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 _____	05/08/2020

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 -** 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 properly prevent and/or contain COVID-19. COVID-19 is an infectious disease by a new virus causing respiratory illness with symptoms of cough, fever, and in severe cases difficulty breathing that could result in severe impairment or death. The facility failed to establish and maintain an infection prevention and control program designed to provide a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infections. In addition, the facility failed to establish a system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility. Specifically, 1. Review of the facility's infection control logs for March 2020 and April 2020 showed the facility failed to accurately track and trend infections of the residents in the facility. 2. Facility failed to develop a system for resident and staff surveillance for COVID-19 symptom monitoring and intervention. 3. Facility staff (Certified Nursing Aide (CNA)1, CNA2, CNA3, CNA4, CNA5) failed to properly wear cloth face masks and/or did not perform hand hygiene after touching cloth face masks. 4. Failed to disinfect reusable blood pressure (BP) cuff after use on 5 of 5 unsampled residents (R) (R8, R9, R10, R11, R12) observed for vital sign monitoring. 5. Failed to ensure personal protective equipment (PPE) gown fully covered staff (CNA3)'s uniform when providing cares to sampled resident (R1) and changing linen in sampled resident (R2)'s room. Both R1 and R2 were on droplet transmission based precautions. 6. Failed to wash hands for at least the required 20 seconds after providing cares to sampled resident (R1) who was on droplet transmission based precautions. 7. Failed to wear PPE mask when (Licensed Nurse (LN)1 provided cares to sampled resident (R1) who was on droplet transmission based precautions. 8. Failed to provide cares that prevented urinary tract infections for 1 of 1 unsampled resident (R6) observed for mechanical lift transfers. 9. Failed to change gloves when moving from dirty to clean tasks during incontinence care for 1 of 1 unsampled resident (R5) observed for incontinence care. These failures represented systemic failures which increased the risks for the spread of COVID-19 and other communicable diseases and infections amongst residents and staff. Findings include: During an interview on 5/7/20 at 1:30 PM Administrator, Director of Nursing (DON), Infection Preventionist (IP) and Unit Manager 1 (UM)1 stated that facility census was 57, facility was still admitting residents, the facility had no current COVID-19 positive residents or staff. It was further stated, none of staff had been tested for COVID-19 but all were asymptomatic. Only one resident tested for COVID-19 with test results negative. New residents admitted to the facility or who go out into the community for [MEDICAL TREATMENT] [MEDICAL CONDITION] treatments are placed in droplet transmission based precautions. 1. Infection control logs Review of facility policy, Surveillance of Infections, last reviewed 7/25/19, showed The Infection Preventionist (IP) conducts surveillance of infections among residents and associates to ensure appropriate follow-up actions are taken to prevent the spread of infection. The IP conducts surveillance of healthcare-associated infections (HAIs) by: .reviewing culture reports and other pertinent lab data . Review of facility's Healthcare-Associated Infection Summary Report by Resident Days, dated March 2020, included Line Listing of Patient Infections, dated March 2020, showed resident's name, admitted , type of infection, symptoms/onset, cultures date/site/results), treatment, precautions, if infection criteria was met, and if infection was healthcare acquired infection or community acquired infection. An entry was shown for R13 for skin infection for symptoms of red, pus drainage, painful, warm with culture sent on 3/19/20. The results of the culture, such as type of organism, was not entered, but the form showed the infection was a healthcare-associated infection. In addition, an entry was shown for R14 for wound infection. Under symptoms wound infection [MEDICAL CONDITION] redness was entered, under culture (date/site/results), a circle with a line through the circle was entered, under treatment, antibiotic was listed and the form showed the infection was a healthcare-associated infection. The date for symptom onset was not shown. None of the 17 infections listed had an organism listed. The log failed to document if the ordered antibiotic was appropriate to treat the infection or if, and when, the infection was resolved. The March 2020 report also included a map of the facility color coded with type of infection, but there was no organism identified on the map and therefore the facility map was very limited to assess the potential relationship and spread of infection in the facility. Review of facility's Infection Control Tracking-Resident, Antibiotic and Organism Cultured Out, as part of Healthcare-Associated Infection Summary Report by Resident Days, dated April 2020, showed a column for date, resident, room #, date of onset, site, organism, antibiotic, and length of tx (treatment) for each of the 11 infections listed on the form. Under the column for organisms, no data was entered for any of the 11 infections listed. The Line Listing of Patient Infections, dated April 2020, showed resident's name, admitted , type of infection, symptoms/onset, cultures (date/site/results), treatment, precautions, if infection criteria was met, and if infection was healthcare acquired infection or community acquired infection. No culture data was entered for any of the 11 infections listed. Two of the infections listed C&S (culture and sensitivity) but the organism was not entered or shown. When asked to explain the lack of organisms or cultures, IP stated that he was not employed by the facility in April when the infections occurred and he would have to look at the lab results to find the organisms. The facility's, Infection Control Tracking-Resident, Antibiotic and Organism Cultured Out, dated April 2020, showed the specific issue or infection trends identified this month (if any) with increased skin rash, fungal, increased UTI (urinary tract infection) entered. Under actions taken relating to the specific issues or trends identified, the report showed increased hygiene, pericare. It is unclear how the issues or infection trends and action required or indicated could have been determined without the organisms identified. The log failed to document if the ordered antibiotic was appropriate to treat the infection or if, and when, the infection was resolved. The April 2020 report also included a map of the facility color coded with type of infection, but there was no organism identified for the month and therefore the facility map was very limited to assess the potential relationship and spread of infection in the facility. During an interview on 5/8/20 between 12:45 PM and 1:30 PM with DON and IP, when asked if April 2020 Infection control report was complete, IP stated, no. When asked about the limited data for tracking infection such as type of organism, if antibiotic resolved infection, date of symptom onset and if this negatively impacted the tracking, identification of trends and evaluation of appropriate interventions, DON stated absolutely, should have more data for analysis. 2. Resident and staff surveillance for COVID-19 symptoms During an interview on 5/8/20 between 12:45 PM and 1:30 PM with DON and IP, in response to surveyor request for staff surveillance for monitoring COVID-19 symptoms, or staff line listing of illnesses, call-ins, staff leaving work mid-shift due to illness, or did not pass initial shift COVID-19 screening, DON stated that when staff calls in sick a tracking sheet is completed. A three colored form is completed which goes to the supervisor, personnel file and employee health. DON provided copies of several Absence Report forms. When asked who tracks the absence report forms, DON stated that Staffing Coordinator has been keeping track of these. When asked if IP, DON, or someone from nursing reviewed the forms as a surveillance system of staff illnesses that might indicate COVID-19, DON stated she has been the DON since April and previously was MDS (Minimum Data Set, assessment and data reporting) Coordinator and has also been fulfilling IP role until 5/4/20 when IP started and Unit Manager Role until 5/4/20 when UM1 started and just hasn't had the time to get everything done. Review of Absence Report forms showed: *LN2 reported on 4/18/20 that her spouse was sick and COVID-19 test

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

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) was pending. Facility did not provide documented evidence of follow-up to ensure staff did not have any exposure to persons with known or presumed COVID-19, and needed to take additional precautions or actions, before returning to work. *CNA3 reported on 4/9/20 that her mother-in-law was exhibiting symptoms of COVID. Notation by DON on form that I requested she get tested and stay home for her next two scheduled days and contact me on Monday 4/13/20. Facility did not provide documented evidence of follow-up about COVID-19 testing of staff or mother-in-law. *CNA6 reported on 4/29/20 that she was not feeling well. Facility did not provide documented evidence that staff did not experienced any COVID-19 symptoms. *CNA3 reported on 4/25/20 being hospitalized due to heart versus respiratory. Facility did not provide documented evidence if hospitalization was related to COVID-19. *LN5 reported on 4/25/20 of diarrhea. Facility did not provide documented evidence if there were any other COVID-19 symptoms and how facility ensured return to work criteria was met. *CNA7 reported on 3/29/20 that daughter was hospitalized . Facility did not provide documented evidence of reason for hospitalization or if hospitalization was related to COVID-19. *CNA8 reported on 4/21/20 that her son has been up all night not feeling well. Facility did not provide documented evidence if son's illness was related to COVID-19. *CNA5 reported on 4/23/20 of fever. Facility did not provide documented evidence that CNA's fever was not related to COVID-19. *LN6 reported on 3/26/20 that she had nausea and low grade temp(erature). Facility did not provide documented evidence that symptoms were not related to COVID-19. Facility staff screening prior to start of shift included taking temperature and questions about contact with known COVID-19 person and if SOB or coughing was present. During the same interview with DON and IP, when asked how resident's COVID-19 symptoms were tracked, if resident had increased temperature, low oxygen saturation level, or cough/shortness of breath based on monitoring, DON stated that electronic health record has a respiratory user defined assessment that enables an automatic alert to DON for any increases in temperature or other symptoms and she follows up on to see if chronic issue such as [MEDICAL CONDITION] or allergy and does research and documents in chart. This data was not aggregated so data could be trended or analyzed. When asked if facility was utilizing CDC's Respiratory Surveillance Line List for staff and resident data collection and monitoring to help identify trends and cases to identify an outbreak, IP stated, no, I just came across it a few days ago and will start that. IP stated that no other system for staff and resident data collection for monitoring COVID-19 specific symptoms was used. CDC Symptoms of Coronavirus, https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html, accessed 5/15/20, showed people with COVID-19 have had a wide range of symptoms reported - ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to [MEDICAL CONDITION]. People with these symptoms may have COVID-19: Cough, shortness of breath or difficulty breathing, fever, chills, muscle pain, sore throat, new loss of taste or smell. This list is not all possible symptoms. Other less common symptoms have been reported, including gastrointestinal symptoms like nausea, vomiting, or diarrhea. CDC's Preparing for COVID-19: Long-term Care Facilities, Nursing Homes, https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, accessed 5/14/20, showed Address asymptomatic and pre-symptomatic transmission, implement source control for everyone entering a healthcare facility (e.g., healthcare personnel, patients, visitors), regardless of symptoms. As part of routine practice, HCP (Healthcare personnel) (including consultant personnel and ancillary staff such as environmental and dietary services) should be asked to regularly monitor themselves for fever and symptoms of COVID-19. HCP should be reminded to stay home when they are ill . 3. Failed to properly wear cloth face masks and/or did not perform hand hygiene after touching cloth face masks. Observation on 5/7/20 at 2:50 PM showed CNA1 coming out of dirty utility room with cloth face covering/mask below her nose with her nares (opening of nose) exposed. CNA1 walked about 15 feet down the hall and emptied trash bags. CNA1 then entered room [ROOM NUMBER] with mask still below her nares. Observation on 5/7/20 at about 3:10 PM showed CNA1 enter R5's room. CNA1 touched her cloth mask and moved it to better cover her nose, CNA1 did not perform hand hygiene after touching cloth mask. CNA1 provided incontinence cares to R5. During a concurrent observation and interview on 5/7/20 at about 3:20 PM CNA1's mask was not covering her nares and CNA1 stated that her mask was not staying on and giving her problems. During a concurrent observation and interview on 5/7/20 at 2:05 PM showed CNA2 in 100 Hall with cloth mask very loose and not covering her nares. CNA2 stated that facility provides cloth masks and stated, my mask is too big and it's loose and acknowledge mask was not covering her nares. Observation on 5/7/20 at 2:25 PM showed CNA4 with his bandanna not covering his nares, CNA4 looked at surveyor and repositioned bandanna to cover his nares and went into R6's room. Surveyor entered R6's room and observed CNA4's bandanna not covering his nares and CNA4 repositioned bandanna to cover his nares, no hand hygiene was performed after touching bandanna. CNA4's bandanna was positioned at the nape of his neck. CNA4 and CNA1 assisted R6 using mechanical lift to transfer from bed to wheelchair. After R6 was positioned in her wheelchair, CNA1's mask was observed not covering her nares and just above her upper lip. CNA4's bandanna was observed not covering his nares and just above his lip. CNA4 repositioned his bandanna, and did not perform hand hygiene after, and then removed linen from resident's bed and gave resident her purse. During a concurrent observation and interview on 5/7/20 at about 2:30 PM showed CNA3 touching cloth mask and entering clean utility room. No hand hygiene was performed after touching mask. CNA3 retrieved large blue long-sleeve shirt with buttons the length of the shirt and then again touched cloth mask. No hand hygiene performed after touching mask. Observation on 5/7/20 at 5:00 PM showed LN1 in R5's room with same home made cloth mask he was wearing earlier in R1's room. R5 also had Droplet precautions sign on the door. LN1 was within two feet of R5. During an observation on 5/7/20 between 3:20 PM and 3:45PM CNA5 pulled down her cloth mask and her nares were uncovered. At 3:22 PM, CNA5 again pull down cloth mask and expose her nares. No hand hygiene was performed after either observation of touching cloth mask. CNA5 moved several papers at the nursing station. At 3:25 PM, CNA5 again pull down cloth mask and expose her nares. No hand hygiene was performed after touching mask. Unit Manager 2 looked at CNA5 with CNA5 mask below her nose exposing her nares and didn't say anything to CNA5. CNA5 wheeled vital sign machine and clipboard into R8's room. CNA5 performed hand hygiene and stood within 6 feet of R8 with her mask not covering her nares. CNA5 performed hand hygiene and went to R9's bed. CNA5 performed the same steps for taking vital signs and applied maroon BP cuff on R9's arm. CNA5's mask was not covering her nares while CNA5 stood within 6 feet of R9. CNA5 entered R11's room and placed blue BP cuff on R11's arm. CNA5 touched cloth mask and did not perform hand hygiene after touching mask. CNA5 took oxygen saturation and level and was observed with mask not covering nares while standing about 3 feet away from R11. CNA5 entered R12's room. CNA5's cloth mask was again below CNA5's nose with her nares exposed, her mask was near her mouth. R12's had a mask on but it was below her chin. CNA5 stood about 2 feet away from R12 while taking her BP with her mask not covering her nares. Concurrent observation and interview on 5/7/20 at 4:55 PM showed CNA4 with bandana with nares exposed, the top of the bandana was near his chin. When asked about his bandana, CNA4 stated, I have to breathe, is it a good to be breathing your own carbon [MEDICATION NAME]? CNA4 stated that he didn't use a mask as liked using a bandana instead. During an interview on 5/7/20 at 5:15 PM CNA5 stated mask supposed to cover nose and mouth, but it gets hot and bothers my chin. When asked about hand hygiene after touching mask, CNA5 stated, yes, supposed to do hand hygiene after touching mask. During an interview on 5/8/20 at 12:05 PM when asked about staff training for how to wear cloth masks and performing hand hygiene after touching masks to prevent contamination, DON stated that masks should fully cover staff nose and hand hygiene should be done after touching masks. DON stated that education was done via staff meeting and now writing up more specific instructions and placing in staff mail boxes. During an interview on 5/8/20 at 10:25 PM with DON and IP, both stated that hand washing or sanitizing hands should be done after touching masks, staff should be wearing masks when in facility. CDC's Preparing for COVID-19: Long-term Care Facilities, Nursing Homes, https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, accessed 5/14/20, showed Address asymptomatic and pre-symptomatic transmission, implement source control for everyone entering a healthcare facility (e.g., healthcare personnel, patients, visitors), regardless of symptoms. As part of source control efforts, HCP (healthcare personnel) should wear a facemask or cloth face covering at all times while they are in the healthcare facility. When available, facemasks are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. Facility policy, Chapter 4: Standard and Transmission-Based Precautions, undated, showed cloth face covering: textile (cloth) covers that are intended to keep the person wearing one from spreading respiratory secretions when talking, sneezing, or coughing Associates who enter the facility wearing a personal face mask or covering, should remove their personal face mask/covering and store with personal belongings and apply a facility face mask or cloth face covering at the beginning of their shift They (associates) should also be instructed that if they must touch or adjust their facemask or cloth face covering they should perform hand hygiene immediately before and after HCP should wear a facemask at all times while in the healthcare facility . Facility policy, Hand Hygiene, dated 5/7/20, showed hand hygiene should be performed after touching your face mask or cloth face covering. 4. Failed to disinfect reusable blood pressure (BP) cuff During an observation on 5/7/20 between 3:25 PM and 3:45 PM CNA5 wheeled vital sign machine and clipboard into R8's room. CNA5 took

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) R8's oxygen saturation with pulse oximeter, temperature with scanner that touched resident's forehead, pulse and blood pressure with blood pressure (BP) cuff placed around resident's arm. CNA5 wiped thermometer and pulse oximeter with alcohol swabs. CNA5 did not clean BP cuff. CNA5 performed hand hygiene and went to R9's bed. CNA5 performed the same steps for taking vital signs and applied maroon BP cuff on R9's arm. Again CNA5 did not clean BP cuff. CNA5 then entered R10's room and performed same steps for taking vital signs and applied the same maroon BP cuff just used of R9 on R10's arm. CNA5 exited room and did not clean BP cuff. CNA entered R11's room and placed blue BP cuff on R11's arm. BP cuff was not cleaned. CNA5 entered R12's room and placed same blue BP cuff, not cleaned after use of R11, on R12. During an interview on 5/7/20 at 5:25 PM CNA5 stated, I should have wiped BP cuff after using it on residents. CNA5 stated that she would use sani wipes to clean BP cuffs but there were no sani-wipe container on the vital signs machine that she used earlier. When asked where the sani-wipe containers are located, CNA5 stated, I don't know. During an interview on 5/8/20 at 10:25 PM with DON and IP, both stated that staff should have used sani-wipe to clean BP cuff after using on residents and sani-wipe is preferred to be on the vital sign cart. Facility policy, Cleaning and Disinfection of Non-Critical Patient Care Equipment, revised date 3/13/20, showed non-critical reusable patient care equipment (defined by CDC as items that come into contact with intact skin but not mucous membranes) is cleaned daily and before and after reuse with an EPA (Environmental Protection Agency)-registered hospital disinfectant .Examples of non-critical items include .blood pressure cuffs . 5. Failed to ensure PPE gown fully covers uniform R1 Record review of Medication Administration Record [REDACTED]. On 4/29/20 resident changed rooms to allow isolation and grouping secondary to out of the facility for [MEDICAL TREATMENT]. A holder with gloves hung on resident's door and red colored trash bags in containers were in resident's room. Droplet precautions sign showed eyes and nose and mouth should be fully covered before entry. Observation on 5/7/20 at about 2:15 PM showed CNA3 in R1's room. CNA3 donned gloves and large long-sleeved shirt with buttons covering the length of the shirt. CNA3 placed one arm in the shirt and then the other arm. CNA3 wore the shirt with the buttons in the back. CNA3 donned surgical face mask and goggles. CNA3 stood next to R1's bed within six feet of R1. CNA3 did not fully have the shirt over both arms and shoulders. The shirt did not fully cover CNA3's uniform with CNA3's upper chest and shoulders exposed. CNA3 was observed holding R1's television remote control and standing next to R1's bed. CNA3 doffed gloves, doffed shirt, hung shirt on hooks inside resident's room, doffed goggles and then washed hands at hand sink in resident's room. R1 was heard coughing. During an interview on 5/7/20 at about 2:20 PM, immediately following above observation, when asked how shirt fit her, CNA3 stated the shirt was too small and she couldn't fully get her arms through. CNA3 said that she got a clean shirt from the clean utility room at the start of her shift but will need to get something else that is larger sized. CNA3 stated, I'm one of the bigger ones, and should have grabbed something bigger. When asked if there are shirts that could completely cover and protect her uniform, CNA3 stated that there is sometimes, but wanted to grab something quickly because she wanted to answer the resident's call light. CNA3 stated that shirts are being used as isolation gowns. R2 Record review of Medication Administration Record [REDACTED]. On 4/29/20 resident changed rooms secondary to VOVID-19 cohorting. A holder with gloves hung on resident's door. Droplet precautions sign showed eyes and nose and mouth should be fully covered before entry. During a concurrent observation and interview on 5/7/20 at about 2:30 PM showed CNA3 retrieving large blue long-sleeve shirt with buttons the length of the shirt. CNA3 entered R2's room. CNA3 donned blue shirt by placing one arm and then the other arm into sleeves with buttons on the back. CNA3 was overheard saying the shirt fit much better. CNA3 donned goggles and gloves and picked up meal cover and manila folder from resident's over bed table. CNA3 straightened up resident's room by moving several items around and the made resident's bed and straightened linens and bed covers. Observed shirt/gown falling off CNA3's shoulders while CNA3 moved her arms and bent over. The back of CNA3's uniform was completely exposed and not covered by the shirt/gown. CNA3's upper chest and shoulders were exposed and not covered by the shirt/gown. Surveyor asked Unit Manager (UM)1 to observe CNA3. When asked if CNA3's uniform was protected while in droplet precautions room, UM1 said no. UM1 further stated that her gown is not covering or protecting her uniform and it should be. During an interview on 5/8/20 at 10:25 PM with DON and IP, both stated that gowns should be fully covering staff's uniforms. Facility policy, Transmission-based Precautions and Isolation Procedures, revision date of 5/7/20, showed droplet precautions .gloves and gown as well as goggles (or face shield .) should be worn. CDC's Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007), https://www.cdc.gov/infectioncontrol/guidelines/isolation/appendix/ppe.html, accessed 5/18/20, showed isolation gown should fully cover torso from neck to knees, arms to end of wrist, and wrap around the back. 6. Failed to wash hands for at least the required 20 seconds after providing cares to sampled resident (R1) who was on droplet transmission based precautions. Observation on 5/7/20 at about 2:15 PM showed CNA3 in R1's room. CNA3 was observed holding R1's television remote control and standing next to R1's bed. After being in R1's room for several minutes, CNA3 doffed gloves, doffed shirt, hung shirt on hooks inside resident's room, doffed goggles and then washed hands at hand sink in resident's room. CNA3 washed her hands for eight seconds. R1 was heard coughing. During an interview on 5/7/20 at about 2:20 PM, immediately following above observation, when asked how long CNA3 washed her hands, CNA3 said, I'm supposed to wash hands for 20 seconds, probably did it too short, and supposed to wash for the 'happy birthday' song. When informed happy birthday song is supposed to be done twice, CNA3 stated that she didn't know that. During an interview on 5/8/20 at 10:25 PM with DON and IP, both stated hands should be washed for 20 seconds. Record review of the World Health Organization's How do I wash my hands properly, https://www.who.int/gpsc/clean_hands_protection/en/, accessed 5/14/20 showed Washing your hands properly takes about as long as singing Happy Birthday twice. 7. Failed to wear PPE mask when (Licensed Nurse (LN)1 provided cares to sampled resident (R1) who was on droplet transmission based precautions. Observation on 5/7/20 at 2:20 PM showed LN1 outside R1's room. LN1 was wearing homemade cloth mask. R1 was asking for pain medication. LN1 got pain medication and entered R1's room with homemade cloth mask. LN1 washed hands, donned gloves, donned shirt/gown and goggles. LN1 did not don surgical face mask and continued to wear homemade cloth mask. LN1 stood within 6 feet of R1 and gave R1 her medication. Observation on 5/7/20 at 5:00 PM showed LN1 in R5's room with same homemade cloth mask he was wearing earlier in R1's room. R5 also had Droplet precautions sign on the door. LN1 was within two feet of R5. During an interview on 5/7/20 at about 2:40 PM UM1 stated that staff should be wearing paper mask when in droplet precautions room and if cloth mask is used then the cloth mask is contaminated and should be removed. When informed of observation showing LN1 wearing cloth mask in R1's room, UM1 stated she will talk with LN1. During an interview on 5/8/20 at 10:25 PM with DON and IP, DON also stated she talked with LN1 and LN1's mask should have been changed after it was used and therefore contaminated when it was worn in R1's room. CDC's Preparing for COVID-19: Long-term Care Facilities, Nursing Homes, https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, accessed 5/14/20, showed Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. All recommended PPE should be worn during care of residents under observation; this includes use of 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. Cloth face coverings are not considered PPE and should not be worn by HCP when PPE is indicated. 8. Failed to provide cares that prevented urinary tract infections for 1 of 1 unsampled resident (R6) observed for mechanical lift transfers. Observation on 5/7/20 at 2:25 PM showed CNA4 and CNA1 assisting R6 using mechanical lift to transfer from bed to wheelchair. R6's indwelling urinary catheter bag was observed hanging from mechanical lift hooks. R6's urinary catheter bag was observed above her bladder. Review of facility's Infection Control Tracking-Resident, Antibiotic and Organism Cultured Out, dated April 2020, showed R6 had a urinary tract infection on 4/8/20 that was treated with an antibiotic for 7 days. During an interview on 5/8/20 at 10:25 PM with DON and IP, DON stated that urinary catheter bag should be below the bladder at all times to prevent infections and R6 is known to have urinary tract infections. Facility policy, Urinary Incontinence and Indwelling Urinary Catheter (Foley) Management, dated 5/5/20, showed keep the drainage bag below the level of the patient's bladder to prevent backflow of urine into the bladder, which increases the risk of catheter associated urinary tract infection. 9. Failed to change gloves when moving from dirty to clean tasks during incontinence care for 1 of 1 unsampled resident (R5) observed for incontinence care. Observation on 5/7/20 at about 3:10 PM showed CNA1 enter R5's room. CNA1 provided incontinence cares to R5. CNA1 donned gloves, lowered the head of R5's bed and raised the bed up, opened R5's wet brief and repositioned trash can closer to the bed with same gloved hands, wiped R5's periarea with several wipes. With same gloved hands, CNA1 took off resident's pants, and rolled resident towards the window and said that the brief was wet and wiped the resident's skin several times with wipes and then placed clean new briefs under resident's buttocks with same gloved hands. Without changing gloves, CNA1 then rolled resident towards the door and fastened briefs, placed wipe container in drawer, repositioned two pillows under resident's legs, covered resident with covers, touched resident's bed control and raised head of bed and lower bed, placed stuffed animals next to resident, gave resident her call light and

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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	(continued... from page 3) then bagged trashed and doffed gloves. CNA1 then washed hands and exited the resident's room. During a concurrent observation and interview on 5/7/20 at about 3:20 PM CNA1 stated that she should have brought two gloves in and didn't change her gloves after removing soiled briefs but should have. During an interview on 5/8/20 at 10:25 PM with DON and IP, DON stated gloves should be changed after touching dirty briefs and before touching clean briefs. Facility policy, Hand Hygiene, dated 5/7/20, showed hand hygiene should be performed after contact with body fluids.