STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135139	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVERVIEW REHABILITATION	3550 WEST AMERICANA TERRACE BOISE, ID 83706

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 -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop a systemic consistent process to actively monitor all residents for symptoms consistent with COVID-19. COVID-19 is an infectious disease by a new virus causing respiratory illness with symptoms including cough, fever, new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death. In addition, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections. Specifically, 1. Failed to adhere to transmission based precautions for new admissions for 3 of 3 sampled residents (R3, R4, and R5) and 8 of 8 unsampled residents (R6 to R13) who were all admitted within the past 14 days. 2. Facility failed to develop a consistent system for actively monitoring residents for expanded COVID-19 symptom for 4 of 4 sampled residents (R) (R1, R2, R3, R4) who were in the facility greater than 24 hours, which was the process used for all 26 residents. 3. Failed to disinfect shared glucometer, per manufacturer's instructions, between use on 2 of 2 sampled residents (R) (R1 and R2) observed for blood sugar monitoring. 4. Failed to ensure new dressing was not contaminated with old wound drainage soiled on barrier and perform hand hygiene between dirty to clean tasks for 1 of 1 sampled resident (R4) observed for wound care. These failures represented systemic failures which increased the risks for delayed identification of COVID-19, possible transmission of coronavirus, and therefore increase the risk for spreading COVID-19 and other communicable diseases and infections amongst residents and staff. Findings include: 1. Transmission based precautions During an interview on 6/23/20 at 11:30 AM Administrator and Director of Nursing (DON), who was also the facility's Infection Preventionist (IP), stated that facility census was 26, facility was admitting residents, and the facility had no current known or suspected/presumed positive COVID-19 residents or staff. It was further stated that there was an isolation unit, East Hall, for new admissions. The residents stayed on the isolation unit for 7 to 14 days depending on symptoms. Observation on 6/23/20 between 11:45 AM and 5:00 PM showed 11 residents (R3 to R13) residing in private rooms on East Hall. There were no isolation carts or isolation signs observed outside or near resident doors. Staff were not wearing gowns or eye protection. Record review of facility's Resident List Report, dated 6/23/20, showed R3 to R13 resided on the East Hall and were admitted within the past 14 days. R3 was admitted on [DATE] R4 was admitted on [DATE] R5 was admitted on [DATE] R6 was admitted on [DATE] R7 was admitted on [DATE] R8 was admitted on [DATE] R9 was admitted on [DATE] R10 was admitted on [DATE] R11 was admitted on [DATE] R12 was admitted on [DATE] R13 was admitted on [DATE] Review of R3's progress notes showed resident was admitted from the hospital on [DATE] (11 days ago) with [DIAGNOSES REDACTED]. Resident required assistance with pericare, two person extensive assistance with transfers, toileting and bed mobility and total assistance with bathing and dressing. Observation on 6/23/20 between 11:45 PM and 12:00 PM showed Certified Nursing Assistant (CNA)2 entered R5, R9, R6 rooms and delivered lunch and set up meal trays. Licensed Nurse (LN)1 entered R13's room and delivered lunch and set up meal tray. Rehab staff 1 entered R11's room and delivered lunch. CNA2 and unidentified staff entered R7's room to reposition resident in bed. R3 was observed in her room sitting in wheelchair next to her bed, calling out hello, hello, when are you taking me where I need to go, hello. CNA2 entered R3's room and stood within six feet of resident and told resident she is moving to other side after lunch. Upon entry into the aforementioned resident rooms, the personal protective equipment (PPE) worn by staff were surgical face masks only. No gowns or eye protection was worn. Observation on 6/23/20 between 12:10 PM and 2:30 PM showed CNA1 standing within six feet of R3 in her room with mask partially covering his nose. CNA1 then entered R10's room and asked R10's visitor to wash hands before leaving and then spoke with R10. LN1 was observed in R3's room administering Tylenol. LN1 entered R4's room and spoke with R4's visitor then CNA2 entered room and both LN1 and CNA2 repositioned R4 higher in bed, both staff were within 6 feet of R4 and provided direct resident cares. Between 1:20 PM to 2:30 PM LN1 scanned R4's bladder multiple times, changed lower leg dressing, and punctured resident's right hand twice to start an intravenous infusion. Upon entry into the aforementioned resident rooms, the personal protective equipment (PPE) worn by staff were surgical face masks only. No gowns or eye protection was worn. Observation on 6/23/20 between 4:10 PM and 4:55 PM showed LN1 and CNA1 on East unit without gown or eye protection. R5's room door was open, no isolation cart or gown or eye protection was observed outside, near entrance or hanging on resident's door. During an interview on 6/23/20 at 4:25 PM LN1 stated that R5 was a new admission today and just arrived. When asked what type of PPE was required when providing cares to R5, LN1 stated that paper mask and gloves are needed for cares and no additional PPE is needed. The PPE is the same for R5 like everyone else. When asked when gowns are used during resident cares, LN1 stated that a gown is used when the resident is on isolation and that would mean there is an isolation sign on the resident's door and there are no resident on the East Hall in isolation right now. During an interview on 6/23/20 at 4:30 PM CNA1 stated that a gown is not needed for any resident on East Hall. CNA1 stated that he does not need to wear a gown for caring for R5 even when bathing R5. CNA1 stated that there are no isolation signs for any resident on East Hall and would only wear a gown if there is an isolation sign showing a gown is needed. During concurrent record review and interview on 6/23/20 between 5:00 PM and 6:00 PM with Administrator and DON/IP, DON stated that staff do not need to wear gowns when caring for any resident, even for the first 14 days for new admission. All residents on the East Hall was admitted within the last 14 days. Administrator stated that the average length of stay was 18 days and there are 1 to 5 new admissions every day. Most residents are admitted from the hospital. We don't gown up for everyone that comes unless the resident has a specific infection that requires a gown. When asked if staff needed to wear a gown when providing cares for R5 who was admitted from the hospital today, DON/IP shook her head and stated that R5 had orthopedic [DIAGNOSES REDACTED]. When asked if gowns were needed to be worn by staff when providing cares for R3 and R4 who were also admitted from the hospital within the past 14 days, DON stated that no gowns were needed because R3 had orthopedic problems and R4 had skin issues. When asked about COVID-19 status for R3, R4, and R5, DON stated she would have to look up through the resident's admission documents and laboratory reports and that it was a huge stack of papers to find COVID-19 test results, sometimes the results are buried in a progress note. DON stated that she was not aware of the resident's COVID-19 status. Surveyor reviewed Centers for Disease Control and Prevention (CDC)'s website with Administrator and DON which showed CDC's Preparing for COVID-19 in Nursing Homes, https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, accessed 6/23/20, under Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown. Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP (Health care personnel) should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. Also reviewed with Administrator and DON CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic,

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

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 0880

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Many

(continued... from page 1)
https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html, accessed 6/23/20, which showed Implement Universal Use of Personal Protective Equipment: HCP working in facilities located in areas with moderate to substantial community transmission are more likely to encounter asymptomatic or pre-symptomatic patients with [DIAGNOSES REDACTED]-CoV-2 (severe acute respiratory syndrome coronavirus 2, [MEDICAL CONDITION] that causes COVID-19) infection .They should also: Wear eye protection in addition to their facemask to ensure the eyes, nose, and mouth are all protected from splashes and sprays of infectious material from others. For HCP working in areas with minimal to no community transmission, the universal eye protection and respirator recommendations described for areas with moderate to substantial community transmission are optional. However, HCP should continue to adhere to Standard and Transmission-Based Precautions, including use of eye protection and/or an N95 or equivalent or higher-level respirator based on anticipated exposures and suspected or confirmed [DIAGNOSES REDACTED].cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html, accessed 6/23/20 also showed Testing residents upon admission could identify those who are infected but otherwise without symptoms and might help direct placement of asymptomatic [DIAGNOSES REDACTED]-CoV-2-infected residents into the COVID-19 care unit. However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. Review of facility policy, Coronavirus COVID-19 (Skilled Nursing Facility), revision date 5/22/20, showed newly admitted or readmitted residents where COVID-19 status is unknown will be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE (personal protective equipment). Policy also showed COVID-19 is spread from person-to-person with close contact (6 ft). COVID-19 is mostly transmitted via respiratory droplets when an infected person coughs or sneezes. These droplets land in the mouths or noses of people who are nearly or inhaled into the lungs. It may be possible to become infected by touching a surface that is infected with [MEDICAL CONDITION]. Droplets may remain viable for hours to days on surfaces made from a variety of materials. 2. Resident monitoring for COVID-19 symptoms During an interview on 6/23/20 at 11:30 AM with Administrator and DON)/IP, DON stated that all residents were monitored for COVID-19 symptoms every shift which was documented on the resident's Treatment Admission Record (TAR). Review of facility policy, Coronavirus COVID-19 (Skilled Nursing Facility), revision date 5/22/20, showed recognizing and responding quickly to persons with signs and symptoms of [MEDICAL CONDITION] will prevent further spreading. Symptoms may appear 2-14 days post exposure. Fever, chills, cough, fatigue/muscle pain, shortness of breath/difficulty breathing, anorexia, new loss of taste or smell. Less commonly reported symptoms: sputum production, sore throat, headache, hemoptysis (coughing up blood), and gastrointestinal symptoms such as diarrhea or nausea. Worsening symptoms: trouble breathing persistent pain or pressure in the chest, new confusion or inability to arouse, bluish lips or face. Policy also showed observe newly arriving patients for development of COVID-19 symptoms. CDC's Preparing for COVID-19 in Nursing Homes, https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, accessed 6/10/20, showed Evaluate and Manage Residents with Symptoms of COVID-19: Ask residents to report if they feel feverish or have symptoms consistent with COVID-19. Actively monitor all residents upon admission and at least daily for fever (T?100.0 F) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement Transmission-Based Precautions .Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell .Identification of these symptoms should prompt isolation and further evaluation for COVID-19. Record review of R1, R2, R3, R4 current physician orders, progress notes and TAR showed the following: *R1 was admitted on [DATE] with [DIAGNOSES REDACTED]. In addition, some diabetes-related health issues, such as nerve damage and reduced blood flow to the extremities, increase the body's vulnerability to infection). Order for Assess for signs/symptoms of respiratory infection Q (every) shift: including, but not limited to: COUGH, SORE THROAT, FEVER, NEW ONSET SOB (shortness of breath). If yes to any of the above document in progress note, notify MD (medical doctor), and follow facility COVID-19 Protocol. Every shift COVID-19 Screening Process. The order start date was 6/15/20. *R2 was admitted on [DATE] with [DIAGNOSES REDACTED]. Order for Assess for signs/symptoms of respiratory infection Q (every) shift: including, but not limited to: COUGH, SORE THROAT, FEVER, NEW ONSET SOB. If yes to any of the above document in progress note, notify MD (medical doctor), and follow facility COVID-19 Protocol. Every shift COVID-19 Screening Process. The order start date was 6/15/20. *R3 was admitted on [DATE] with [DIAGNOSES REDACTED]. Order for Assess for signs/symptoms of respiratory infection Q (every) shift: including, but not limited to: COUGH, SORE THROAT, FEVER, NEW ONSET SOB. If yes to any of the above document in progress note, notify MD (medical doctor), and follow facility COVID-19 Protocol. Every shift COVID-19 Screening Process. The order start date was 6/12/20. *R4 was admitted on [DATE] with [DIAGNOSES REDACTED]. Order for Assess for signs/symptoms of respiratory infection Q (every) shift: including, but not limited to: COUGH, SORE THROAT, FEVER, NEW ONSET SOB. If yes to any of the above document in progress note, notify MD (medical doctor), and follow facility COVID-19 Protocol. Every shift COVID-19 Screening Process. The order start date was 6/19/20. There was no documented evidence the facility monitored residents, in accordance with facility provided document, for symptoms associated with COVID-19, as well as current CDC guidelines, including chills, fatigue/muscle pain, anorexia, new loss of taste or smell, sputum production, headache, hemoptysis (coughing up blood), diarrhea or nausea or new confusion. During an interview on 6/23/20 at 4:25 PM when asked what COVID-19 signs and symptoms licensed nurse (LN) expects CNAs to report to her, LN1 stated, cough, congestion, headache, lung sounds, shortness of breath, increased temperature is #1. When asked if there were any other signs or symptoms, LN1 said, sore throat. Many of the symptoms associated with COVID-19 was not stated. During an interview on 623/20 at 4:30 PM when asked what COVID-19 signs and symptoms were residents assessed for, CNA1 stated fever greater than 100.5, shortness of breath, cough and no smell or taste and I would then tell nurse my findings. During an interview on 6/23/20 at about 4:50 PM when asked where signs and symptoms associated with COVID-19 was monitored, DON stated TAR. DON and surveyor reviewed R1's TAR which showed monitoring for cough, sore throat, fever, new onset shortness of breath. When asked about monitoring and assessment of other signs and symptoms associated with COVID-19 such as diarrhea, headache, or new loss of taste or smell, DON stated, I see what you mean. Surveyor informed DON of range of associated COVID-19 signs and symptoms reported by CNA1 and LN1. The facility lacked consistent monitoring of symptoms associated with COVID-19. 3. Glucometers Observation on 6/23/20 at 11:50 AM showed LN2 enter R1's room and administer insulin in resident's arm. LN2 returned to medication cart. LN2 stated that R1's blood sugar was checked immediately prior to insulin with 123 Assure Platinum glucometer (Glucometer is a blood glucose meters device that measure blood glucose levels) which was on medication cart. LN2 removed cloth wipe from package labeled 75% alcohol wipes and wiped glucometer and then wiped medication cart. LN2 then entered R2's room with gloved hands and placed paper towel on overbed table and place glucometer in small plastic cup on paper towel. LN2 placed strip into glucometer, swab resident's finger with alcohol and then pricked finger with lancet with a small bead of blood shown. LN2 brought glucometer towards blood and blood was shown on the strip inserted in glucometer. Blood sugar reading was obtained. LN2 removed gloves and performed hand hygiene. LN2 walked back to medication cart and wiped glucometer with single wipe from 75% alcohol package and then placed glucometer in plastic bag and placed in medication cart drawer. Review of the 75% alcohol wipe package showed EDI ultra pure, manufacture: Dongguan Tianzi Baby Infant and Child Products Co. Ltd. Donyguan City. No EPA registration number was shown on package. Review of the Assure Prism multi blood glucose monitoring system user instruction manual showed Any disinfectant product with the EPA registration number listed on the table may be used on this device. Under section Cleaning and disinfecting procedures, package showed Two disposable wipes will be needed for each cleaning and disinfecting procedure; one wipe for cleaning and a second wipe for disinfecting. Please note only chorox germicidal wipes, dispatch hospital cleaner disinfectant towels with bleach, cavi wipes and pdi super sani-cloth germicidal disposable wipes have been tested with the assure prism multi meter at the time of printing this manual. Use of a single 75% alcohol wipe was not shown as approved for cleaning and disinfecting of glucometer per manufacturer's instructions. During an interview on 6/23/20 between 5:00 PM and 6:00 PM when asked DON and Administrator about following manufacturer's instructions for cleaning and disinfecting glucometers, it was agreed that staff should be following manufacturer's instructions. When informed of observation of staff cleaning/disinfecting glucometer with alcohol wipes, DON stated that in the past bleach wipes were used but there are no bleach wipes right now. Administrator stated that Clorox and Super sani cloth wipes were ordered on April 4thbut have been on back order and can't get these bleach wipes right now through either direct supply or Amazon. Administrator reviewed glucometer manufacturer's instructions and said I never heard of Cavi wipes. Administrator later stated that he ordered Cavi wipes from Amazon during interview and showed surveyor online order. Review of CDC's Infection Prevention during Blood

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 2) Glucose Monitoring and Insulin Administration website, https://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html, accessed 6/29/20, showed whenever possible, blood glucose meters should be assigned to an individual person and not be shared. If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents. 4. Contaminate new wound dressing and no hand hygiene between dirty to clean tasks Record review of R4's progress notes showed resident was admitted on [DATE] from hospital with [DIAGNOSES REDACTED]. Observation on 6/23/20 between 1:20 PM and 2:30 PM showed LN1 changing R4's left leg wound dressing. LN1 stated resident's leg wound had a lot of eschar (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/ edges of the wound). After scanning resident's bladder several times, LN1 removed gloves and donned new gloves. R4's leg was wrapped in ace wrap and elevated on one pillow, there was rust colored blood shown on the sheets near R4's left leg. LN1 removed pillow, socks and unwrapped ace wrap. DON came into room with chux (absorbent waterproof sheet) and LN1 placed the chux under the resident's left leg. LN1 doffed gloves and washed hands. LN1 donned gloves and cut kerlix and cast padding from resident's left leg. LN1 then placed wound cleanser on gauze and rubbed gauze on large approximately 3cm x 4cm area of black/brown eschar area on inner side of calf area. LN1 then doffed gloves and donned new gloves. No hand hygiene was performed after removing gloves, moving from contaminated body site to a clean body site during care, after handling used dressing and before handling clean dressings. LN1 applied santyl cream on eschar area and then applied two 4x4 gauze and ABD pad on top of eschar area. LN1 cut and applied a piece of xeroform petroleum gauze dressing onto the surrounding eschar areas. LN1 then raised resident's left leg up and rust colored blood was observed on the chux. LN1 doffed gloves and donned gloves and cut and applied three pieces of xeroform gauze on resident's leg. LN1 asked resident to raise her leg and wound drainage and blood was observed on the chux. LN1 did not change the chux and apply a new clean chux to protect new dressings from wound drainage. With resident's leg raised, LN1 unrolled kerlix and started to wrap kerlix around leg starting from toes and moved towards knee and then back to toes. When resident placed her leg down, it was directly on top of the old wound drainage and blood on the chux, thereby contaminating the new dressing. LN1 placed one of the ace wraps on resident's leg and starting wrapping leg from knee to toes. After applying the first ace wrap, LN1 moved the chux with the wound drainage and blood away and then placed the second ace wrap around the resident's leg. LN1 doffed gloves and applied new gloves. Then doffed gloves again and washed hands. Donned gloves and then began looking for veins in hands to start an intravenous to administer fluids. During an interview on 6/23/20 at 4:10 PM when asked about performing hand hygiene between glove changes, LN1 stated that she did not perform hand hygiene between each glove change but usually applies hand sanitizer but did not do after each glove change. LN1 stated that chux was used to protect the bed and keep area clean. LN1 nodded in agreement that wound drainage was on chux and that is why she moved chux higher. When surveyor informed LN1 that chux was moved higher after ace wrap, kerlix, santyl, and xeroform was placed on leg and new dressings were placed directly on drainage area on chux. LN1 nodded her head and said that she should have made sure the wound area was clean and new dressing supplies should have been clean. During an interview on 6/23/20 between 5:00 PM and 6:00 PM with Administrator and DON, DON stated that hand hygiene should be done between glove changes when staff are going from dirty to clean tasks and hand hygiene is not needed between clean to clean tasks. DON also stated that a barrier is used between sheets so sheets are not contaminated with wound drainage. Facility policy, Handwashing/Hand Hygiene, revised August 2015, showed use of an alcohol-based hand rub or soap and water after removing gloves, before handling clean or soiled dressing, gauze pads, etc., before moving from a contaminated body site to a clean body site during resident care, and before handling clean dressing. Facility policy, Clean Dressing Change, dated 4/7/20, showed the policy was to provide guidelines for clean dressing changes that protect wounds from .bacterial contamination and staff were directed to ensure you are not cross contaminating your clean field.