STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135038	A. BUILDING _____ B. WING _____	**07/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF BOISE	**808 NORTH CURTIS ROAD 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 -** Some	**Provide and implement an infection prevention and control program.** Based on observation, policy review, nationally recognized standards of practice, 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. A guideline from the CDC on Use of PPE When Caring for Patients with Confirmed or Suspected COVID-19, dated 3/30/20, directed staff to put on an isolation gown and tie all ties on the gown. A guideline from the CDC on How to Safely Remove PPE, undated, directed staff to unfasten the gown ties, taking care to ensure the sleeves did not touch the body when reaching for the ties, and pull the gown away from the neck and shoulders by touching the inside of the gown only. These directions were not followed. On 7/20/20 at 10:02 AM, a sign was on Resident #1's door indicating she was on droplet precautions, and another sign directed staff to use alcohol-based hand rub and apply PPE, including a gown, prior to entering the room. On 7/20/20 at 12:29 PM, CNA #1 entered Resident #1's room. Three cloth isolation gowns were hanging on the bathroom door on individual hooks, and 2 hooks were labeled CNA and the third hook was labeled nurse. CNA #1 was wearing a face shield and face mask, and she took a gown from a hook labeled CNA and put it on by pulling it over her head. On 7/20/20 at 12:32 PM, CNA #1 removed her gloves, removed the gown by pulling it over her head, hung the gown on the middle hook on the bathroom door in Resident #1's room, and then washed her hands. CNA #1 said there were 3 gowns hanging on the bathroom door, and 2 gowns were for CNAs and 1 gown was for the nurse. CNA #1 said she did not think about it when she pulled the gown over her head, and that was not the way she was trained to put on a gown. CNA #1 said she should have untied the gown. On 7/20/20 at 3:24 PM, the IP said it was not acceptable for staff to put on a gown by pulling it over their head. 2. The facility's Transmission-Based Precautions and Isolation Procedures, dated 5/7/20, stated when a resident is placed on transmission-based precautions, the staff should place the type(s) of precaution signage to be initiated outside the resident room in a conspicuous place, such as on the door or on the wall next to the doorway, identifying the CDC categories of transmission-based precautions (e.g. contact, droplet), the instructions for use of PPE, and/or instructions to see the nurse before entering. Resident #2's Progress Notes, dated 7/19/20 at 4:17 PM, documented a COVID-19 swab was collected and sent to the lab. On 7/20/20 at 10:58 AM, there were three drawers containing PPE and receptacles for trash and dirty linen outside of Resident #2's door. There were no precaution signs on Resident #2's door or on the wall nearby. On 7/20/20 at 12:50 PM, RN #2 said Resident #2 returned from the hospital that morning and was on droplet and contact precautions. When asked why no signs were on the door, RN #2 replied Resident #2's COVID-19 test results were negative. Resident #2's Progress Notes, dated 7/20/20 at 2:37 PM, documented COVID-19 test results were not yet received and Resident #2 continued with droplet precautions. On 7/20/20 at 3:50 PM, The IP said Resident #2's door should have signage on it indicating the type of precautions to follow when entering. 3. The facility's Housekeeping Services policy, dated 6/10/20, stated when cleaning isolated rooms staff were to remove their PPE before leaving the room and follow hand hygiene protocol. The facility's Hand Hygiene Policy, dated 5/7/20, stated the facility should provide education on hand hygiene and include when to perform hand hygiene with alcohol-based hand rub and with soap and water, including: * before and after all resident contact, * after contact with potentially infectious material, * after removal of gloves. The facility's Transmission-Based Precautions and Isolation Procedures, dated 5/7/20, under Standard Precautions, stated hand hygiene must be performed before and after all resident contact and contact with potentially infectious material. The facility's Stop - Droplet Precautions sign, and the Stop - Contact Precautions sign, undated, stated everyone must clean their hands before entering and when leaving the room. These policies and directions were not followed. On 7/20/20 at 12:43 PM, Driver #1 entered Resident #3's room. Three signs were on Resident #3's door: Stop - Droplet Precautions, Stop - Contact Precautions, and a list of PPE to put on and take off, including hand hygiene after removing PPE. Driver #1 proceeded to clean surfaces and equipment in Resident #3's room. Driver #1 then removed his PPE and placed it in a bin inside Resident #3's room. He then exited Resident #3's room and returned to his cart without performing hand hygiene. Driver #1 said he was the facility resident driver, but he was not driving residents anywhere, due to the pandemic, and was reassigned to disinfect room surfaces. Driver #1 said he did not perform hand hygiene when he came out of Resident #3's room but he should have. On 7/20/20 at 4:00 PM, the Administrator said when Driver #1 entered Resident #3's room he should follow the prescribed precautions, and he should have practiced hand hygiene when he exited the room. 4. The facility provided a CDC document on the Sequence for Putting on PPE, including a gown, which required staff to fasten the back of neck and waist. On 7/20/20 at 1:15 PM, Driver #1 put on a black gown and entered Resident #4's room who had signage on her door indicating she was on droplet and contact precautions. Driver #1's gown was not tied at the waist and hung to his sides without covering his backside. He proceeded to clean surfaces and equipment in Resident #4's room and when the task was completed he exited the room. When asked, Driver #1 said he did not tie the back of his gown. On 7/20/20 at 3:47 PM, the IP said gowns with ties must be tied at the top and the bottom.

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