Completed 7/15/20 By DNS/Designee 2. DNS/Designee will audit staff for</p>		

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F 880	<p>Continued From page 3</p> <p>container of sanitizing wipes. She wiped down the toilet and then wiped down the sink/countertop area. LPN #1 removed her gloves and exited the restroom carrying the container of sanitizing wipes. LPN #1 did not perform hand hygiene after removing her gloves.</p> <p>LPN #1 walked down the hall to the nurse's station, sat down in a chair, and placed the container of sanitizing wipes in a cupboard under the nurse's desk. LPN #1 said she "probably should use some hand sanitizer," and then she obtained a small container of hand sanitizer and performed hand hygiene. LPN #1 said she should have performed hand hygiene after she removed her gloves in the bathroom and she did not.</p> <p>On 7/1/20 at 3:58 PM, the DNS said hand hygiene should be performed before and after resident care, before and after being in a resident's room, and after cares were completed for a resident. The DNS said staff should perform hand hygiene after removing gloves, and the nurse should have changed her gloves and performed hand hygiene after she wiped down the toilet.</p> <p>2. The facility's policy for Laundry and Bedding, Soiled, undated, stated clean linens were to be protected from dust and soiling during transport and storage to ensure cleanliness.</p> <p>On 7/1/20 at 10:50 AM, Laundry Staff #1 was observed pulling a 3-shelved, 34-inch high cart on wheels down the unit to the linen closet. The cart had a 12-inch high stack of linens on the top and second shelves. There were no linens on the bottom shelf. The cart had a sheet over the top of it and the sheet hung down over the cart leaving</p>	F 880	<p>compliance in following hand hygiene policy and CDC guidelines, weekly starting, 5 staff members a week will be audited. 7/15/20</p> <p>3. All hand hygiene audits to be reviewed by DNS or infection control staff on weekly bases.</p> <p>All focus Hand hygiene audits will occur weekly. All audits to be reviewed for trends or concerns, by QA/Administrator. QA committee/Administrator will review for possible adjustment of the frequency of monitoring as deemed.</p> <p>Example two: All clean linen should be past in such a manner as not to be contaminated, when being transported. Laundry staff #1 was educated on proper procedure for passing clean linen on 7/13/20 Individual Residents: No residents identified. Identify residents of similar situations: It has the potential to affect all residents.</p> <p>All residents were monitored by clinical team for respiratory concerns with the respiratory screens for three days to insure no one was affected by this practice. No residents were affected. Systemic changes measures to prevent reoccurrence: 1. Administrator educated Laundry staff # 1 on proper methods of transporting clean linen. 2. All Laundry staff educated on proper technique for transporting clean linen, to and from laundry room. 3. Laundry staff to use only the top shelf</p>		

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F 880	Continued From page 4 the linens on the second shelf exposed. On 7/1/20 at 10:51 AM, Laundry Staff #1 said she covered the cart and brought sheets and blankets to the closet to put them away. When asked about the linen on the current linen cart, she said it was "mostly" covered. On 7/1/20 at 3:00 PM, the Administrator said the laundry should be completely covered during transport.	F 880	of linen cart for transporting clean linen, until new cover has arrived. Staff to use larger blanket, so to have no linen exposed during transport. Housekeeping supervisor to monitor, for compliance. 4. Administrator/ housekeeping manager to audit staff on a weekly bases, for compliance. 5. New custom made linen cart cover ordered to cover all three shelves. order placed and shipped on 7/14/2020. Linen transport audit will occur weekly. All audits to be reviewed for trends or concerns, by QA/Administrator. QA committee/Administrator will review for possible adjustment of frequency of the monitoring as deemed appropriate.		