STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135056	A. BUILDING _____ B. WING _____	**07/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LINCOLN COUNTY CARE CENTER	**511 EAST FOURTH STREET SHOSHONE, ID 83352**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** Based on observation, policy review, and staff interview, it was determined the facility failed to ensure infection control prevention practices were consistently implemented to provide a safe and sanitary environment. This failure created the potential for negative outcomes by exposing residents to the risk of infection and cross-contamination including COVID-19. Findings include: 1. The CDC website, accessed 7/6/20, documented hand hygiene should be performed immediately after glove removal. The facility's policy for Transmission Based Precautions (Isolation)/Glove Use, dated 10/2017, directed staff to wash their hands after removing gloves. On 7/1/20 at 3:31 PM, Resident #2 was wheeled into one of the shared bathrooms by a staff member. At 3:35 PM, Resident #1 turned on the bathroom call light, and at 3:36 PM LPN #1 entered the restroom and assisted Resident #1 off the toilet. LPN #1 wheeled Resident #1 back to her room, then she walked down the hall to the nurse's station. At 3:39 PM, LPN #1 returned to the bathroom wearing gloves and holding a container of sanitizing wipes. She wiped down the toilet and then wiped down the sink/countertop area. LPN #1 removed her gloves and exited the restroom carrying the container of sanitizing wipes. LPN #1 did not perform hand hygiene after removing her gloves. LPN #1 walked down the hall to the nurse's station, sat down in a chair, and placed the container of sanitizing wipes in a cupboard under the nurse's desk. LPN #1 said she probably should use some hand sanitizer, and then she obtained a small container of hand sanitizer and performed hand hygiene. LPN #1 said she should have performed hand hygiene after she removed her gloves in the bathroom and she did not. On 7/1/20 at 3:58 PM, the DNS said hand hygiene should be performed before and after resident care, before and after being in a resident's room, and after cares were completed for a resident. The DNS said staff should perform hand hygiene after removing gloves, and the nurse should have changed her gloves and performed hand hygiene after she wiped down the toilet. 2. The facility's policy for Laundry and Bedding, Soiled, undated, stated clean linens were to be protected from dust and soiling during transport and storage to ensure cleanliness. On 7/1/20 at 10:50 AM, Laundry Staff #1 was observed pulling a 3-shelved, 34-inch high cart on wheels down the unit to the linen closet. The cart had a 12-inch high stack of linens on the top and second shelves. There were no linens on the bottom shelf. The cart had a sheet over the top of it and the sheet hung down over the cart leaving the linens on the second shelf exposed. On 7/1/20 at 10:51 AM, Laundry Staff #1 said she covered the cart and brought sheets and blankets to the closet to put them away. When asked about the linen on the current linen cart, she said it was mostly covered. On 7/1/20 at 3:00 PM, the Administrator said the laundry should be completely covered during transport.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE