STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135130	A. BUILDING _____ B. WING _____	06/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ASPEN TRANSITIONAL REHABILITATION	2867 EAST COPPER POINT DRIVE MERIDIAN, ID 83642

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, and staff interview, it was determined the facility failed to ensure infection control prevention practices were maintained to provide a safe and sanitary environment. This was true for 6 of 9 residents (#1, #2, #3, #6, #7, and #9) who were observed for infection prevention practices. This failure created the potential for negative outcomes by exposing residents to the risk of infection and cross-contamination. Findings include: 1. The facility's Hand Washing policy, dated 5/26/20, directed staff to perform hand hygiene: * Before applying and removing any PPE. * Before and after applying and removing gloves. * After contact with any equipment or environmental surface that might have been soiled or contaminated. The facility's Covid-19 Emergency Plan, dated 5/20/20, directed staff to place newly admitted residents and residents who returned from outside appointments, on quarantine for 14 days, even with negative Covid-19 test results. The plan directed staff to wear surgical masks, gowns, goggles, and gloves when working with residents in quarantine. These policies were not followed. The CDC website, accessed on 6/17/20, under Coronavirus Disease 2019 Using PPE and Strategies for Optimizing the Supply of Isolation Gowns, documented health care providers were to perform hand hygiene prior to donning (putting on) and after doffing (taking off) PPE. Extended use of cloth isolation gowns may be worn by a single health care provider. Each resident room had either a triangle or star sign outside their door. The rooms with a triangle sign had directions from the CDC and/or printed instructions by the facility on how to appropriately don and doff PPE. On 6/9/20 at 8:15 AM, CNA #2 said resident rooms with a triangle sign outside their door were residents under quarantine and staff had to wear PPE before entering these rooms. CNA #2 said the resident rooms with a star sign outside their door were residents who were out of the quarantine period. CNA #2 said the facility placed all their new admissions in quarantine for 14 days. a. On 6/9/20 at 11:15 AM, LPN #2 carried a medication cup containing pills in her hand and walked towards Resident #6's room. Resident #6's room had a triangle sign outside his door and a PPE cart was observed outside his room with written instructions directing staff how to don and doff PPE. LPN #2 placed the medication cup on top of the PPE cart, knocked on the door, turned the door handle down and opened the door. LPN #2 then took the cloth gown that was hanging on the wall inside the room and put it on. LPN #2 then put on the goggles and gloves. LPN #2 did not perform hand hygiene before donning PPE according to the instructions outside of the room. LPN #2 then picked up the medication cup and entered Resident #6's room. On 6/9/20 at 11:25 AM, LPN #2 said she should have performed hand hygiene before donning her PPE. On 6/9/20 at 11:35 AM, during delivery of meal trays, CNA #1 knocked on Resident #6's door. CNA #1 opened the door and took the cloth gown that was hanging on the wall which was used previously by LPN #2. CNA #2 then performed hand hygiene and put on the goggles and gloves. CNA #2 then took Resident #6's tray from the food cart and delivered it to Resident #6. At 11:37 AM, CNA #1 stepped out of Resident #6's room, took off the gown and put it in the basket labeled dirty gowns outside Resident #6's room and performed hand hygiene. On 6/9/20 at 12:00 PM, LPN #2 was asked if she recognized the gown on the basket outside Resident #6's room. LPN #2 said it was the gown she used earlier when she administered Resident #6's medication. When asked if she put the gown in the basket, LPN #2 said she did not put the gown in the basket. LPN #2 said she hung the gown on the hook inside Resident #6's room with the intention to re-use it later. On 6/9/20 at 12:07 PM, CNA #1 said she was not aware she re-used the gown that was hanging on the wall of Resident #6. CNA #1 said she usually used a new gown and goggles when she entered any residents' room. b. On 6/9/20 at 11:15 AM, Resident #2's room had a triangle sign outside his door and a PPE cart was observed outside his room with written instructions directing staff how to don and doff PPE. Physical Therapy Assistant #1 (PTA) was in Resident #2's room and assisted her with her therapy exercises. PTA #1 had on a reusable PPE gown, goggles, a surgical mask, and gloves. PTA #1 assisted Resident #2 with her walker with both gloved hands on the walker and then stepped out of the room into the hallway to give Resident #2 privacy while she used the restroom. At 11:17 AM, PTA #1 then removed his goggles with his gloved hands and wiped the inside and outside of the goggles with the front of his gown and placed the contaminated goggles back on his face. He did not sanitize or replace the goggles and did not perform hand hygiene. At 11:22 AM, Resident #2 told PTA #1 he could go back into the room and he went into the room and closed the door. At 11:30 AM, PTA #1 came out of Resident #2's room and removed the gown, gloves, goggles, and performed hand hygiene. On 6/9/20 at 11:35 AM, PTA #1 put on a new gown, goggles, and gloves prior to entering Resident #3's room. Resident #3's room had a triangle sign outside his door and a PPE cart was observed outside his room with written instructions directing staff how to don and doff PPE. At 12:00 PM, PTA #1 exited the room and removed his gown, gloves, and goggles without performing hand hygiene. He then picked up a box of therapy equipment (theraband, weights, a ball, and a laptop computer) that he brought out of the room. He walked down to the therapy gym where he disinfected the equipment and the box with sanitation wipes. He did not perform hand hygiene prior to or after disinfecting the equipment. On 6/9/20 at 12:08 PM, PTA #1 said he did not remember touching his mask when he was outside of Resident #2's door. He said he had wiped down his goggles with his gown because they had fogged up. He said he should have performed hand hygiene after removing his gloves. c. On 6/9/20 at 8:25 AM, CNA #2 delivered Resident #1's food to her room. Resident #1's room had a triangle sign outside her door and a PPE cart was observed outside her room with directions from the CDC on how to don and doff PPE. CNA #2 left the room and removed her gown, gloves, and mask. She did not perform hand hygiene according to the instructions outside of the room. She then reached into a box of new masks, which potentially contaminated the masks in the box, and placed a mask on her face. She then performed hand hygiene. On 6/9/20 at 8:58 AM, CNA #2 said she should have performed hand hygiene after she doffed her PPE. d. On 6/9/20 at 8:35 AM, LPN #1 carried a syringe and medication cup containing pills in her hand and walked towards Resident #9's room. Resident #9's room had a triangle sign outside her door and a PPE cart was observed outside her room with written instructions directing staff how to don and doff PPE. LPN #1 placed the syringe on top of the glove box which was on top of the PPE cart and the medication cup on top of the PPE cart. LPN #1 put on gloves, then she opened the PPE cart, took one of the cloth gowns and put it on. LPN #1 then picked up the syringe and the medication cup and entered Resident #9's room. LPN #1 did not perform hand hygiene before donning her PPE as the instructions directed. On 6/9/20 at 10:48 AM, LPN #1 said she thought she performed hand hygiene before she donned her PPE. LPN #1 said she should have performed hand hygiene before donning her PPE. On 6/9/20 at 2:08 PM, the DON said she expected staff to perform hand hygiene before donning and doffing PPE. The DON said the staff could reuse the goggles, but they should be sanitized after each use, and gowns could be reused only by the same staff, provided it was not soiled. The DON said staff should not be using gowns that were used by another staff. 2. The facility's Clean Linen Handling policy and procedure, dated 3/12/18, documented clean linen was transported, stored, and distributed in a sanitary way. This policy was not followed: On 6/9/20 at 1:25 PM, Housekeeper #1 was observed as she delivered residents' clothing in Hall 1. The laundry cart had some of the residents' clothing on a hanger and some clothes were folded. The laundry cart had a cover on one side and the other side was open. On top of the laundry cart were about 4-5 folded clothes items. Housekeeper #1 was asked why there were clothes on top of the laundry cart and why they were not inside the laundry cart. Housekeeper #1 said those clothes were unlabeled and she did not know who they belonged to. Housekeeper #1 said the clothes were on top of the laundry cart for about two days. Housekeeper #1 said the laundry cart

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 -** Some	(continued... from page 1) was always open on one side whenever she delivered the clean clothes to the residents. On 6/9/20 at 2:45 PM, the Housekeeper Supervisor said the laundry cart should be covered on both sides when it left the laundry room. The Housekeeper Supervisor also said unlabeled clothes should not be left on top of laundry cart. The Housekeeper Supervisor said the unlabeled clothes should be kept in the laundry room until they determined who they belonged to.