

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

PRINTED: 09/03/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/29/2020
NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
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F 000	INITIAL COMMENTS The following deficiency was cited during a COVID-19 Focused Infection Control and complaint survey conducted from July 28, 2020 to July 29, 2020. The survey was conducted by: Laura Thompson, RN, BSN - Team Leader Brad Perry, LSW Presie Billington, RN Survey Abbreviations: BOM = Business Office Manager CDC = Centers for Disease Control and Prevention CNA = Certified Nursing Assistant DON = Director of Nursing EPA = Environmental Protection Agency ICP = Infection Control Preventionist LN = Licensed Nurse LPN = Licensed Practical Nurse LSW = Licensed Social Worker NA = Nursing Assistant PPE = Personal Protective Equipment RN = Registered Nurse SSA = Social Services Assistant	F 000			
F 880 SS=L	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	F 880		9/1/20	

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

TITLE

(X6) DATE

Electronically Signed

08/13/2020

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 880	<p>Continued From page 1 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 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 	F 880			

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F 880	<p>Continued From page 2</p> <p>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 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, staff interview, policy review, review of the facility's employee screening logs, work schedules, and time sheets, it was determined the facility failed to ensure infection control prevention practices were implemented and maintained to prevent and contain COVID-19. This failure resulted in the likelihood of serious harm, impairment, or death to all staff and the 58 residents in the facility. Findings include:</p> <p>1. The facility's COVID-19 policy, updated 7/13/20, documented the facility would provide a COVID-19 positive unit that was separated by a physical barrier from other areas of the facility. The policy also documented the facility would have designated staff for that unit, and the facility would follow CDC guidelines.</p>	F 880	<p>This plan of correction constitutes the facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission of, or agreement with, the deficiencies or conclusions contained in the department's inspection report.</p> <p>Deficiencies related to: F880 Infection Control</p> <p>1. Correction/s as it relates to the resident/s:</p> <p>Residents' #10 #16, #19, # 29 no longer reside in facility.</p> <p>Residents' #1, #4 #11 #12,#13 #14,#15</p>		

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F 880	<p>Continued From page 3</p> <p>The CDC website, accessed on 7/31/20, Responding to Coronavirus in Nursing Homes, documented facilities were to assign dedicated healthcare professionals to work only on the COVID-19 care unit.</p> <p>This policy and the guidelines were not followed.</p> <p>The facility's North hall was separated with a plastic barrier which covered floor to ceiling and wall to wall located between room 52 and room 53 on the right side of the hall and between room 61 and room 60 on the left side of the hall. The North section, beyond the barrier housed residents who had tested positive for COVID-19 and the residents South of the barrier housed residents who had tested negative for COVID-19.</p> <p>The facility's COVID-19 surveillance and tracking form, dated 7/9/20 to 7/20/20, documented test results for Residents #1 - #4 and #24 - #29, who resided in the North hall between the plastic barrier and the back door. These residents had tested positive for COVID-19.</p> <p>The facility's COVID-19 surveillance and tracking form, dated 7/20/20 to 7/24/20, documented test results for Residents #11 - #19, who resided in the North hall between the fire doors and the plastic barrier. These residents had tested negative for COVID-19.</p> <p>The facility's daily assignment sheets, dated 7/24/20 to 7/28/20, documented CNA and Nurse staff assignments for the North hall. The sheets had documented all staff working each shift for that hallway. There was no indication that staff assignments were designated for the COVID-19</p>	F 880	<p>#24 #25 reside in designated units with designated staff.</p> <p>Res #12 and #13 had no negative effects from staff crossing between units and improper use of PPE</p> <p>Resident # 1,2,3,4,5,6,7,8,9 20 21, 24 and 25 had no negative effects from improper PPE use by staff</p> <p>Resident #11 had no negative effects from plastic barrier being unzipped exposing negative rooms to positive rooms.</p> <p>Res #9 and #22 are being offered hand hygiene before and after meals</p> <p>Residents currently in facility that tested positive for Covid have recovered with no negative effects.</p> <p>2. Action/s taken to protect residents in similar situations: Facility has designated Covid positive and Covid negative units with dedicated staff assignments in place. Facility has PPE stations for units with donning/doffing areas as indicated. Upon notification of immediate Jeopardy relating to infection control, the facility immediately educated staff to special droplet precautions including: PPE use, donning/doffing of PPE, proper cleaning and disinfecting of equipment, and hand hygiene. Facility established separate entrances for Covid positive units, Staff logs were</p>		

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F 880	<p>Continued From page 4</p> <p>positive unit and COVID-19 negative unit of the hallway.</p> <p>On 7/28/20 at 9:25 AM, CNA #7 was on the North hall COVID-19 positive unit and unzipped one of two zippers on the plastic barrier and walked through to the COVID-19 negative unit, zipped closed the barrier and went into Residents #13's and Resident #14's room. At 9:32 AM, CNA #7 came out of the room with a used incontinent brief in a trash bag and disposed of it, doffed (took off) her gloves, and performed hand hygiene and donned (put on) new gloves. CNA #7 then unzipped the zipper on the plastic barrier and went back into the COVID-19 positive unit. At 9:42 AM, CNA #7 and CNA #9 went into Resident #24's and Resident #25's room and made the bed of Resident #25.</p> <p>On 7/28/20 at 10:15 AM, CNA #7 and CNA #8 were in the hallway of the COVID-19 negative unit of the North hall. At 10:20 AM, CNA #7 went into Resident #19's room and came out with a disposable meal carton, disposed of it, performed hand hygiene, and donned new gloves. At 10:25 AM, CNA #7 then went back into the COVID-19 positive unit and closed the zipper on the barrier. At 10:26 AM, CNA #8 went into the COVID-19 positive unit after she unzipped and then closed the zipper on the barrier. At 10:34 AM, CNA #7 and CNA #8 left the COVID-19 positive unit and went into the negative unit and went into Resident #13's and Resident #14's room. At 10:37 AM and 10:40 AM, respectively, CNA #8 and CNA #7 left Residents #13's and Resident #14's room and went into Resident #12's room.</p> <p>On 7/28/20 at 10:39 AM, LPN #2 left the medication cart in the COVID-19 negative unit</p>	F 880	<p>updated to include active screening by staff member.</p> <p>Plastic barrier/zipper was repaired on North hall and East hall.</p> <p>3. Measures taken or systems altered to ensure that solutions are sustained:</p> <p>Daily monitoring of residents through review of 24* report and clinical meetings will occur to identify infection signs and symptoms that might warrant need for transmission based precautions. Identified issues will be addressed immediately.</p> <p>Facility has designated a new Infection Control Nurse with start date 8/11/20</p> <p>Facility will update orientation program to provide for education and competency testing in transmission based precautions.</p> <p>Staff educated to:</p> <ul style="list-style-type: none"> a) Process of active screening at facility for all employees regarding Covid symptoms and taking of temperature prior to their assigned shift by a designated staff member. b) Proper hand hygiene for staff , Hand hygiene before/after glove use, between residents c) Assisting residents with hand hygiene before/after meals d) Proper use of PPE including donning/doffing of PPE. e) Fit testing for N-95 masks, and use. f) How to enter through plastic barrier on Covid positive unit ensuring zipper closed 		

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F 880	<p>Continued From page 5 and went into the COVID-19 positive unit through the plastic barrier in the North hall. At 11:02 AM, LPN #2 came back through the plastic barrier from the COVID-19 positive unit to the COVID-19 negative unit and to the medication cart.</p> <p>On 7/28/20 at 10:45 AM, CNA #8 came out of Resident #12's room and went into Resident #13's and Resident #14's room.</p> <p>On 7/28/20 at 10:46 AM, CNA #7 left Resident #12's room and went into Resident #15's and Resident #16's room.</p> <p>On 7/28/20 at 10:50 AM, CNA #9 came through the barrier from the COVID-19 positive unit and into the COVID-19 negative unit in the North hall.</p> <p>On 7/28/20 at 9:20 AM, LPN #2 said she was the nurse for both the COVID-19 positive and COVID-19 negative units in the North hall. She said the facility did not have dedicated staff for the COVID-19 positive unit.</p> <p>On 7/28/20 at 9:55 AM, CNA #7 and CNA #9 said staff helped each other out and worked the whole North hall on both sides of the barrier. They said the facility had enough staff to take care of the residents' needs.</p> <p>On 7/28/20 at 10:52 AM, CNA #8 said she worked the whole North hall on both sides of the barrier. She said the facility had enough staff to take care of the residents' needs.</p> <p>On 7/28/20 at 1:05 PM and 4:35 PM, the Staffing Coordinator said the facility assigned dedicated CNAs to the COVID-19 positive unit and those staff should not work the COVID-19 negative unit.</p>	F 880	<p>and no gaps.</p> <p>g) Placing residents on precautions including posting of signage with instructions and setting up PPE station.</p> <p>h) Following precaution signs posted</p> <p>i) Using dedicated medical equipment for Covid + residents, cleaning of medical equipment per manufacturer directions</p> <p>Housekeeping staff educated to proper cleaning/disinfecting of beds and high touch surfaces following manufacturer directions for use and dwell times.</p> <p>4. Plans to monitor performance to ensure solutions are sustained and person responsible: Hand washing audits observing 5 or more employees will be conducted daily x 1 week, then weekly x4 with documented observations by ICN/DON/. Identified errors will be immediately corrected. Future auditing to be determined by QAPI.</p> <p>Donning/Doffing/PPE audits observing 5 or more employees will be conducted daily x 1 week, then weekly x4with documented observations by ICN/DON Identified errors will be immediately corrected. Future auditing to be determined by QAPI.</p> <p>Audits observing 5 or more employees appropriately accessing barriers of units will be conducted daily x 1 week, then weekly x4 with documented observations by ICN/DON. Identified errors will be immediately corrected. Future auditing to be determined by QAPI.</p>		

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F 880	<p>Continued From page 6</p> <p>She said a nurse was assigned to work both the COVID-19 positive and COVID-19 negative units in the North hall. The Staffing Coordinator said the facility had enough consistent staff and had not altered staffing schedules even after residents began testing positive for COVID-19.</p> <p>On 7/28/20 at 1:15 PM, the Administrator said CNAs should not work both the COVID-19 positive and COVID-19 negative unit in the North hall or go between the barriers. She said due to lack of nurses the facility did not have a dedicated nurse in the North hall COVID-19 positive unit.</p> <p>On 7/28/20 at 4:45 PM, CNA #10 said she worked the whole North hall on both sides of the barrier.</p> <p>On 7/28/20 at 5:02 PM, CNA #11 said she would help in both the COVID-19 positive and COVID-19 negative units in the North hall if her co-workers needed help.</p> <p>On 7/29/20 at 2:00 PM, RN #1 said she was the nurse for the whole North hall during her shift.</p> <p>On 7/29/20 at 2:45 PM, the ICP said the facility tried to maintain dedicated staff for the COVID-19 positive unit. She said the same nurse worked both the COVID-19 positive and COVID-19 negative units in the North hall due to lack of staff.</p> <p>Due to conflicting interviews, it was unclear if the facility had tried to mitigate staff shortages to provide dedicated staff to the COVID-19 positive unit in the North hall, specifically nurses.</p> <p>2. The CDC website, accessed on 7/31/20,</p>	F 880	<p>Staff attestation sign in logs will be reviewed daily for compliance by ICN/DON with concerns immediately investigated.</p> <p>A random visual audit of housekeeping procedures to ensure compliance to cleaning/disinfecting of beds/ high touch surfaces will occur daily x 1 week then weekly x 4. Future auditing to be determined by QAPI</p> <p>The Quality Assurance and Performance Improvement Committee will meet weekly to discuss findings of audits for any recommendations/ root cause analysis. Any concerns will be followed up with appropriate action plan.</p> <p>5. Who will be responsible for ensuring compliance: ED/DON</p>		

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F 880	<p>Continued From page 7</p> <p>Preparing for COVID-19 in Nursing Homes, stated facilities were to screen all staff at the beginning of their shift for fever and symptoms of COVID-19, have staff leave work if they are ill, and staff with a positive screening at entry were to leave the facility.</p> <p>This guideline was not followed.</p> <p>The facility's Staff Temperature Attestation Logs from 7/24/20 to 7/28/20, directed staff to take and record their own temperature and answer yes or no if they had respiratory symptoms such as difficulty breathing, sore throat, cough, congestion, nausea, vomiting, diarrhea, chills, fever, shortness of breath, muscle aches, malaise, change in ability to taste or smell and/or runny nose, and to sign the log.</p> <p>The facility's hourly employee time sheets from 7/24/20 to 7/28/20 were reviewed and compared with the employee Staff Temperature Attestation Logs from the same dates. The following inconsistencies were identified.</p> <p>Staff were identified who worked without being screened prior to the beginning of their shift.</p> <p>* The screening logs and time sheets, dated 7/24/20, documented 4 CNAs, 4 LNs, and 2 administrative staff were not screened prior to working their shifts.</p> <p>* The screening logs and time sheets, dated 7/25/20, documented 2 CNAs, 2 LNs, 1 Hospitality Aide, and 1 administrative staff were not screened prior to working their shifts.</p> <p>* The screening logs and time sheets, dated</p>	F 880			

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F 880	<p>Continued From page 8</p> <p>7/26/20, documented 7 CNAs, 1 Hospitality Aide, and 1 LN were not screened prior to working their shifts.</p> <p>* The screening logs and time sheets, dated 7/27/20, documented, 2 LNs, 1 CNA, and 1 administrative staff were not screened prior to working their shifts.</p> <p>* The screening logs, and time sheets for day shift, dated 7/28/20, documented 2 LNs were not screened prior to working their shifts.</p> <p>On 7/28/20 at 9:54 AM, CNA #1 said he came to work at 6:00 AM and took his own temperature, and answered questions in the screening log. CNA #1 said he donned a gown, N95 respirator mask, and goggles and went to the South hall.</p> <p>On 7/28/20 at 10:12 AM, Laundry Aide #1 said she took her temperature before coming to work, but forgot to check herself in. Laundry Aide #1 said she donned a gown, a mask, and goggles and collected the dirty gowns and washed them.</p> <p>On 7/28/20 at 10:28 AM, the Dietary Manager and Cook #1 both said they checked their own temperatures and answered the questions in the screening log.</p> <p>On 7/28/20 at 10:30 AM, the Graduate Nurse said she took her own temperature.</p> <p>On 7/28/20 at 10:33 AM, BOM said she came to work around 7:00 AM and took her own temperature and answered the questions in the screening log and checked herself in.</p> <p>On 7/28/20 at 10:35 AM, CNA #2 said she took</p>	F 880			

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F 880	<p>Continued From page 10 facility through a back door and proceeded to check her own temperature and filled out the screening log without another staff's assistance. RN #1 said she always checked herself in.</p> <p>On 7/29/20 at 2:45 PM, the ICP said she expected staff to screen themselves before each shift, take their own temperatures, and record signs and symptoms of COVID-19. She said she thought self-screening of staff was allowed. The ICP said when they were in the facility, she, the DON, or the Administrator reviewed the screening logs to make sure staff who worked did not have fevers and/or COVID-19 symptoms. She said she did not check the logs to see if staff who worked had screened themselves before their shifts.</p> <p>On 7/29/20 at 3:40 PM, the Administrator said she thought staff could screen themselves.</p> <p>3. The facility's COVID-19 policy, updated 7/13/20, directed staff to dispose of gowns before leaving a COVID-19 positive room. The policy also directed staff to put on clean gloves upon entry into resident rooms.</p> <p>The facility's Hand Hygiene policy, revised 08/2019, directed staff to perform hand hygiene before and after using gloves and after contact with residents or objects in their environment.</p> <p>The facility's Transmission-Based Precautions policy, revised 10/2018, directed staff to place signs and instructions on residents' doors who were in isolation precautions.</p> <p>These policies were not followed.</p> <p>The facility's in-service training, dated 7/11/20,</p>	F 880			

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

PRINTED: 09/03/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/29/2020
NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
(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 11</p> <p>directed staff to wear a disposable gown over the top of a washable gown in COVID-19 positive rooms and then dispose of the disposable gown when leaving the room.</p> <p>The facility's in-service training, dated 7/23/20 and 7/24/20, directed staff they could wear the same gown when in COVID-19 positive rooms and to remove the gown when they left the hallway. The training sign-in sheet did not document CNA #9, CNA #10, and CNA #11 had received this training.</p> <p>a. On 7/28/20 at 8:48 AM, the Administrator informed the surveyor that after the surveyor was in the North side of the plastic barrier in the North hall, the surveyor was expected to doff the gown and gloves and leave out the back door and then to walk around the building and don new PPE at the front entrance. The Administrator said to not go back through the building via the plastic barrier.</p> <p>The following were observed in the North hall on 7/28/20:</p> <p>On 7/28/20 at 9:25 AM, CNA #7 was on the North hall COVID-19 positive unit and unzipped one of two zippers on the plastic barrier wearing gloves and a red reusable PPE gown and walked through to the COVID-19 negative unit, zipped closed the barrier and went into Resident #13 and #14's room with the same gown and gloves. At 9:32 AM, CNA #7 came out of the room with a used incontinent brief in a trash bag and disposed of it and performed hand hygiene and donned (put on) new gloves and kept the same gown on. CNA #7 then unzipped the zipper on the plastic barrier and went back into the COVID-19 positive</p>	F 880			

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

PRINTED: 09/03/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/29/2020
NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
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F 880	<p>Continued From page 12</p> <p>unit. CNA #7 then took a red used reusable gown off a hook in the hallway in the COVID-19 positive unit and placed it over the top of the red reusable gown she had worn prior to and after leaving the COVID-19 negative unit. CNA #7 said each staff had a dedicated gown in the COVID-19 positive unit and used those in residents' rooms on the unit. CNA #7 said staff were to double gown when in the COVID-19 positive unit.</p> <p>On 7/28/20 at 9:33 AM, CNA #7 instructed the surveyor to place a clean red reusable gown over the top of the green reusable gown the surveyor had worn into the COVID-19 positive unit. CNA #7 said after the surveyor was done in the COVID-19 positive unit they had to doff the gown and gloves and leave out the back door and then to walk around the building and don new PPE at the front entrance.</p> <p>On 7/28/20 at 9:42 AM, CNA #7 and CNA #9 went into Resident #24's and Resident #25's room in the COVID-19 positive unit and made Resident #25's bed. CNA #7 and CNA #9 had two reusable gowns on. CNA #7 had two red reusable gowns on and CNA #9 had a green reusable gown with a red gown on top of it.</p> <p>On 7/28/20 at 10:15 AM, CNA #7 and CNA #8 were in the hallway of the COVID-19 negative unit on the North hall and each were wearing a red reusable gown. At 10:20 AM, CNA #7 went into Resident #19's room and came out with a disposable meal carton, disposed of it, performed hand hygiene, and donned new gloves. At 10:25 AM, CNA #7 then went back into the COVID-19 positive unit with the same gown on and closed the zipper on the barrier. At 10:26 AM, CNA #8 went into the COVID-19 positive unit with the</p>	F 880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/29/2020
NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
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F 880	<p>Continued From page 13</p> <p>same gown on and then closed the zipper on the barrier. At 10:34 AM, CNA #7 and CNA #8 left the COVID-19 positive unit into the negative unit wearing red reusable gowns and gloves and went into Residents #13 and #14's room with the same gown and gloves on. At 10:37 AM and 10:40 AM, respectively, CNA #8 and CNA #7 left Resident #13 and #14's room with the same gowns, doffed their gloves, performed hand hygiene, donned new gloves and went into Resident #12's room.</p> <p>On 7/28/20 at 10:45 AM, CNA #8 left Resident #12's room with the same gowns, doffed her gloves, performed hand hygiene, donned new gloves and went into Residents #13 and #14's room with the same gowns on.</p> <p>On 7/28/20 at 10:46 AM, CNA #7 left Resident #12's room with the same gowns, doffed her gloves, performed hand hygiene, donned new gloves and went into Residents #15 and #16's room with the same gowns on.</p> <p>On 7/28/20 at 10:39 AM, LPN #2 left the medication cart in the COVID-19 negative unit and went into the COVID-19 positive unit through the plastic barrier in the North hall wearing a green reusable gown. At 11:02 AM, LPN #2 came back through the plastic barrier from the COVID-19 positive unit to the COVID-19 negative unit and to the medication cart wearing the same green reusable gown. At 11:02 AM LPN #2 said she had just been in the COVID-19 positive area and had placed a reusable gown over the top of her green reusable gown. She said she had worn the green gown in both units.</p> <p>On 7/28/20 at 11:52 AM, CNA #9 came through the barrier from the COVID-19 positive unit and</p>	F 880			

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

PRINTED: 09/03/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/29/2020
NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
(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 14 into the COVID-19 negative unit in the North hall wearing a green reusable gown.</p> <p>On 7/28/20 at 4:58 PM, the COVID-19 positive unit in the North hall had three hooks on the walls with a red reusable gown on each hook. The inside area of two of the gowns were exposed to the hallway air.</p> <p>On 7/28/20 at 9:28 AM, LPN #2 said staff were supposed to doff PPE when leaving the COVID-19 positive unit and before entering the COVID-19 negative unit in the North hall. LPN #2 said staff were to don new gowns and gloves after entering the COVID-19 negative unit and pointed to an empty area in the hallway just inside the unit and said there should have been a PPE cart there but there was not.</p> <p>On 7/28/20 at 9:55 AM, CNA #7 and CNA #9 said they used the same reusable gown for both the COVID-19 positive and COVID-19 negative units in the North hall. CNA #7 and CNA #9 said they put on used gowns dedicated for their individual use, that hung in the COVID-19 positive hallway, over the top of the gowns they wore in both the COVID-19 positive and COVID-19 negative units.</p> <p>On 7/28/20 at 10:52 AM, CNA #8 said she used the same reusable gown for both the COVID-19 positive and COVID-19 negative units in the North hall. CNA #8 said she put on a used gown, that hung in the COVID-19 positive hallway, over the top of the gown she wore in both the COVID-19 positive and COVID-19 negative units.</p> <p>On 7/28/20 at 4:45 PM, CNA #10 said she used the same reusable gown for both the COVID-19 positive and COVID-19 negative units in the North</p>	F 880			

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

PRINTED: 09/03/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/29/2020
NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
(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 15</p> <p>hall. CNA #10 said she put on a used gown, that hung in the COVID-19 positive hallway, over the top of the gown she wore in both the COVID-19 positive and COVID-19 negative units.</p> <p>On 7/28/20 at 5:02 PM, CNA #11 said she was told by another CNA that while in the COVID-19 positive unit she could wear a disposable gown over the top of her reusable gown. CNA #11 said after she disposed of the top gown, she would go into the COVID-19 negative unit with the reusable bottom gown that she wore in both units.</p> <p>b. The facility placed their COVID-19 negative residents and residents whose COVID-19 test results were pending in the South hall unit. Staff wore protective gowns, masks, and a face shields or goggles. The following were observed in the South hall on 7/28/20:</p> <p>At 9:20 AM, CNA #1 was inside Residents #1 and #2's room. Two gowns (one red and one white) were observed hung on the wall. CNA #1 was wearing a green gown, goggles, and an N95 respirator mask. CNA #1 stripped the sheets of Residents #1's and Resident #2's bed with his gloved hands. CNA #1 also removed the pillow cases of Residents #1's and Resident #2's pillows. CNA #1 then placed the white sheets and pillow cases inside a clear plastic bag and tied it in a knot. CNA #1 said Residents #1 and #2 were transferred to the COVID-19 positive unit. CNA #1 said he would also strip the beds of Resident #3 and #4 after he was done with Residents #1 and #2's beds.</p> <p>At 9:29 AM, CNA #1 was wearing a green gown and entered Resident #3's and Resident #4's room. Two red gowns were observed hanging on</p>	F 880			

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

PRINTED: 09/03/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/29/2020
NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
(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 16</p> <p>the wall. CNA #1 then performed hand hygiene and put on new gloves. CNA #1 then stripped the sheets of Residents #3's and Resident #4's beds. CNA #1 also removed the pillow cases of Residents #3's and Resident #4's pillows. CNA #1 then placed the white sheets and pillow cases inside a clear plastic bag and tied it in a knot. CNA #1 said Residents #3 and #4 were transferred to the COVID-19 positive unit the day before. CNA #1 then removed his gloves, performed hand hygiene and carried the plastic bags to the soiled utility room.</p> <p>At 9:41 AM, CNA #1 entered Residents #5's and Resident #6's room wearing the same green gown and came out with a disposable food tray and threw it away in a big blue trash can. CNA #1 then removed his gloves and performed hand hygiene.</p> <p>At 9:42 AM, CNA #1 entered Residents #7's and Resident #8's room wearing the same green gown and closed the door.</p> <p>At 9:44 AM, CNA #1 exited Resident #7's and Resident #8's room and entered the shower room with the same green gown.</p> <p>On 7/28/20 at 9:54 AM, CNA #1 said he came to work at 6:00 AM and wore the green gown, goggles and N95 respirator mask at the Bistro entrance of the facility after checking himself in. CNA #1 said he kept the same gown during his entire shift unless it was soiled then he would change his gown. CNA #1 and the surveyor then went to Residents #1's and Resident #2's room and to Resident #3's and Resident #4's rooms afterwards. CNA #1 said he believed he used the gown that was hanging on the wall inside</p>	F 880			

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

PRINTED: 09/03/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/29/2020
NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
(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 17</p> <p>Residents #1 and #2's rooms and Resident #3's and Resident #4's rooms to put over his green gown when he stripped the bedsheets off their beds. CNA #1 said he did not know how long those gowns were there and he did not know who else used them. CNA #1 said it was the Staffing Coordinator who trained him in donning and doffing of PPE.</p> <p>c. On 7/28/20 at 1:10 PM, Resident #28's door had a hanging device which contained PPE including disposable gowns, face masks, and gloves. A "STOP" sign which stated to see the nurse before entering the room was posted below the hanging device. The SSA was inside Resident #28's room and was wearing a green gown, gloves, face mask, and a face shield. She placed the personal belongings, including the luggage of Resident #28, in one corner of her room. The SSA then removed her gloves and performed hand hygiene and kept her green gown on. The SSA then walked out of the South hall with her green gown, face mask, and face shield on.</p> <p>On 7/28/20 at 1:20 PM, the Graduate Nurse said Resident #28 was in the hospital and tested positive for COVID -19. The Graduate Nurse said Resident #28 would be readmitted to the COVID-19 unit and the SSA was putting all her personal belongings together and would bring them to the COVID-19 unit.</p> <p>On 7/28/20 beginning at 1:45 PM, the SSA had a cart and walked toward Resident #28's room. The SSA performed hand hygiene and donned a pair of gloves before she entered Resident #28's room. When the SSA came out of Resident #28's room, she had Resident #28's personal belongings inside the cart. The SSA removed her</p>	F 880			

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

PRINTED: 09/03/2020
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
(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 18</p> <p>gloves and performed hand hygiene and walked through the back door.</p> <p>The SSA said she entered Resident #28's room two times and she did not put another gown on top of her green gown. The SSA said she was directed to put on another gown on top of the gown she was wearing before entering residents' rooms with actual or suspected cases of COVID-19 and she did not do it.</p> <p>d. On 7/28/20 at 4:53 PM, CNA #4 entered Residents #9 and #10's room and took the residents' temperatures. CNA #4 did not put on another gown on top of her green gown.</p> <p>On 7/28/20 at 5:09 PM, CNA #4 entered Residents #20's and Resident #21's room and took their vital signs wearing the same green gown when she entered Resident #9's and Resident #10's room.</p> <p>On 7/28/20 at 5:14 PM, CNA #4 said she did not want to wear the gowns that hung inside Residents #9 and 10's room because she did not know who else had used them.</p> <p>On 7/28/20 at 4:59 PM, LPN #1 said Residents #9 and #10 had been tested for COVID-19 and the results were pending. LPN #1 said staff should wear another gown on top of their gowns when they enter Residents #9's and Resident #10's room. LPN #1 said Resident #9 had complained of a sore throat and of being tired. She said Resident #10 had hoarseness in her voice.</p> <p>On 7/28/20 at 5:15 PM, CNA #1 said he thought the night shift hung the two gowns inside</p>	F 880			

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

PRINTED: 09/03/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/29/2020
NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
(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 19</p> <p>Residents #9 and #10's room and could be reused by the staff to put over their gowns when they entered the room. CNA #1 said he believed those gowns could be used by morning and evening shift staff unless it was soiled.</p> <p>On 7/29/20 at 2:00 PM, LPN #1 said Resident #9 and Resident #10 tested positive for COVID-19 and they were transferred to the COVID-19 positive unit.</p> <p>e. On 7/28/20 at 12:10 PM, two gowns, one red and one white, were observed hanging on the wall inside Resident #9's and Resident #10's room. CNA #2 said Resident #9 and Resident #10 were tested for COVID-19 and the results were pending. CNA #2 said they were instructed to put another gown on top of the gown they were already wearing when they entered their room.</p> <p>On 7/28/20 at 1:30 PM, CNA #3 had a green gown, gloves, respirator mask, and face shield on while talking to Resident #10 inside their room. CNA #3 had no other gown on top of her green gown. CNA #3 then removed her gloves and performed hand hygiene before she exited Resident #10's room. CNA #3 then entered Resident #23's room, who tested negative for COVID-19.</p> <p>On 7/28/20 at 1:32 PM, CNA #3 said she had gone into Resident #10's room and gave her ice cream. CNA #3 said she was aware Resident #10's COVID-19 test was pending and she should have put another gown over her green gown. CNA #3 said it was the Staffing Coordinator who trained her in donning and doffing of PPE.</p> <p>On 7/28/20 at 4:59 PM, LPN #1 said there should</p>	F 880			

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

PRINTED: 09/03/2020
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/29/2020
NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
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F 880	<p>Continued From page 20</p> <p>be a "STOP" sign to see the nurse and PPE cart before entering their room. LPN #1 and the surveyor then went to Resident #9 and #10's room. LPN #1 said she did not know why Residents #9 and #10's room did not have a "STOP" sign to see the nurse and a PPE cart at their door.</p> <p>On 7/28/20 at 5:14 PM, CNA #4 said she knew Resident #9 and Resident #10 had their COVID-19 test done and the results were pending. CNA #4 said she should have put another gown on top of her green gown when she entered their room but she forgot. CNA #4 said if there was a sign and a PPE cart outside the door it would have reminded her to wear another gown over her green gown.</p> <p>f. The facility had a COVID-19 positive unit on the East hall. The entrance to the hall had a plastic barrier with a zipper down the middle. Observations were conducted in this hall on 7/28/20 from 9:00 AM to 11:15 AM.</p> <p>At 9:00 AM, CNA #11 was wearing a pair of gloves and went and grabbed a new clean pair from a box on top of a cart in the hallway. CNA #11 then went and removed the gloves she was wearing and threw them in the trash and applied the new clean pair of gloves without performing hand hygiene.</p> <p>At 9:02 AM, the Hospitality Aide was getting gloves to enter a resident room. She went into the resident's room while still putting on the gloves. After speaking with the resident, the Hospitality Aide removed her gloves prior to exiting the room and did not perform hand hygiene. She then grabbed another pair of clean gloves from a box</p>	F 880			

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

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NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
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F 880	<p>Continued From page 21 and put them on.</p> <p>Beginning at 9:10 AM, CNA #12 exited a resident's room, with gloves on, went to a trash can in the hallway and opened the lid and threw away some trash. CNA #12 then entered another resident's room with the same pair of gloves and exited a short time later with a disposable food tray and threw it away in the trash. CNA #12 did not remove her gloves or perform hand hygiene. CNA #12 then went to a phone, located on the wall in the middle of the hallway, and placed a call using the same pair of gloves. CNA #12 then grabbed a clean face mask from a box and placed it on a resident. She then went to the clean laundry cart, located in the hallway, grabbed 2 clean wash cloths and gave them to the Hospitality Aide. CNA #12 did not change her gloves or perform hand hygiene during this time.</p> <p>At 9:22 AM, the Hospitality Aide went to the plastic barrier while wearing gloves, unzipped it halfway and was speaking to another staff on the other side. She received a stack of clean towels from the staff person on the other side of the barrier. The Hospitality Aide opened the door to the shower room and went in with the towels. She exited a short time later with half the stack of towels still in her hands, she was wearing the same gloves. The Hospitality Aide then walked down the hallway to where the clean linen cart was located and placed the remaining clean towels into the cart. The Hospitality Aide did not change her gloves or perform hand hygiene.</p> <p>At 9:23 AM, the Hospitality Aide went into a resident's room for a short time and exited with the same gloves. She went to the plastic barrier again and unzipped it halfway and someone on</p>	F 880			

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

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FORM APPROVED
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F 880	<p>Continued From page 22</p> <p>the other side handed her a meal in a to-go box with plastic silverware and a napkin on top of the box. She placed her right gloved hand on top of the silverware and napkin and held the box underneath with her left hand. The Hospitality Aide went into a resident's room to give them the food. She did not change her gloves or perform hand hygiene.</p> <p>On 7/28/20 at 11:04 AM, the Hospitality Aide stated she had worked in the facility since June 2020. She stated she did not have "specific training" on infection prevention but "followed a mentor for a day."</p> <p>On 7/29/20 at 2:00 PM, CNA #12 stated infection prevention training was done usually at the end of the shift in a small group or "huddle." She stated training was done by the Administrator, DON, ICP, and Staffing Coordinator. CNA #12 said she was asked if she knew the steps she was trained to first and then was observed performing them and it was "checked off." She stated hand hygiene should be done before and after performing care and when putting on and taking off gloves. CNA #12 said hand hygiene should also be performed between residents and in between resident rooms.</p> <p>On 7/29/20 at 2:05 PM, LPN #3 said the Staffing Coordinator provided training to staff on that day. He said for "less experienced staff," the Staffing Coordinator or ICP watched and helped them with putting on and taking off PPE, but for those staff with more experience, "It's more we check it off on a piece of paper and sign it."</p> <p>On 7/28/20 at 1:15 PM, the Administrator stated hospitality aides were used to assist CNAs. She</p>	F 880			

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F 880	<p>Continued From page 23</p> <p>stated they were trained on donning and doffing of PPE, assisting with Hoyer (mechanical lift) transfers, and assisting with dining. The Administrator stated hospitality aides were not to obtain or report vital signs.</p> <p>On 7/29/20 at 2:45 PM, the ICP said staff were trained to double gown while on the COVID-19 positive unit or in a COVID-19 positive room. She said she could not find that guidance from the CDC, did not think it was in the facility's policy and thought it had come from the Staffing Coordinator. The ICP said she expected staff to doff their gloves and all of their gowns before they re-entered the COVID-19 negative unit from the COVID-19 positive unit. The ICP said in the South hall, she expected staff to remove both gowns after exiting residents' rooms who were in precautions and put a new gown on before entering another resident's room. She said staff should not have worn the same gown or gloves in both the COVID-19 positive and COVID-19 negative units because they could be contaminated with COVID-19 and could pass it to residents who were COVID-19 negative. The ICP said multiple staff should not reuse the same gown to put over their gowns. She said a "Stop" sign to see the nurse and a PPE cart should have been placed outside of Residents #9's and Resident #10's room. The ICP said she expected staff to perform hand hygiene after doffing gloves.</p> <p>4. The facility's COVID-19 policy, updated 7/13/20, documented the facility's designated unit for residents who were COVID-19 positive was to be separated by a physical barrier from other areas of the facility.</p> <p>This policy was not followed.</p>	F 880			

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F 880	<p>Continued From page 24</p> <p>The facility's North hall was separated with a plastic barrier which covered floor to ceiling and wall to wall located between room #52 and #53 on the right side of the hall and between room #61 and #60 on the left side of the hall. The North section, beyond the barrier housed residents who had tested positive for COVID-19 and the residents housed South of the barrier had tested negative for COVID-19.</p> <p>On 7/28/20 from 9:24 AM to 9:55 AM, the plastic barrier in the North hall had two zippers which were both approximately two feet from each wall. The zipper to the East side was closed, with the exception of two opened gaps that were each two to three inches wide and one and two feet in length, respectively. This gap allowed air to travel back and forth from the COVID-19 positive and COVID-19 negative units of the hallway. At 10:15 AM, the gaps to the East side had been closed.</p> <p>On 7/28/20 from 10:15 AM to 10:25 AM, the zipper to the West side was opened two to three inches wide and six feet high. This gap allowed air to travel back and forth from the COVID-19 positive and COVID-19 negative units of the hallway. At 10:25 AM, CNA #7 closed the zipper on the barrier.</p> <p>On 7/28/20 from 4:45 PM to 5:12 PM, the zipper to the West side was opened two to three inches wide and six feet high. This gap allowed air to travel back and forth from the COVID-19 positive and COVID-19 negative units of the hallway. Residents' room doors were opened in the COVID-19 negative unit for Residents #11 - #19 and room doors were opened in the COVID-19 positive unit for Residents #1 - #4 and #24 - #28.</p>	F 880			

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F 880	<p>Continued From page 25</p> <p>On 7/28/20 at 4:45 PM, the zipper to the East side was closed and a sign on the barrier directed staff not to use that side because it was broken.</p> <p>On 7/29/20 at 2:12 PM, the zipper to the East side was closed, with the exception of two opened gaps that were each two to three inches wide and one and two feet in length, respectively.</p> <p>On 7/29/20 at 2:45 PM, the ICP said she was aware of the broken zipper on the plastic barrier on the North hall and said it needed to be fixed. She said she expected staff to keep the zipper closed when they were not going between the COVID-19 negative and COVID-19 positive units.</p> <p>5. The facility's Hand Hygiene policy, revised August 2019, directed staff to assist residents with hand hygiene before and after their meals.</p> <p>This policy was not followed.</p> <p>On 7/28/30 at 12:05 PM, CNA #1 handed a food tray to CNA #2 who was inside Resident #9 and 10's room. CNA #2 set-up the tray for Resident #10. CNA #2 then went to the door to get another tray from CNA #1. CNA #2 then set-up the tray for Resident #9. Resident #9 picked up the bread with her right hand and started eating. CNA #2 did not offer hand hygiene to Resident #9 and Resident#10 prior to eating.</p> <p>On 7/28/20 at 1:05 PM, Resident #22 said he was not offered hand hygiene before eating his lunch.</p> <p>On 7/28/20 at 1:10 PM, Resident #9 said she was not offered hand hygiene before eating her lunch.</p>	F 880			

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F 880	<p>Continued From page 26</p> <p>On 7/28/20 at 1:30 PM, CNA #2 said she should have offered hand hygiene to Resident #9 and Resident #10 before eating their meals and did not.</p> <p>On 7/29/20 at 2:45 PM, the ICP said staff were expected to offer residents hand hygiene before every meal.</p> <p>6. The facility's COVID-19 policy, updated 7/13/20, documented the facility would provide dedicated medical equipment for a resident with suspected or known COVID-19 positive and ensure the equipment was cleaned and disinfected per manufacturer's instructions.</p> <p>The CDC website accessed on 8/4/20, documented blood pressure cuffs could become contaminated with infectious agents and contribute to the spread of health-care associated infections and should be disinfected with an EPA registered low or intermediate level disinfectant.</p> <p>On 7/28/20 at 9:33 AM, the Hospitality Aide came out of room #36 with the vital sign machine and reported a resident's vital signs to LPN #3. She then took the vital sign machine into room #35 to obtain vital signs. She then came out of room #35 and placed the vital sign machine in the hallway without disinfecting it. The Hospitality Aide did not disinfect the vital sign machine between residents or after use.</p> <p>On 7/29/20 at 2:45 PM, the ICP said the facility did not have enough medical equipment and staff were expected to disinfect the vital sign machine in between residents' use or contact with the equipment.</p>	F 880			

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F 880	<p>Continued From page 27</p> <p>7. Clorox Bleach Germicidal Healthcare cleaner directions for use state to apply directly onto surface until thoroughly wet, and when using a spray bottle hold 6 to 8 inches from surface, and to keep surface visibly wet for the required contact time. According to the EPA List N: Disinfectants for Use Against COVID-19, the Clorox Bleach Germicidal Healthcare spray should be used on hard nonporous surfaces and follow disinfection directions for norovirus, poliovirus, and rhinovirus.</p> <p>On 7/28/20 at 9:37 AM, Housekeeper #1 and Housekeeper #2 entered the East hall from a door at the end of the hall which led to the outside of the building. They had a cart with them. Housekeeper #1 and Housekeeper #2 were wearing respirator face masks, face shields, gowns, and gloves. They removed their gowns and put on new gowns without removing their gloves.</p> <p>At 9:44 AM, Housekeeper #1 went into room #30 to clean an empty bed near the door. Housekeeper #1 used a spray bottle of Clorox Bleach for Healthcare and sprayed the top half of the mattress. She then used a white cloth she had removed from a plastic covered container on the top of the laundry cart to wipe down the mattress from top to bottom. Housekeeper #1 then used the same cloth to wipe down the call button.</p> <p>At 9:44 AM, Housekeeper #2 grabbed a cloth from the same plastic container on top of the housekeeping cart and sprayed the Clorox Bleach onto the cloth. She entered room #30 and began wiping down high touch surface areas in the area next to the door such as the door knobs,</p>	F 880			

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F 880	<p>Continued From page 28</p> <p>the bedside table, and she also wiped down the underside of the bed. Housekeeper #2 walked out of the room to the cart near the door, placed the used cloth in a dirty linen bag and grabbed another white cloth from the plastic bin on top of the cart. She went back into the room, sprayed the cloth with the Clorox Bleach and wiped down the door.</p> <p>On 7/28/20 at 9:59 Housekeeper #1, with Housekeeper #2 present, were asked about the cleaning agents they used. Housekeeper #1 stated they used the Clorox Bleach for Healthcare on the beds and high touch surface areas. Housekeeper #1 stated the contact time for the Clorox Bleach to disinfect was 10 minutes. Housekeeper #1 stated the cloths in the plastic bin on top of the cart had "some water on them."</p> <p>Housekeeper #1 and Housekeeper #2 did not follow the manufacturer directions for use by spraying the disinfectant directly onto the surface.</p> <p>On 7/29/20 at 3:40 PM, the Administrator and DON were informed of a determination of Immediate Jeopardy for 42 CFR §483.80 (F880) and the Immediate Jeopardy template was presented.</p>	F 880			