STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	05/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	1001 SOUTH HILTON STREET BOISE, ID 83705

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 -** Immediate jeopardy **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 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's COVID-19 unit (Hall 300) had fans blowing throughout the unit and towards the non-COVID-19 units (Hall 200 and Hall 100), COVID-19 unit did not have consistent staff assigned as evidenced by staffing schedule showing 12 staff members (Certified Nursing Assistant (CNA) 1, CNA2, CNA10, CNA13, CNA16, CNA26, CNA25, CNA27, Licensed Nurse (LN) 4, LN8, LN9, LN16) had worked on the COVID-19 unit and the next day worked on non-COVID-19 unit, including CNA2 who reported COVID-19 symptoms the day after working on COVID-19 unit and then non-COVID-19 unit and subsequently tested COVID-19 positive. In addition, 1 of 1 staff (CNA1) observed did not properly re-don personal protective equipment (PPE) and this was not addressed in staff training or postings, and 2 of 3 staff (CNA1 and CNA24) observed failed to properly clean and disinfect pulse oximeter after use on several residents on both COVID-19 and non COVID-19 units. In addition, the disinfectant used was not effective against emerging [MEDICAL CONDITION] pathogens and human coronavirus. These failures increased the likelihood for serious injury, serious harm, or death and required immediate action to prevent transmission of COVID-19 from positive and/or presumptive COVID-19 residents to negative COVID-19 residents and staff. The facility census was 57; which included 18 known or presumed COVID-19 positive residents in Hall 300 COVID-19 unit and 2 known COVID-19 positive residents in non-COVID-19 units. This is in addition to 2 residents who died from COVID-19 and 4 current residents who were COVID-19 positive and since recovered. There were 15 staff who were COVID-19 positive and either returned to work or were still out and one staff member had COVID-19 symptoms with test results pending. On [DATE] at 3:47 PM the Administrator, Director of Nursing (DON), Infection Preventionist Nurse (IP), and Corporate Nurse (CN) was informed of Immediate Jeopardy (IJ) determination for 42 CFR 483.80 (F880) and the IJ template was emailed on [DATE]. On [DATE] at 3:05 PM the DON was informed it was determined the immediacy was removed based on onsite verification that IJ removal plan was implemented. The Administrator was not present in the facility. Additionally, After using glucometer to check blood sugar for 1 of 2 blood sugar testing observations, staff did not use a barrier to protect used glucometer from contaminating non sampled resident (R) (R10)'s room environment. Findings include: Record review of Midnight Census Report showed the facility census was 48. 300 Hall Census Sheet, COVID-19 Resident and Staff Line Listing showed 18 known or presumed COVID-19 positive residents in Hall 300 COVID-19 unit and 2 known COVID-19 positive residents in non-COVID-19 Hall 100. This is in addition to 2 residents who died from COVID-19 and 4 current residents who were COVID-19 positive and since recovered. The majority of the residents had multiple room changes from Hall ,[DATE] to Hall 300 and sometimes back to Hall ,[DATE]. There were 15 staff who were COVID-19 positive and either returned to work or were still out and one staff member had COVID-19 symptoms with test results pending. 1. Fans in COVID-19 unit During an interview on [DATE] at 7:40 AM, LN23, who was also a Resident Care Manager (RCM), stated that Hall 300 was designated as a COVID-19 unit ,[DATE] weeks ago, with residents having mild to moderate COVID-19 symptoms in late March. All staff wear a gown, mask (either surgical mask or N95), eye protection, and gloves, enough PPE supplies are available, N95 masks are worn in Hall 300 since opening but N95 masks only started in Hall 100 and Hall 200 about a week ago. Observation on [DATE] at 7:50 AM showed facility was configured in a cross pattern, with Hall 200 at the top of the cross, conference room and kitchen at the bottom of the cross, Hall 100 on the left side of the cross and Hall 300 on the right side of the cross. The entry to Hall 300 had closed heavy metal doors and special droplet/contact transmission-based precaution signs on the doors. LN23 stated that anyone that entered Hall 300 could not go to other parts of the facility that same day. Two staff members, CNA1 and LN9, on Hall 300 wore eye protection, surgical mask, N95 mask, long gown, and gloves. It was notably hotter in Hall 300. Observed four fans blowing air in Hall 300; all four fans were facing COVID-19 Hall 300 entrance doors in the direction of non-COVID-19 Hall 100 and Hall 200 on the other side of the doors. Hall 300 had residents residing in rooms 305, 307, 309, 311, 313, 315 and 317 on the left side of the hall and rooms 310, 312, 314, and 316 on the right side of the hall. The room numbers became higher the further away from the entrance doors. Record review of 300 Hall Census Sheet and COVID-19 Resident Line Listing and observation showed on the left side of Hall 300 was: *room [ROOM NUMBER]: this was the first room closest to the entrance door. R6 and R7, both presumed COVID-19 positive, resided here. The room door was opened. *room [ROOM NUMBER]: R8 and R9, both COVID-19 positive, resided here. The room door was closed. A large standing fan, blowing in the direction of the entrance doors, was outside the room. The fan was about 15 feet from the Hall 300 entrance doors. *room [ROOM NUMBER]: R12, COVID-19 positive, resided here. The room door was open. *room [ROOM NUMBER]: R15, COVID-19 positive, resided here. The room door was open. *room [ROOM NUMBER]: R18, COVID-19 positive, resided here. The room door was open. *room [ROOM NUMBER]: R20 and R21, both COVID-19 positive, resided here. The room door was closed. *room [ROOM NUMBER]: R24, COVID-19 negative but symptomatic on [DATE] and R25, COVID-19 negative but symptomatic on [DATE], resided here. The room door was open. A large standing fan, blowing in the direction of the entrance doors, was outside the room. On the right side of Hall 300 was: *room [ROOM NUMBER]: R13, COVID-19 positive, and R14, presumed COVID-19 positive, resided here. The room door was open. *room [ROOM NUMBER]: R16 and R17, both COVID-19 positive, resided here. The room door was open. *room [ROOM NUMBER]: R19, COVID-19 positive, resided here. The room door was closed. A commercial carpet drying fan, labeled Hawk air mover, was outside the room. Fan used for drying carpets; designed take dry air from above and direct it across the floor, working at high-velocity airflow rates. *room [ROOM NUMBER]: R22 and R23, both COVID-19 positive, resided here. The room door was opened. A large standing fan, blowing in the direction of the entrance doors, was outside the room. During concurrent observation and interview on [DATE] at about 8:00 AM, CNA1's face was flushed with perspiration on face and stated it's very warm here the building is old, built in the 50's. The fans have been here for three weeks, think it's very warm when the (Hall 300) doors are closed. Observation on [DATE] at about 8:00 AM showed Hall 300 doors opened for about 5 minutes while staff transferred each meal tray into a meal cart that was already in Hall 300. 18 residents resided in Hall 300. Observation on [DATE] from 8:00 AM to 9:30 AM showed surveyor's hair blowing continuously, when standing near room [ROOM NUMBER], from one or all three fans blowing forcible air located outside room [ROOM NUMBER], room [ROOM NUMBER] and room [ROOM NUMBER]. A table with masks, cleaning solutions, tissue boxes, papers and manila folders was located outside Social Services office across from room [ROOM NUMBER] and 309. The manila folder and papers were observed flapping from the forcible air blown from fans. CNA1 moved large trash barrel lined with plastic bag down the hall, plastic bag was heard making a very loud crinkly noise and was observed moving vigorously when passing standing fans. CNA1 and LN9 was overheard stating how hot it was and observed wiping their foreheads which glistened and appeared wet. During a concurrent observation and interview on [DATE] at 8:35 AM in the social services office on Hall 300, DON stated that all residents on COVID-19 Hall 300 were known or presumed COVID-19 positive. DON further stated that the fans have been in place since COVID-19 Hall 300 opened on [DATE]. When asked about concerns with fans blowing in COVID-19 Hall 300 and towards non-COVID Halls 100 and 200, DON stated that facility's regional team has seen the fans without any concerns. Surveyor pointed to the wall of social services office where multiple papers taped to

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

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) the wall was observed to be moving and flapping around from the forcible air blown from the fans. When asked if DON saw papers flapping from the fans, DON nodded his head in acknowledgment. DON stated that in March, Hall 300 was under construction and no residents resided here but facility was allowed to finish construction 7 days before [DATE] and opened Hall 300 as their dedicated COVID-19 unit on [DATE]. Prior to [DATE], known or presumed positive COVID-19 residents resided on Halls 100 and 200 with transfer to Hall 300 on or after [DATE] when construction was completed. During an interview on [DATE] at 9:50 AM with DON and IP, IP stated that Hall 300 has a separate air handling system and fans are for staff comfort because it is too hot, especially with PPE. During an interview on [DATE] at 2:40 PM with Administrator, DON, and IP, Administrator stated that the building was built in 1974 and the windows and siding are old which makes it hot inside the building. Fans in Hall 300 are for staff and resident comfort and temperatures cannot be regulated in each resident room, each hall has its own runs and there is no co-mingling of air between runs. Observation on [DATE] at 3:15 PM showed two unknown staff members talking with Hall 300 doors opened. The doors were opened at least several minutes. Overheard over staff walkie system on [DATE] at 3:20 PM move fans, can't be pointed towards fire door, needs to be pointed the other way. During concurrent record review and interview on [DATE] at 5:20 PM when asked about facility's policy, Infection Prevention and Control Interim Policy for Suspected or Confirmed Coronavirus (COVID-19), dated [DATE], which showed, a resident with known or suspected COVID-19, immediate infection and control measures will be put in place. Resident will be placed in an Airborne Infection Isolation Room (AIIR) that is constructed and maintained in accordance with current guidelines .If no AIIR is available in the facility, the resident should be transferred as soon as possible to a facility with an AIIR. While awaiting transfer, place a facemask on the resident and place resident in a private room with the door closed, preferably not in a room where room exhaust is recirculated within the building without HEPA filtration . IP stated that the facility did not have any AIIRs, residents were offered transfer to facility with AIIRs, facility COVID-19 outbreak started on [DATE], and fans are not blowing far enough past Hall 300 doors and there is no direct bleed from Hall 300 to Hall ,[DATE]. During concurrent observation and interview on [DATE] at 5:45PM showed Hall 300 fans were pointed away from Hall 300 entrance doors and towards exit. Surveyor and IP agreed and pointed fans towards Hall 300 entrance doors to conduct tissue test (rudimentary test where tissue is placed at the bottom of closed doors to assess pressure differences between two areas; tissue should move from positive to negative pressure). At about 6:00 PM, IP placed tissue at the bottom of closed doors and the tissue moved in the direction of the Hall 300; this indicated that air was not moving from Hall 300 to Halls ,[DATE], although sufficient time may not have been allowed to conduct tissue test. During interview on [DATE] at 7:05 AM Maintenance Director stated that at least one fan is usually blowing in Hall 300 and was unaware four fans were currently in use in Hall 300. Maintenance Director stated that the commercial carpet drying fan was from housekeeping and not Maintenance. During interview on [DATE] at 8:30 AM with Maintenance Director, Admission staff who used to work in Maintenance, DON, Administrator, Corporate Nurse, IP, and Idaho State survey team members including Life Safety surveyor, Survey Director and managers, Maintenance Director stated that the Hall 300 temperature measured 68 to 72.5 degrees Fahrenheit this morning, there's one thermostat in one room that controls temperature for the entire hall, observed four fans in Hall 300 this morning and the fans were pointed in all different directions; some were pointed towards the Hall 300 entrance doors and others were pointed towards the exit, the direction of the fans seemed to be based on where staff are standing, the fans are facing towards nursing carts, where nurses are standing at the cart, some are facing towards the corridor (Hall 300 entrance) and others facing towards the exit. Maintenance Director further stated that the heat was turned off and staff turned on and off the heat all the time. When asked if the air conditioner was on, Maintenance Director stated, no, still in heat mode. Not an automated system. System needed to be manually put into a cool mode to drop the temperature. DON stated it's very hot with all PPE on and that's why the fans are there. Review of temperature for Boise area on [DATE] showed a high temperature of 82 degrees Fahrenheit, accessed [DATE], https://w2.weather.gov/climate/getclimate.php?wfo=boi. Record review of facility's policy, Infection Prevention and Control Interim Policy for Suspected or Confirmed Coronavirus (COVID-19), dated [DATE], showed, it is the policy of this facility to minimize exposures to respiratory pathogens .and adhere to Standard, Contact and Airborne Precautions . The Centers for Disease Control and Prevention (CDC)'s Guidelines for Environmental Infection Control in Health-Care Facilities, updated [DATE], accessed [DATE], https://www.cdc.gov/infectioncontrol/guidelines/environmental/index.html, showed airflow between two different areas such as rooms or hallways should be from clean-to-dirty airflow. The COVID-19 Hall 300 is considered dirty and the four fans blowing forced air towards the non-COVID-19 Hall 100 and Hall 200 was not aligned with the principle of clean-to-dirty airflow. CDC's Nursing Home Infection Preventionist Training Course Environmental Cleaning module, accessed [DATE], https://www.train.org/cdctrain/training_plan/3814, showed infection prevention principle of clean-to-dirty work flow to prevent contamination. State Operations Manual Appendix PP-Guidance to Surveyors for Long Term Care Facilities, revision [DATE], stated if using fans in laundry processing areas, prevent cross-contamination of clean linens from air blowing from soiled processing areas (i.e., the ventilation should not flow from soiled processing areas to clean laundry areas). This reference outlines basic infection prevention principle from clean-to-dirty airflow direction to prevent contamination. CDC's Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings Mode of transmission, accessed [DATE], https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html, states current data suggest person-to-person transmission most commonly happens during close exposure to a person infected with [MEDICAL CONDITION] that causes COVID-19, primarily via respiratory droplets produced when the infected person speaks, coughs, or sneezes. Droplets can land in the mouths, noses, or eyes of people who are nearby or possibly be inhaled into the lungs of those within close proximity. Transmission also might occur through contact with contaminated surfaces followed by self-delivery to the eyes, nose, or mouth. The contribution of small respirable particles, sometimes called aerosols or droplet nuclei, to close proximity transmission is currently uncertain. 2. Consistent staff assigned to COVID unit Record review of facility's policy, Infection Prevention and Control Interim Policy for Suspected or Confirmed Coronavirus (COVID-19), dated [DATE], showed, in the event of a facility outbreak when AIIR rooms are not available in the community, institute outbreak management protocols: 7. Implement consistent assignment of employees. Policy attachment, COVID-19 Proactive Preparation Planning showed .10. Review and identify staff deployment (i.e. consistent assignment). CDC's Preparing for COVID-19: Long-term Care Facilities, Nursing Homes, accessed [DATE], https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fprevent-spread-in-long-term-care-facilities.html, showed Dedicate Space in the Facility to Monitor and Care for Residents with COVID-19: dedicate space in the facility to care for residents with confirmed COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19. Assign dedicated HCP to work only in this area of the facility. In addition, HCP (health care professionals) continue to be sources of introduction of COVID-19 into nursing homes . Recent experience with outbreaks in nursing homes has also reinforced that residents with COVID-19 may not report typical symptoms such as fever or respiratory symptoms; some may not report any symptoms. Unrecognized asymptomatic and pre-symptomatic infections likely contribute to transmission in these settings. During an interview on [DATE] at 8:35 AM DON stated that staff who work on Hall 300 have to leave the facility and are not allowed in other parts of the building until the next day. Staff can work on the Hall 300 on one day and work Hall 100 or Hall 200 the next day. Staff can work on the Hall ,[DATE] and then work on Hall 300 on the same day but cannot work on Hall 300 and then work on Hall ,[DATE] on the same day. The general rule is when you come to Hall 300 you leave from Hall 300 and don't re-enter the building. During an interview on [DATE] at 9:50 AM IP stated that staff who work on Hall 300 can work on Hall 100 or Hall 200 the next day as long as staff passes screening at the start of their shift. During an interview on [DATE] at about 7:45 AM CNA24 stated she works where she is assigned; there is no specific staff assigned to Hall 300. She stated she worked Hall 100 yesterday for 8 hours and then worked Hall 300 for 4 hours. During an interview on [DATE] at 9:05 AM IP stated that CNA26 was first staff member with COVID-19 symptoms on [DATE] and then on [DATE] R2 was the first resident with COVID-19 symptoms. Subsequently, multiple residents and staff had COVID-19 symptoms, several residents and staff were COVID-19 positive. IP stated that several residents continued to go out to appointments as well as out in the community. IP stated that facility recommended residents not going out into the community and practice social distancing but these were elements outside their control. Staff were also lax in infection control and prevention and were counseled and re-educated. IP stated that CNA26 was patient zero. Initially, the facility didn't have PPE, used cloth masks when Hall 300 COVID-19 unit opened on [DATE] as couldn't get surgical face masks or N95 masks despite calling several community and government entities. Record review of COVID-19 Resident and Staff Line Listing and R2's progress notes showed CNA26 was ill at work on [DATE] and was sent home for

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F 0880

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 2)

self-monitoring. CNA26 had a cough and reported direct exposure to known COVID-19 positive person, date of exposure was not documented. CNA26 tested positive for COVID-19 on [DATE]. On [DATE], R2, who resided on Hall 200, had fever and low oxygen saturation levels with suspected COVID-19. On [DATE], R2 was transferred to the hospital and tested positive for COVID-19 on [DATE]. R2 was intubated in the ICU, recovered and readmitted to facility on [DATE]. Record review of Daily Staffing Sheet showed CNA26 was assigned to work as a restorative nursing aide ([DATE], 23, 24, 2020) as well as Hall 100 ([DATE] and 18, 2020). During an interview on [DATE] at 10:00 AM Staffing Coordinator (SC) stated that he schedules staff and makes staffing assignments. When asked how staff assignments are made, SC stated use of new software program based on a template. When asked if there are any parameters or guidelines for scheduling staff on Hall 300, SC stated that he tries first to use a list of staff who have volunteered to work on Hall 300 and also refers to list of staff who requested not to work on Hall 300. SC stated that we try to keep consistent staffing best we can but we had a lot of people out. We use whoever we can find. When asked if a staff could work on Hall 300 on Monday and then Hall 200 on Tuesday, SC stated, I don't see why we wouldn't allow that. Maybe staff want to work on another hall, not burn them out. Once staff goes into Hall 300, they can't come back out through the building, but if they go home after their shift, they can work any hall the next day. During concurrent record review and interview on [DATE] at 11:55 AM with DON, IP, Corporate Nurse, MDS Coordinator, facility policy, Infection Prevention and Control Interim Policy for Suspected or Confirmed Coronavirus (COVID-19), dated [DATE], was reviewed which showed, in the event of a facility outbreak when AIIR rooms are not available in the community, institute outbreak management protocols: 7. Implement consistent assignment of employees. DON and IP nodded their heads and stated consistent assignment of staff is achieved by asking which staff are willing and unwilling to work on Hall 300 and try to keep staff consistent to the best of their ability, which is especially difficult with staff being out. DON stated that nursing leadership has all worked the floors recently to supplement staffing. DON further stated that think we do 90% consistent staffing, if staff work on Hall 300 they only work on Hall 300 and only time we pull someone off is when we have a crisis. We want consistent staffing in Hall 300 to prevent staff from spreading COVID-19. IP stated our staffing requires staff to work Hall 300 and then have 16 hours in between and then come back next calendar day. We haven't done that, instead staff who work Hall 300 have two day break and then return to work and then they are allowed to work Hall ,[DATE], this gives time for symptoms to develop after working Hall 300. When asked how facility defines consistent assignment of employees or consistent staffing as outlined in their policy and if CMS Guide to Improving Nursing Home Employee Satisfaction which references Pioneer Network's definition of consistent assignment (sometimes called primary or permanent assignment) that refers to the same caregivers (RNs, LPNs, CNAs) consistently caring for the same residents almost (80% of their shifts) every time they are on duty is used, DON, IP, Corporate Nurse nodded their heads and said yes that meets the intent of their policy. When asked if use of consistent staffing helps ensures staff are familiar with the resident to identify subtle changes of conditions with COVID-19 symptoms, IP stated, yes and also staff could be vector for transmitting COVID-19 when staff work on COVID-19 Hall 300 on one day and Hall ,[DATE] the next day. When asked how facility addresses pre-symptomatic or asymptomatic COVID-19 amongst staff, for which daily staff screening of assessing temperature and symptoms would not detect, IP stated that consistent staffing is to the best of our ability, we can't see if there are no symptoms. *LN9 Observation on [DATE] between 7:50 AM and 12:45 PM showed LN9 on COVID-19 Hall 300 administering medications, checking blood sugars and transferring resident with hoyer lift with CNA1. LN9 was the only LN working on the COVID-19 Hall 300. Concurrent observation and interview on [DATE] at 7:45 AM showed LN9 on non-COVID-19 Hall 100 administering medications. LN9 stated that she worked on the COVID-19 Hall 300 yesterday and was working on the non-COVID Hall 100 today. Record review of Daily Staffing Sheet for [DATE] (start date for Hall 300) to [DATE] showed LN9 worked Hall 300 on [DATE] and the following day, [DATE], worked on Hall 100. *CNA1 Observation on [DATE] between 7:50 AM and 12:45 PM showed CNA1 on COVID-19 Hall 300 providing cares. During an interview on [DATE] at 9:30 AM CNA1 stated that she works solely on Hall 300 since Hall 300 was opened as a COVID-19 unit. CNA1 mentioned two CNAS work Hall 300 on her days off. Record review of Daily Staffing Sheet for [DATE] (start date for Hall 300) to [DATE] showed CNA1 worked Hall 300 on [DATE] and the following day, [DATE], worked on Hall 200. *CNA2 Record review of Daily Staffing Sheet for [DATE] (start date for Hall 300) to [DATE] showed CNA2 worked Hall 300 on [DATE] and the following day, [DATE], worked on Hall 200. Record review of COVID-19 Staff Line Listing showed CNA2 had COVID symptoms, date of suspected illness, on [DATE], the day after working on Hall 300 and then working on Hall 200. On [DATE], CNA2 reported she had a sore throat 3 days ago ([DATE]-[DATE]) and was tested on [DATE] for COVID-19. Test results on [DATE] showed CNA2 was COVID-19 positive. *CNA10 Record review of Daily Staffing Sheet for [DATE] (start date for Hall 300) to [DATE] showed CNA10 worked Hall 300 on [DATE] and the following day, [DATE], worked on Hall ,[DATE]. CNA10 again worked Hall 300 on [DATE] and the following day, [DATE], worked on Hall 100. *CNA13 Record review of Daily Staffing Sheet for [DATE] (start date for Hall 300) to [DATE] showed CNA13 worked Hall 300 on [DATE] and the following day, [DATE], worked on Hall 200. CNA13 again worked Hall 300 on [DATE] and the following day, [DATE], worked on Hall 100. *CNA16 Record review of Daily Staffing Sheet for [DATE] (start date for Hall 300) to [DATE] showed CNA16 worked Hall 300 on [DATE] and the following day, [DATE], worked on Hall 100. CNA16 again worked Hall 300 on [DATE] and the following day, [DATE], worked on Hall 100. *CNA20 Record review of Daily Staffing Sheet for [DATE] (start date for Hall 300) to [DATE] showed CNA26 worked Hall 300 on [DATE] and the following day, [DATE], worked on Hall ,[DATE]. *CNA25 Record review of Daily Staffing Sheet for [DATE] (start date for Hall 300) to [DATE] showed CNA25 worked Hall 300 on [DATE] and the following day, [DATE], worked on Hall 200. *CNA27 Record review of Daily Staffing Sheet for [DATE] (start date for Hall 300) to [DATE] showed CNA27 worked Hall 300 on [DATE] and the following day, [DATE], worked on Hall 100. *LN4 Record review of Daily Staffing Sheet for [DATE] (start date for Hall 300) to [DATE] showed LN4 worked Hall 300 on [DATE] and the following day, [DATE], worked on Hall ,[DATE]. *LN8 Record review of Daily Staffing Sheet for [DATE] (start date for Hall 300) to [DATE] showed LN8 worked Hall 300 on [DATE] and the following day, [DATE], worked on Hall ,[DATE]. *LN16 Record review of Daily Staffing Sheet for [DATE] (start date for Hall 300) to [DATE] showeLN16 worked Hall 300 on [DATE] and the following day, [DATE], worked on Hall 100. 3. Re-donning PPE Record review of facility's policy, Infection Prevention and Control Interim Policy for Suspected or Confirmed Coronavirus (COVID-19), dated [DATE], showed, it is the policy of this facility to minimize exposures to respiratory pathogens .and adhere to Standard, Contact and Airborne Precautions Policy attachment, COVID-19 Proactive Preparation Planning showed .12. Re-train all employees on Infection Prevention and Control: hand hygiene, PPE Observation on [DATE] between 7:50 AM and 12:45 PM showed CNA1 on COVID-19 Hall 300 providing cares wearing long lab coat/gown surgical mask, N95 mask and eye protection. Observation on [DATE] at 12:45 showed CNA1 returning from break and re-donning PPE in the COVID-19 changing 318 room. With bare hands, CNA1 donned previously worn long lab coat/gown with buttons present on the length of the gown. CNA1 placed one arm into the lab coat/gown and then placed the other arm through and then fastened each button. CNA1 then placed walkie talkie ear piece around ear, donned previously worn N95 mask, surgical face mask and eye protection. CNA1 touched multiple surfaces of the masks and eye protection. Hand hygiene with hand sanitizer was observed after all PPE was donned. However, no hand hygiene was observed after donning previously worn, and therefore contaminated, lab coat/gown before touching ear piece, masks and eye protection. During concurrent observation, interview and record review on [DATE] at 2:35 PM when asked how staff should re-don PPE after returning from a break during their shift, IP stated staff should wear gloves or do hand hygiene to prevent contaminating themselves or their PPE. When informed that staff was using bare hands to re-don PPE and did not perform hand hygiene after touching contaminated gown and before touching multiple surfaces of masks and eye protection, IP stated that staff were re-educated on donning/doffing PPE but additional education is needed. Surveyor and IP reviewed inservice, Donning and Doffing Protected PPE, dated [DATE], that was posted outside COVID-19 Hall 300 which showed how to remove a gown for reuse: while wearing clean gloves, carefully untie the gown and remove it The inservice also had a infographic with basic overview of how to safely don and doff PPE equipment, however the inservice did not cover the process for re-donning which staff did daily after breaks because of extended and reuse of PPE. IP stated that education and posters for donning and doffing did not cover re-donning process and that will need to be addressed. Record review of PPE In-Service for Clinical Staff, dated [DATE], presented by DON showed 300 Hall is our COVID-19 Unit. While on this hall staff are to wear a gown, gloves, face shield or goggles, N95 mask and surgical mask over the N95 we have cloth, reusable and washable, gowns to sue and disposable ones. You can choose to wear either one .Once you (sic) shift is over you go into room [ROOM NUMBER] and change out of your PPE, observing correct donning and doffing procedures for reusable and disposable PPE 4. Cleaning and disinfection of reusable medical equipment Observation on [DATE] at 12:20 PM showed CNA1 on COVID-19 Hall 300 taking R12's temperature and oxygen saturation with pulse oximeter. CNA1 wiped pulse oximeter with Microkill Plus (red top) sani-cloth wipes, performed hand hygiene and then entered R8's room. Two minutes did not lapse between exiting R12's room and entering R8's room. CNA1 took R8's temperature and oxygen saturation with pulse oximeter. CNA1 wiped pulse

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	135077	A. BUILDING _____ B. WING _____	**05/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVAMERE TRANSITIONAL CARE & REHAB - BOISE	**1001 SOUTH HILTON STREET BOISE, ID 83705**

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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) oximeter with Microkill sani-cloth wipes, performed hand hygiene and 20 seconds after took R9's temperature and oxygen saturation. CNA1 wiped pulse oximeter with Microkill sani-cloth wipes, performed hand hygiene and 10 seconds later entered R6's room and proceeded to take R6's temperature and oxygen saturation using the process above. 40 seconds was time between wiping pulse oximeter and using it on R7. After taking R7's pulse and oxygen saturation, CNA1 wiped pulse oximeter. After pulse oximeter was used on R7, the pulse oximeter was not observed to be wet for 2 minutes. During an interview on [DATE] at 12:40 when asked about the contact time for sani-wipes used, CNA1 was not aware of a contact time. CNA1 stated that she thinks the pulse oximeter is wet for about 15 to 30 seconds. LN9 joined the conversation and stated that there's a dwell time. Surveyor, CNA1 and LN9 reviewed sani-wipe container label and LN9 stated, These say 2 minutes. LN9 further stated that there's a dwell time and sometimes you need to use multiple wipes to keep it wet. CNA1 stated I didn't know I had to keep it wet for a period of time. Review of Micro-kill plus (red top) label showed to disinfect hard, non-porous surfaces, thoroughly wet the surface to be treated. Treated surface must remain visibly wet for two minutes. Observation on [DATE] at about 7:10 AM showed CNA24 on Hall 100