STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135004	A. BUILDING _____ B. WING _____	**05/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BOUNDARY COUNTY NURSING HOME	**6640 KANIKSU STREET BONNERS FERRY, ID 83805**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and consistently implement infection control policy and procedures in accordance with CDC guidelines for hand washing to prevent the spread of infectious disease from one resident or staff member to another person in the facility. Findings include; 1. The lunch meal was observed on 5/21/20 from 12:02 PM until 12:35 PM. The meal was served from a steam table in a very large dining room. All staff wore face masks. Most residents wore face masks and removed them only to eat. Staff brought residents into the dining room [ROOM NUMBER] by 1 and seated residents at tables with good social distancing. Although alcohol gel hand dispensers were present on each table; with few exceptions, staff did not remind, encourage, or assist residents to perform hand hygiene before and after eating. While feeding a resident, licensed nurse LN2 repeatedly held the bottom of her facemask away from her face. LN2 did not perform hand hygiene after touching her face and/or facemask. Surveyor informed charge nurse LN1 of the observation. LN2 observed LN1 holding her facemask away from her face with one hand while feeding a resident. LN2 immediately intervened and instructed LN2 to keep her facemask properly applied while within six feet of a resident and directed LN2 to perform hand hygiene whenever she touched her face or facemask. LN2 said the mask was warm and she just needed some air. 2. On 5/21/20 at 11:20 AM, NAC 2 brought a mechanical lift out of resident room [ROOM NUMBER] and parked it in the corridor near the shower room then walked to the nurse station. When interviewed at 11:25 AM NAC2 confirmed she used the lift to get R2 out of bed. When asked if she sanitized the lift, LN2 said she did not. NAC2 said the lift was wiped down a couple of times a day. NAC2 said she thought the night shift cleaned lifts but she did not know how often. When asked if the lifts were sanitized after each use, NAC2 said No, maybe every other time or so. NAC2 sanitized the lift with sanitizing wipes immediately after the interview. 3. During observation of care on 5/21/20 at 11:35 AM, NAC3 used the stand-assist lift (mechanical lift for persons who can bear some weight to stand) to transport R2 to the toilet in the shower room. Once in the shower room, NAC3 removed R2's incontinence brief then used the lift controls and lowered R2 onto the toilet. NAC2 removed her gloves and put on clean gloves without first performing hand hygiene. NAC3 placed a clean brief in R2's pants then left the room to allow private toilet time. When R2 called out, NAC3 put on gloves then moistened and soaped disposable wipes. NAC3 stood R2 off the toilet using the lift then wiped and cleaned R2. While still wearing the soiled gloves, NAC3 applied ointment with a gloved hand, then fastened the brief. NAC3 used the lift to place R2 in the wheelchair. NAC3 did not encourage or assist R2 to wash her hands after using the toilet. R2 went directly to the dining room. On 5/21/10 the findings were reviewed with charge nurse LN1 who was acting for the Director of Nursing. LN1 said the facility expected staff wash or sanitize hands after removing gloves, before moving from a contaminated body site to a clean body site or before performing a clean procedure such as applying ointment. LN1 said NAC3 should absolutely have removed gloves and washed her hands after assisting R2 with toileting. LN1 said NAC3 should not have applied ointment with soiled gloves on. LN1 said staff should have assisted R2 to wash hands after toileting. LN1 said she thought staff provided hand hygiene for residents before and after meals, it was a facility expectation. CDC (Centers for Disease Control) website for May 2020 listed steps to prevent the spread of COVID-19 that included 1. Clean your hands often. Wash your hands often with soap and water for at least 20 seconds. If soap and water are not available, clean your hands with an alcohol-based hand sanitizer that contains at least 60% alcohol. Washing hands is especially important after blowing your nose, coughing, or sneezing; going to the bathroom; and before eating or preparing food. CMS State Operations Manual: If residents need assistance with hand hygiene; staff should assist with washing hands after toileting, before meals, and use of ABHR (alcohol based hand rub) or soap and water at other times when indicated. Appropriate use of PPE (personal protective equipment includes but is not limited to the following: Gloves and hand hygiene performed before moving form a contaminated- body site to a clean- body site during resident care. Staff must perform hand hygiene: After removing protective equipment (e.g., gloves, gowns, facemask's) Review found the facility's current infection control policies were consistent with CMS and the CDC guidelines regarding hand washing after removing gloves, after toileting, and before eating.

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