

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:  <b>135080</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/28/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRANGEVILLE HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 EAST NORTH SECOND STREET GRANGEVILLE, ID 83530</b>		
(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 &amp; Medicaid Services (CMS) on July 22, 2020 onsite at Grangeville Health and Rehabilitation Center.</p> <p>The facility was found to be in substantial compliance with 42 CFR §483.73 related to E-0024 (b)(6).</p> <p>Facility Resident Census 42 . Resident sample 5</p> <p>The CMS Team: Surveyor #29087</p> <p>Federal surveyors can be reached at: US Department of Health and Human Services Centers for Medicare and Medicaid Services 701 Fifth Avenue Suite 1600 Mailstop 400 Seattle, WA 98104 206.615.2313 206.615.2088 (Fax)</p>	E 000			

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

TITLE

(X6) DATE

Electronically Signed

08/03/2020

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.

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:  <b>135080</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/28/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRANGEVILLE HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 EAST NORTH SECOND STREET GRANGEVILLE, ID 83530</b>		
(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	
F 000	INITIAL COMMENTS  A COVID-19 Focused Infection Control Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on July 22, 202 onsite at Grangeville Health and Rehabilitation Center with completion of offsite record review on July 28, 2020.  The facility was not in substantial compliance with 42 CFR §483.80 infection prevention and control related to use of personal protective equipment for transmission-based precautions.  Facility Resident Census 42. Resident sample 5.  The CMS Team: Surveyor # 29087  Federal surveyors can be reached at: US Department of Health and Human Services Centers for Medicare and Medicaid Services 701 Fifth Avenue Suite 1600 Mailstop 400 Seattle, WA 98104 206.615.2313 206.615.2088 (Fax)	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.	F 880		8/13/20	

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

TITLE

(X6) DATE

Electronically Signed

08/03/2020

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.

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:  <b>135080</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/28/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRANGEVILLE HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 EAST NORTH SECOND STREET GRANGEVILLE, ID 83530</b>		
(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	
F 880	<p>Continued From page 1</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 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"> <li>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</li> <li>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</li> <li>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</li> <li>(iv) When and how isolation should be used for a resident; including but not limited to: <ul style="list-style-type: none"> <li>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</li> <li>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</li> </ul> </li> <li>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct</li> </ul>	F 880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135080</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/28/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRANGEVILLE HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 EAST NORTH SECOND STREET GRANGEVILLE, ID 83530</b>		
(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	
F 880	<p>Continued From page 2</p> <p>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 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 implement accepted infection control standards related to donning (putting on) and doffing (taking off) PPE (personal protective equipment) for residents on droplet precautions due to 14-day quarantine for residents newly admitted to the facility. This failure potentially placed residents in the facility at risk for exposure to the COVID virus and potential for facility transmission of COVID-19.</p> <p>Findings include:</p> <p>During the entrance interview on 7/22/20 at 8:45 AM, the administrator and the DNS reported the facility was COVID-free with no residents or staff tested positive for COVID-19. The administrator reported the surrounding community had no COVID spread. The facility had four residents on droplet precautions for new admission 14-day</p>	F 880	<p>F-880</p> <p>Resident Specific:</p> <p>Please see systemic changes</p> <p>Other Residents:</p> <p>Please see systemic changes</p> <p>Systemic Changes:</p> <p>All Housekeeping and Therapy staff have been in-serviced on donning and doffing of PPE with appropriate individual return demonstration.</p> <p>Monitors:</p> <p>DON or designee will observe 3</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135080</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/28/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRANGEVILLE HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 EAST NORTH SECOND STREET GRANGEVILLE, ID 83530</b>		
(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	
F 880	<p>Continued From page 3 quarantine status.</p> <p>During observations conducted 7/22/20 at 10:45 AM on the 100 Hall resident room 104 had signage that indicated droplet + precautions. Observation revealed no PPE or supplies for droplet precautions outside the room. Nursing assistant CNA1 explained the process for room 104. Room 106 was empty and had an adjoining bathroom with room 104 so room 106 was the "clean side" where staff donned PPE. PPE and other supplies were in room 106. CNA1 said staff washed hands and donned PPE in room 106 then entered room 104 through the bathroom. PPE was doffed in the room and staff exited 104 directly into the corridor.</p> <p>On 7/22/20 at 11:10 AM housekeeper (HK1) correctly donned PPE in room 106 and entered room 104 through the bathroom. HK1 completed the cleaning of room 104 then doffed PPE at the door and exited directly into the corridor still wearing the goggles. When HK1 reached the housekeeping cart in the corridor HK1 realized HK1 still had the goggles on. HK1 removed the goggles, took them into room 106, and placed the soiled, potentially contaminated goggles on a paper towel on the sink counter. HK1 sanitized the goggles with bleach wipes but then placed the goggles back down on the same paper towel which was contaminated when the soiled goggles were placed on it.</p> <p>When asked: If the goggles were not considered clean when placed on the paper towel; was the paper towel still considered clean now? HK1 replied; "Oh no it's not, I will redo it." HK1 sanitized her hands and again sanitized the goggles then placed them on a clean paper towel</p>	F 880	<p>Housekeeping and Therapy staff perform Donning and Doffing of PPE to ensure proper policy and procedures being followed weekly X 3 and Monthly X 2</p> <p>DON or designee will report findings at QA meeting and will make changes to the above plan of correction as needed.</p> <p>Date of Compliance: August 13th 2020</p>		

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:  <b>135080</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/28/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRANGEVILLE HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 EAST NORTH SECOND STREET GRANGEVILLE, ID 83530</b>		
(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	
F 880	<p>Continued From page 4 which served as a barrier between the goggles and the sink surface.</p> <p>On 7/22/20 at 11:45 AM the clinical nurse manager (CNM1) was present during observation as therapy staff (TS1) donned PPE to enter resident room 110 to deliver a recliner chair. Signage indicated droplet precautions and PPE supplies were located in a movable cart in the corridor next to the door to room 110. TS1 wore a mask and donned gown then gloves and finally a face shield.</p> <p>At 11:47 AM TS1 removed gloves and placed them in the trash bin in the room and immediately donned new gloves. TS1 did not wash hands or use alcohol based hand gel with glove change. TS1 wiped down the hand truck with bleach wipes then removed gloves and performed hand hygiene when exiting the room.</p> <p>In an interview immediately following the observation, CNM1 confirmed TS1 donned PPE in incorrect order. CNM1 said the face shield should be donned before gloves. Gloves should be donned last. Additionally CNM1 confirmed TS1 failed to perform hand hygiene with glove change.</p> <p>CNM1 said she provided weekly education on donning and doffing PPE. CNM1 said the education included the order to don and doff PPE and the proper use of barriers. CNM1 said TS1 and HK1 had training regarding PPE.</p> <p>Signage posted in the facility indicated the order to don and doff PPE. Order to don; 1. Gown 2. Mask and eye protection 3 gloves and order to doff 1. Gloves 2. Gown 3. Mask and eye</p>	F 880			

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:  <b>135080</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/28/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRANGEVILLE HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 EAST NORTH SECOND STREET GRANGEVILLE, ID 83530</b>		
(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	
F 880	Continued From page 5 protection. The posted signage was consistent with the CDC (Centers for Disease Control and Prevention) guidelines for PPE use.	F 880			