

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

PRINTED: 08/28/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/15/2020
NAME OF PROVIDER OR SUPPLIER VALLEY VISTA CARE CENTER OF ST MARIES			STREET ADDRESS, CITY, STATE, ZIP CODE 820 ELM STREET ST MARIES, ID 83861		
(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 14, 2020 Through July 15, 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

08/11/2020

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>The following deficiency was cited during a COVID-19 Focused Infection Control survey which was conducted on July 14, 2020 through July 15, 2020.</p> <p>The survey was conducted by:</p> <p>Cecilia Stockdill, RN, Team Coordinator Sallie Schwartzkopf, LCSW</p> <p>Survey Abbreviations:</p> <p>CNA = Certified Nursing Assistant DNS = Director of Nursing Service PPE = Personal Protective Equipment</p>	F 000		
F 880 SS=E	<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. 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</p>	F 880		9/8/20

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F 880	<p>Continued From page 1</p> <p>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> <p>§483.80(e) Linens.</p>	F 880			

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F 880	<p>Continued From page 2</p> <p>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 implemented and maintained 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 facility's policy, Personal Protective Equipment - Contingency and Crisis Use of Isolation Gowns (COVID-19 Outbreak), dated April 2020, stated, "Extend use of isolation gowns so that same gown is worn by the same HCP when interacting with more than one resident known to be infected with the same infectious disease..."</p> <p>This policy was not followed.</p> <p>On 7/14/20 at 9:32 AM, Resident #3 had 3 yellow fabric gowns hanging from individual hooks inside the room on the door. A green sign was posted on the door, which indicated Droplet Precautions were in place.</p> <p>On 7/14/20 at 10:10 AM, CNA #4 entered Resident #3's room and grabbed a yellow cloth gown from the inside of Resident #3's door which</p>	F 880	<p>This Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because the provisions of the federal and state law require it. This provider maintains that the alleged deficiencies do not individually, or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit this providers capacity to render adequate resident care. Furthermore, the provider asserts that it is in substantial compliance with regulations governing the operation and licensure of long term facilities, and this Plan of Correction, in its entirety, constitutes this providers alleged compliance. Completion dates are provided for the procedural procession purposes to comply with state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in compliance with requirements of</p>		

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F 880	<p>Continued From page 3</p> <p>was hanging from the first hook on the left. When CNA #4 finished with Resident #3's cares, she returned the yellow gown to the hook where she obtained it.</p> <p>On 7/14/20 at 10:30 AM, CNA #6 exited Resident #3's room. Two gowns were hanging on the inside of the door and CNA #6 was wearing the same gown that CNA #4 used previously. CNA #6 said she was using the gown that was hanging on the first hook inside on the left of the door, and she was not aware the gown was previously worn by another person. CNA #6 said the gown was supposed to be labeled with a piece of tape, and staff were to use their own gown during their shift.</p> <p>On 7/14/20 at 1:35 PM, the DNS said the isolation gowns were reusable, and when staff removed the gown they should fold it from the outside in and hang it up on the door. The DNS said only one person should wear the gown, and it was not intended for multiple people to wear the same gown. The DNS said each employee should choose where to hang their gown on the door, the gown should be sent to the laundry at the end of their shift, and each gown was good for 100 washes.</p> <p>2. The facility's Handwashing/Hand Hygiene policy, dated August 2019, stated all personnel should follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors, including before and after direct contact with residents, and after contact with objects in the immediate vicinity of the resident.</p> <p>The facility's Standard Precautions policy, dated July 2020, stated standard precautions applied to</p>	F 880	<p>participation or that corrective action was necessary</p> <p>F 880</p> <p>Residents: Resident #3: Gowning procedure was changed with regards to staff use of gowns in isolation rooms. Resident 1#: Resident was monitored for any signs or symptoms of illness due to staff member hand hygiene. None noted Resident 2#: Resident was monitored for any signs or symptoms of illness due to staff member hand hygiene. None noted</p> <p>Other Residents: Other residents that will be placed on isolation have the potential to be affected by this deficient practice. All residents could be affected by deficient hand hygiene practices. CNA #4 & 6 were educated on proper donning and doffing of gowns. Also education provided to them regarding marking and usage of assigned gowns. CNA #1 & 3 were educated on proper hand hygiene as well as procedure for handling soiled linens. Other staff educated on proper donning and doffing procedures with return</p>		

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F 880	<p>Continued From page 4</p> <p>the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. The policy stated:</p> <p>* Hand hygiene referred to handwashing with soap or the use of alcohol-based hand rub (ABHR), which did not require access to water.</p> <p>* Hand hygiene was performed with ABHR or soap and water before and after contact with the resident, and after contact with items in the resident's room.</p> <p>On 7/14/20 at 11:15 AM, CNA #1 was observed holding a soiled linen bag in her left hand while assisting Resident #1 to her seat in the East Wing common area. CNA #1 had her right hand on Resident #1's back and belt. While walking to the seat, CNA #1 passed the soiled linen bag to CNA #2 who took it into the soiled linen room.</p> <p>After seating Resident #1, CNA #1 rolled two side tables in front of two chairs in preparation for lunch service by grasping the tops of the tables. CNA #1 did not perform hand hygiene prior to touching the tables and after holding Resident #1 by her clothing.</p> <p>CNA #1 then assisted CNA #3 by grasping Resident #2 under her left arm and sliding Resident #2 up in her reclining wheelchair. CNA #1 then performed hand hygiene.</p> <p>On 7/14/20 at 11:50 AM, CNA #1 said after assisting a resident with personal cares, the CNAs took the soiled linen bag to the soiled linen room and washed their hands with soap and water thoroughly. CNA #1 stated she should have performed hand hygiene prior to touching</p>	F 880	<p>demonstration as well as usage of assigned gowns</p> <p>Other staff educated on hand hygiene with return demonstration.</p> <p>Licensed Nursing staff educated on appropriate and signage for such precautions.</p> <p>Systemic Changes: All staff educated on the correct and proper donning and doffing procedures. All staff educated on proper usage of assigned gowns. All staff educated on different precautions and types of PPE used for each precaution.</p> <p>Monitoring: Infection Preventionist or designee to perform weekly for a month then random monitoring of 5 staff members of donning and doffing of PPE, hand hygiene audits. IP or designee to perform weekly for a month then random staff interviews regarding PPE usage and hand hygiene. Results to be reviewed at monthly QAPI meeting.</p>		

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F 880	<p>Continued From page 5 residents and dining tables.</p> <p>On 7/14/20 at 1:30 PM, the DNS said the protocol for handling soiled linen after assisting a resident with personal cares required a CNA to place the soiled linens in a bag and take it to the soiled linen room, and then perform hand hygiene. The DNS said it was not acceptable for staff to touch residents or items after handling a soiled linen bag.</p> <p>3. The facility's policy for Personal Protective Equipment-Using Gowns, revised September 2010, stated staff were to untie the back of the gown when removing it.</p> <p>A document provided from the facility, titled "How to Safely Remove PPE", undated, directed staff to unfasten the gown ties when removing the gown, and to be careful to avoid contact with the sleeves of the gown.</p> <p>This policy and guidance was not followed.</p> <p>On 7/14/20 at 10:10 AM, CNA #4 was in the hall assisting Resident #3 who was in her wheelchair. Resident #3 had a sign on her door indicating she was on Droplet Precautions, which requires face masks and gloves were worn when entering the room, and a gown and goggles should be worn if there was risk of spraying respiratory secretions. CNA #4 grabbed a yellow cloth gown from the inside of Resident #3's door which was hanging from the first hook on the left. The gown was tied at the top, and CNA #4 put it on by pulling it over her head.</p> <p>On 7/14/20 at 10:13 AM, CNA #4 opened the</p>	F 880			

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F 880	Continued From page 6 door to Resident #3's room and removed the gown by pulling it over her head. She returned the gown to the hook, performed hand hygiene, and exited the room. On 7/15/20 at 8:45 AM, CNA #4 said she did not untie the gown. CNA #4 said the reusable gown had the ties fastened so it could be hung up. CNA #4 said staff were not trained to leave the gown tied and pull it over their head.	F 880			