



BRAD LITTLE – Governor
DAVE JEPPESEN – Director

IDAHO DEPARTMENT OF
HEALTH & WELFARE

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

September 18, 2020

Brandi Jeffries, Administrator
Prestige Care & Rehabilitation - The Orchards
1014 Burrell Avenue
Lewiston, ID 83501-5589

Provider #: 135103

Dear Ms. Jeffries:

On **September 10, 2020**, a survey was conducted at Prestige Care & Rehabilitation - The Orchards by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies and a directed plan of correction. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3). **Please provide ONLY ONE completion date for each federal in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance.

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567, Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 28, 2020**. Failure to submit an acceptable PoC by **September 28, 2020**, may result in the imposition of penalties by **October 21, 2020**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

REMEDIES

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Imposition of Denial of Payment for New Admissions (DPNA):

Payment will be denied for all NEW Medicare and Medicaid admissions, beginning 30 days after the date the enforcement letter is sent, on **October 18, 2020**, in accordance with the statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal regulations at 42 CFR §488.417. Your Medicare Administrative Contractor will be notified of the date the denial of payment begins. DPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated.

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• **Imposition of Directed Plan of Correction (DPOC):**

In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction is imposed on the facility. In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the letter, on **October 3, 2020**. The DPOC may be completed before or after that date. The effective date is not deadline for completion of the DPOC. However, the State Agency will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice. Please send all documentation to the State Agency via ePOC.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567.

Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions.

We must recommend to the CMS Seattle location and/or State Medicaid Agency that your provider agreement be terminated on **March 10, 2021**, if substantial compliance is not achieved by that time.

Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Belinda Day, RN or Laura Thompson, RN, Supervisors Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

Go to the middle of the page to **Information Letters** section and click on **State** and select

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the following:

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **September 28, 2020**. If your request for informal dispute resolution is received after **September 28, 2020**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in regulations at 42 CFR §498.40, et. seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than 60 days after receiving this letter.

Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

The Interim Manager, Julius Bunch; LTC Certification and Enforcement Branch; Centers for Medicare and Medicaid Services, 701 5th Ave., Suite 1600, Seattle, WA 98104 or via email: Julius.Bunch@cms.hhs.gov.

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically, or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health and Human Services,
Department Appeals Board,
MS 6132, Director, Civil Remedies Division, 330
Independence Ave., S.W., Cohen Building - Room G-644,
Washington, D.C. 20201,
(202) 565-9462

Thank you for the courtesies extended to us during the survey. If you have any questions,

Brandi Jeffries, Administrator
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comments or concerns, please contact Belinda Day, RN, or Laura Thompson, RN, Supervisors,
Long Term Care Program at (208)334-6626, option #2.

Sincerely,

A handwritten signature in cursive script, appearing to read "Laura Thompson".

Laura Thompson, RN, Supervisor
Long Term Care Program

lt/lj

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

PRINTED: 10/02/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135103	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2020
NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHABILITATION - THE ORCHARDS			STREET ADDRESS, CITY, STATE, ZIP CODE 1014 BURRELL AVENUE LEWISTON, ID 83501		
(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 September 9, 2020 to September 10, 2020. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6).</p> <p>The survey was conducted by:</p> <p>Brad Perry, LSW, Team Leader Cecilia Stockdill, RN</p>	E 000			

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

TITLE

(X6) DATE

Electronically Signed

09/28/2020

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 deficiencies were cited during a COVID-19 Focused Infection Control survey conducted on September 9, 2020 to September 10, 2020. The survey was conducted by: Brad Perry, LSW, Team Leader Cecilia Stockdill, RN Survey Abbreviations: CDC = Center for Disease Control and Prevention CNA = Certified Nursing Assistant DON = Director of Nursing ICP = Infection Control Preventionist LPN = Licensed Practical Nurse PPE = Personal Protective Equipment RN = Registered 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:	F 880		10/9/20	

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

TITLE

(X6) DATE

Electronically Signed

09/28/2020

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	Continued From page 1 §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; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (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: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880			

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F 880	<p>Continued From page 2</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, policy review, and staff interview, it was determined the facility failed to ensure infection control prevention practices were implemented and maintained to prevent the spread of COVID-19 and other infectious diseases. This failure placed all staff on the COVID + at risk of contracting COVID-19 and/or other infections. Findings include:</p> <p>1. The CDC website, accessed on 9/11/20, included a document dated 5/22/20, titled Responding to Coronavirus in Nursing Homes. The document stated healthcare providers must wear eye protection and an N95 or higher-level respirator at all times while on the COVID-19 positive unit.</p> <p>This guidance was not followed.</p> <p>On 9/9/20 from 1:35 PM to 2:40 PM, observations were conducted of facility staff on the facility's COVID-19 positive unit, as follows:</p> <p>* At 1:35 PM and 1:40 PM, LPN #1 was in the COVID-19 unit hallway and at the nurses' station</p>	F 880	<p>1. The plan for implementation of corrective actions for each specific deficiency cited:</p> <p>a. Staff are to wear N95 masks and eye protection when working in the COVID positive unit per CDC guidance.</p> <p>b. Staff to wear gloves when using sanitation wipes to clean in facility.</p> <p>c. Staff to wear gloves when bussing tables.</p> <p>2. Address how the facility will correct each deficiency as it relates to the individual:</p> <p>a. Staff education to be provided at mandatory all-staff meeting to ensure understanding of:</p> <p>i. Staff are to wear N95 masks and eye protection when working in the COVID positive unit per CDC guidance.</p>		

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F 880	<p>Continued From page 3 with an N95 mask on and no eye protection.</p> <p>* At 1:40 PM, RN #2 was at the COVID-19 unit nurses' station with an N95 mask on and no eye protection.</p> <p>* At 1:45 PM, CNA #2 was at the COVID-19 unit hallway with an N95 mask on and no eye protection.</p> <p>* At 2:03 PM, CNA #3 was at the COVID-19 unit hallway with an N95 mask on and no eye protection.</p> <p>On 9/9/20 at 1:35 PM, LPN #1 said staff wore N95 masks at all times in the COVID-19 unit and donned (put on) eye protection, gowns, and gloves before going into residents' rooms or when providing resident care.</p> <p>On 9/9/20 at 2:10 PM, CNA #3 said staff wore N95 masks at all times in the COVID-19 unit and donned eye protection, gowns, and gloves before going into residents' rooms.</p> <p>On 9/9/20 at 2:20 PM, RN #2 said staff wore N95 masks at all times in the COVID-19 unit and donned eye protection, gowns, and gloves before going into residents' rooms.</p> <p>On 9/9/20 at 2:20 PM, CNA #2 said staff wore N95 masks at all times in the COVID-19 unit and donned eye protection, gowns, and gloves before going into residents' rooms or when providing resident care.</p> <p>On 9/9/20 at 2:50 PM, the DON, with the Administrator present, said the COVID-19 unit was under droplet precautions and staff were</p>	F 880	<p>ii. Staff to wear gloves when using sanitation wipes to clean in facility.</p> <p>iii. Staff to wear gloves when bussing tables.</p> <p>3. Address how the facility will act to protect residents in similar situations, for each deficiency:</p> <p>a. Infectious Preventionist will continue ongoing oversight of all staff infection control policies and procedures.</p> <p>4. Address what measures will be put into place or systemic changes made to ensure that the problem does not recur, for each deficiency:</p> <p>a. All staff are to wear N95 masks and eye protection when working in the COVID positive unit per CDC guidance,</p> <p>b. All staff to wear gloves when using sanitation wipes to clean in facility.</p> <p>c. All staff to wear gloves when bussing tables.</p> <p>5. Indicate how the facility will monitor its performance to make sure that solutions are sustained, for each deficiency:</p> <p>a. Infectious Preventionist to audit N95 masks and eye protection when working in the COVID positive unit, and to wear gloves when using sanitation wipes, and glove use when bussing tables daily for 2</p>		

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F 880	<p>Continued From page 4</p> <p>expected to wear N95 masks while on the unit. The DON said she thought staff only had to wear eye protection and full PPE when in the residents' rooms or when providing resident care. The Administrator said she thought staff only needed to wear a mask in the hallway because there was no risk of encountering a splash or splatter from a resident when in the hallway, but they should wear a face shield in residents' rooms.</p> <p>2. The CDC website, accessed 9/11/20, included guidance dated 4/30/20, which documented signage was to be placed at the entrance to the COVID-19 unit instructing staff they must wear eye protection and an N95 or higher-level mask at all times while on the unit.</p> <p>This guidance was not followed.</p> <p>On 9/9/20 at 1:30 PM, two surveyors entered the COVID-19 positive unit from the outside. A sign was present on the door that documented, "Do Not Use This Door." There was no sign posted on the door that indicated the area was an isolation area and it was necessary to wear eye protection and an N95 or higher-level mask when entering the area.</p> <p>On 9/9/20 at 2:20 PM, RN #2 said there was no sign on the COVID-19 unit entrance door.</p> <p>On 9/9/20 at 2:50 PM, the Administrator, with the DON present, said there was not a sign on the COVID-19 unit entrance door. The Administrator said she expected staff to know what PPE they were to wear when inside that unit. The DON said there was not a sign on the COVID-19 unit entrance door. The DON said no one should enter the unit except staff who worked in the unit.</p>	F 880	<p>weeks, then 3 times per week for 2 weeks, then 3 times monthly for 2 months. Then will discuss with QAPI team, need to continue audit.</p> <p>6. The name and title of the person responsible for implementing acceptable corrective action, for each deficiency:</p> <p>a. Infectious Preventionist to be responsible for deficiency.</p>		

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F 880	<p>Continued From page 5</p> <p>3. The CDC website, accessed 9/11/20, provided guidance that Standard Precautions were used for all patient care. The guidance further stated that PPE (including gloves) was used whenever there was possible exposure to infectious material.</p> <p>This guidance was not followed.</p> <p>a. On 9/9/20 from 2:03 PM to 2:08 PM, CNA #3 was wiping down handrails and residents' door handles in the COVID-19 positive unit with a disinfectant Sani-wipe with no gloves on. After using a Sani-wipe with her right hand, she transferred the used wipe to her left hand and cupped it there. CNA #3 then used her left hand to take out a Ziploc bag with clean wipes in it from her left pants pocket and retrieved a new wipe. She then finished wiping down more handrails and door handles with her right hand while cupping the used wipe in her left hand. CNA #3 then placed the second used wipe into her left cupped hand. She then disposed of the wipes in the nurses' station and then retrieved a new wipe from the Ziploc bag in her pocket and continued to wipe down the handrails and door handles.</p> <p>On 9/9/20 at 2:10 PM, CNA #3 said she had not worn gloves while wiping down the handrails and door handles on the COVID-19 positive unit.</p> <p>On 9/9/20 at 2:50 PM, the DON said she expected staff to wear gloves when cleaning surfaces in the COVID-19 positive unit. She said there was a potential for cross contamination when CNA #3 had cupped the used wipes in her hand and then retrieved the new wipes out of her pocket.</p>	F 880			

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F 880	<p>Continued From page 6</p> <p>b. On 9/9/20 at 8:33 AM, Hospitality Aide #1 was observed in the dining area and was clearing dishes from the dining tables where residents had just finished eating breakfast. Hospitality Aide #1 was not wearing gloves, and as she brought the used dishes to the bussing cart she scraped the remaining food from the plates into a receptacle on the bussing cart. Hospitality Aide #1 also poured out remaining liquid from the glasses she had cleared from the table, and she placed the used glasses, plates, and silverware into tray bins on the bussing cart with her bare hands.</p> <p>On 9/9/20 at 10:20 AM, Hospitality Aide #1 said the staff did not wear gloves when serving food and when bussing the tables. Hospitality Aide #1 said she did not remember who she talked to, but she asked someone about wearing gloves and that person said they did not need to wear gloves when clearing the tables.</p> <p>On 9/9/20 at 12:50 PM, RN #1 was observed in the dining area, and she was clearing dishes from the dining tables where residents had just finished eating lunch. RN #1 was wearing gloves as she bussed the dishes from the tables in the same manner as described above. RN #1 said she did not think it was expected for staff to wear gloves when they bussed tables, but she chose to wear gloves as her personal decision.</p> <p>On 9/9/20 at 12:55 PM, CNA #1 was observed bussing dishes from a tray she carried to the bussing cart. CNA #1 was not wearing gloves, and she said she just fed a resident in her room. CNA #1 said sometimes she wore gloves when she worked in the dining room, but the staff had been given different directions at different times</p>	F 880			

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F 880	Continued From page 7 regarding whether they were to wear gloves. On 9/9/20 at 2:53 PM, the Administrator said the facility did not have a policy for bussing tables. On 9/9/20 at 3:08 PM, the DON said staff should wear gloves when bussing dishes in the dining room.	F 880			
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced	F 882		10/9/20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135103	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2020
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F 882	<p>Continued From page 8</p> <p>by: Based on record review and staff interview, it was determined the facility failed to ensure an ICP with specialized training in infection control and prevention was appointed to the facility. This failure had the potential to negatively impact all 46 residents who resided in the facility and all of the staff. This deficient practice created the potential for staff to not receive appropriate infection control prevention training and provide resident care inconsistent with current standards of practice for infection prevention and control. Findings include:</p> <p>On 9/9/20, the facility provided documentation that the ICP was "Not Yet Certified."</p> <p>On 9/9/20 at 9:00 AM, the DON said the ICP was new to the role and had not completed CDC infection control training yet.</p> <p>On 9/9/20 at 1:20 PM, the Administrator said she thought the ICP had specialized infection control training and would look into that.</p> <p>On 9/9/20 at 5:02 PM, an email sent by the Administrator documented the ICP's credentials and training. The email did not document the ICP had specialized training for infection control and prevention.</p>	F 882	<p>F882 : Infection Preventionist Qualifications</p> <p>1. The plan for implementation of corrective actions for each specific deficiency cited:</p> <p>a. Infection Preventionist has completed CDC Infection Preventionist certification.</p> <p>2. Address how the facility will correct each deficiency as it relates to the individual:</p> <p>a. Infection Preventionist has completed CDC Infection Preventionist certification.</p> <p>3. Address how the facility will act to protect residents in similar situations, for each deficiency:</p> <p>a. Infection Preventionist has completed CDC Infection Preventionist certification.</p> <p>b. Director of Nursing will also complete CDC Infection Preventionist certification as backup.</p> <p>4. Address what measures will be put into place or systemic changes made to ensure that the problem does not recur, for each deficiency:</p> <p>a. Infection Preventionist has completed CDC Infection Preventionist certification.</p> <p>5. Indicate how the facility will monitor its performance to make sure that solutions</p>		

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

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F 882	Continued From page 9	F 882	<p>are sustained, for each deficiency:</p> <p>a. Infection Preventionist has completed CDC Infection Preventionist certification.</p> <p>b. Director of Nursing will also complete CDC Infection Preventionist certification as backup.</p> <p>6. The name and title of the person responsible for implementing acceptable corrective action, for each deficiency:</p> <p>a. Infectious Preventionist to be responsible for deficiency.</p>		