February 14, 2019

Craig Johnson, Administrator  
Boundary County Nursing Home  
6640 Kaniksu Street  
Bonners Ferry, ID  83805-7532

Provider #: 135004

Dear Mr. Johnson:

On **January 31, 2019**, a survey was conducted at Boundary County Nursing Home by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.
After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 25, 2019**. Failure to submit an acceptable PoC by **February 25, 2019**, may result in the imposition of penalties by **March 19, 2019**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in **Title 42, Code of Federal Regulations**.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **March 7, 2019 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **May 1, 2019**. A change in the seriousness of the deficiencies on **March 17, 2019**, may result in a change
The remedy, which will be recommended if substantial compliance has not been achieved by **May 1, 2019** includes the following:

**Denial of payment for new admissions effective May 1, 2019.** [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 31, 2019**, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **May 1, 2019** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:
go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

This request must be received by **February 25, 2019**. If your request for informal dispute resolution is received after **February 25, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,

![Signature]

Debby Ransom, RN, RHIT, Chief
Bureau of Facility Standards
The following deficiencies were cited during the federal recertification survey conducted January 28, 2019 to January 31, 2019.

The surveyors conducting the survey were:

Teresa Kobza, RDN, LD, Team Coordinator
Karen George, RN

Abbreviations

CNA = Certified Nursing Assistant
DNS = Director of Nursing Services
LPN = Licensed Practical Nurse

Free of Accident Hazards/Supervision/Devices

§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, manufacturers guidelines, policy review, and record review, it was determined the facility failed to ensure staff utilized mechanical lifts properly to reduce potential injuries. This was true for 2 of 2 residents (#1 and #6) reviewed for supervision and accidents. These failed practices placed residents at risk of bone fractures and other injuries related inappropriate use of a mechanical lift.

Corrective Action:
Resident #1 and #6 have had a Transfer Assessment tool completed to evaluate their safety with transfers. Their care plans have been updated to reflect their transfer process. Wheel chair and Geri

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
### F 689

**Continued From page 1**

Findings include:

- **The facility's The use of Mechanical Lifts Policy, revised 12/13/18**, documented staff utilized mechanical lift equipment when residents could no longer support their weight on their own. The policy documented the facility used a Arjo Maxi Move Mechanical lift device and staff needed to demonstrate and verbalize the correct procedure to operate the lift.

- **The facility's Transfers Policy, revised 10/17/18**, documented a resident's ability to transfer was assessed at the time of admission. The policy documented wheelchair brakes needed to be locked during all transfers.

- **The Arjo Maxi Move Instructions for Use, dated April 2010**, documented the Arjo was designed for safe usage with one caregiver. The instructions documented there were circumstances that dictated the need for a two-person transfer "such as combativeness, obesity, contractures etc." The instructions documented it was the responsibility of the facility to determine if a one or two person transfer was more appropriate based on "the task, resident load, environment, capability, and skill level of the staff members."

- a. **Resident #1** was admitted to the facility on 10/19/18, with diagnoses which included dementia and chronic pain.

- **An annual Minimum Data Set (MDS) assessment, dated 11/4/18**, documented Resident #1 had severe cognitive impairment and she was dependent on one staff member for chair brakes are being locked for all transfers.

Identification of other residents who have the potential to be affected:

All current residents have the potential to be affected. A Transfer Assessment tool has been developed and completed on all residents to ensure transferred safely and their Plan of Care updated to reflect any necessary changes. The Transfer Assessment tool will be completed by a Licensed Nurse upon admission, quarterly and with any significant change in medical condition. The policy titled Mechanical Lifts, Use of(PolicyTech Ref#1608) has been updated to included completion of this tool at the designated frequency.

**Systemic Changes:**

Staff Inservice provided on Transfer Assessment tool use and completion frequency, resident plan of care changes, adherence to the Mechanical Lift policy and locking brakes on wheel chairs and Geri chairs. Mechanical lift policy updated to include the Transfer Assessment tool guidelines and use.

**Quality Monitoring:**

Audit of resident transfer process will be completed on all residents requiring mechanical lift for transfers weekly x 4 weeks, then bi-weekly x 8 weeks.

**Responsible Party:** Director of Nursing
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Bed mobility, transfers, and toilet use. The MDS documented Resident #1 weighed 185 pounds.

Resident #1’s Care Area Assessment, dated 11/2/18, documented she was considered obese.

The care plan area addressing Resident #1’s Activities of Daily Living (ADL), revised 11/6/18, documented Resident #1 required extensive to total assistance with all ADL’s and cares. The care plan documented Resident #1 had a history of being combative with care and she needed the assistance of one or two staff depending on her behaviors. The care plan documented she used a Geri chair for positioning. The care plan documented Resident #1 required the assistance of one to two staff with bed mobility depending on her cooperation, mood, or anxiety. The care plan documented Resident #1 required the assistance of one staff for all transfers with the Arjo lift, and the assistance of two staff when she was uncooperative or agitated.

On 1/29/19 at 9:57 AM, CNA #7 was observed assisting Resident #1 to the bathroom with the use of the Arjo lift. CNA #7 was the only staff member in the bathroom. Resident #1’s Geri chair was near the left-hand side wall approximately one inch from the wall. Resident #1’s Geri chair brakes were not locked as CNA #7 raised Resident #1 off her seat. The Geri chair slid forward approximately two to three inches. After Resident #1 was free of the chair CNA #7 placed her onto the toilet. After Resident #1 finished using the restroom, CNA #7 raised her with the Arjo lift and assisted her back into her Geri chair. Resident #1’s Geri chair brakes were not locked, and as Resident #1 was lowered into...
F 689 Continued From page 3
the Geri chair the chair moved back and forth and back again and rested against the wall as Resident #7 was situated into the chair.

According to the Arjo's manufacturer instructions, the facility was to assess Resident #1 for the use of one to two staff personnel based on Resident #1's size. Resident #1's clinical record did not contain documentation the assessment was completed.

Facility staff failed to complete an assessment according to the manufacturer's instructions and ensure Resident #1's Geri chair brakes were locked prior to transferring Resident #1.

b. Resident #6 was admitted to the facility on 5/13/16, with diagnoses which included dementia, prosthetic arthroplasty (replacement) of the hip, contracture of hand joint, and rigidity of the muscles.

A quarterly MDS assessment, dated 11/3/18, documented Resident #6 had severe cognitive impairment and documented she was dependent on one staff member for dressing, transfers, and toilet use. The MDS documented Resident #6 had bilateral range of motion impairments to her lower extremities and a range of motion impairment to one of her upper extremities.

The care plan area addressing Resident #6's ADLs, revised 8/7/18, documented Resident #6 required extensive to total assistance of one to two staff with all ADLs and cares, depending on her behaviors and resistance. The care plan documented Resident #6 required two staff personnel for all transfers with the Arjo lift if she

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was agitated or combative and she needed transferred.

On 1/28/19 at 1:12 PM, CNA #6 was observed assisting Resident #6 from her wheelchair and into her bed with the use of the Arjo lift. Resident #6 was observed with severely contracted legs and left hand. CNA #6 attached Resident #6’s sling onto the Arjo lift and after she finished attaching the sling, she moved to stand in front of the controller of the Arjo lift. CNA #6 did not lock Resident #6’s wheelchair brakes. CNA #6 was standing near the controller of the Arjo lift while Resident #6 was lifted into the air with the lift. CNA #6 moved Resident #6 over to her bed and assisted her into bed.

On 1/29/19 at 9:39 AM, CNA #5 was observed assisting Resident #6 from her wheelchair and into her bed with the use of the Arjo lift. CNA #5 attached Resident #6’s sling onto the Arjo lift and then locked Resident #6’s right brake of her wheelchair, the brake closest to her. CNA #5 moved to stand in front of the controller of the Arjo lift. CNA #5 did not lock Resident #6’s left wheelchair brake. CNA #5 was standing near the controller of the Arjo lift while Resident #6 was lifted into the air with the lift. CNA #5 moved Resident #6 over to her bed and assisted her into bed.

According to the Arjo’s manufacturer instructions, based on Resident #6’s contractures the facility was to assess Resident #6 to determine if one or two staff were needed to safely transfer her. Resident #6’s clinical record did not contain documentation the assessment was completed.
**F 689 Continued From page 5**

Resident #6’s wheelchair brakes were not locked when she was transferred and she was not assessed consistent with Arjo’s manufacturer’s instructions, to determine if one or two staff were needed when transferring her.

On 1/30/19 at 10:53 AM, Registered Nurse (RN) #1 stated residents’ transfers plans were determined based on multiple factors. RN #1 stated staff assessed a residents' fall risk, if they could stand, if they were resistive with cares, and their body tone. RN #1 stated the assessment was on the care plan.

On 1/30/19 at 11:00 AM, LPN #2 stated the facility did not have a documented assessment as to if residents were safe with one or two staff transfers. LPN #2 stated what was on the care plan was how residents should be transferred. LPN #2 stated Resident #1’s and #6’s care plans stated they could be assisted by one or two staff, and the CNAs had the option to use two people. LPN #2 stated Resident #1 and Resident #6 could be resistive with cares at times. LPN #2 stated the manufacturer guidelines for the Arjo lift documented only one person was required for use. LPN #2 stated staff competencies related to the proper mechanics of the Arjo lift were reviewed annually.

On 1/30/19 at 2:28 PM, the DNS stated residents' wheelchair brakes should "always be locked" during transfers. The DNS stated the nurses assessed residents' needs often and the facility did not have documented assessment for the Arjo lift to determine if one or two staff were required to safely transfer the residents.

**F 812 Food Procurement, Store/Prepare/Serve-Sanitary**

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§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.

(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.

(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.

(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:

Based on observation, review of facility policy and the 2017 FDA Food Code, and staff interview, it was determined the facility failed to ensure food was handled properly and maintained according to safe practices and proper hand hygiene was performed. This was true when Potentially Hazardous Food (PHF) cold food temperatures were not maintained at safe temperatures and/or were not assessed prior to service. The facility failed to ensure staff performed adequate hand hygiene to prevent possible cross-contamination of dirty to clean areas in the kitchen. These failed practices placed 12 of 12 residents (#1, #3, #4, #6, #7, #8, #9, #12, #13, #16, #18 and #72 at risk for adverse health outcomes. All foods items are being handled and maintained in accordance with the professional standards for food service safety. Staff are ensuring foods are maintained at a safe temperature and the temperatures are being assessed prior to serving.

Potential to affect other residents:
This failed practice has the potential to...
#9, #12, #13, #16, #18, and #72) reviewed who dined in the facility and the other 10 residents who dined in the facility, at risk of adverse health outcomes. Findings include:

1. The facility's Dietary Personal Hygiene Policy, revised 1/9/19, documented staff should wash their hands after handling soiled equipment or utensils. The policy documented staff should wet their hands, apply soap, rub their hands together for one minute and, rinse well and dry their hands.

On 1/30/19 at 12:10 PM, Cook #1 was observed moving between tasks and she approached the sink, applied soap, rubbed her hands together under running water, banged her hands against the side of the sink, and obtained a paper towel to dry her hands. The whole process lasted 5 seconds.

On 1/30/19 at 12:14 PM, Cook #1 repeated the steps above, and the process lasted four seconds.

On 1/30/19 at 12:14 PM, the Certified Dietary Manager (CDM), who was present for the observation, stated she would expect staff to wash their hands minimally for 15-20 seconds.

On 1/30/19 at 1:47 PM, Cook #2 was observed washing her hands in the dish room. She approached the sink, wet her hands, applied soap, rubbed her hands together, rinsed her hands off, and obtained a paper towel to dry her hands. The whole process lasted 6 seconds.

The CDM, who was present for the observation, stated she did not see the staff member washing affect all residents who reside and dine in the Extended Care Facility.

Systemic Changes:
All dietary staff have been educated on the proper storage and handling of cold food items. Education completed on safe temperature range for cold foods and how and when to obtain temperatures of cold food items.

Quality Monitoring:
An audit tool has been developed for monitoring of all temperatures of foods prior to service. Audit to be completed per the Certified Dietary Manager or designee 5 x per week x 2 weeks, 3 x weekly x 4 weeks then 1 x weekly x 6 weeks.

Corrective Action #2:
Staff are performing proper hand hygiene to prevent cross-contamination of dirty to clean areas in the kitchen.

Other Residents who have the potential to be affected:
All residents have the potential to be affected by staff not completing proper hand hygiene.

Systemic Changes:
All dietary staff provided with education on proper hand hygiene practices. A Hand Hygiene competency will be completed on all dietary staff to ensure they are following the Personal Hygiene and Handwashing policy for Nutritional Services(Policy Ref# 765).This policy has
Continued From page 8
her hands because Cook #2 was so quick. The
CDM stated she would in-service staff on proper
hand hygiene.

2. The 2017 FDA Food Code, Chapter 3, Part 3-5, Limitation of Growth of Organisms of Public
Health Concern, subpart 3-501.12
Time/Temperature Control for Safety Food,
documents refrigerated foods are to be
maintained at 5 C (41 F [Fahrenheit]) or less.

On 1/30/19 at 11:45 AM, Cook #1 was observed
assessing the temperatures of food items. Cook
#1 approached a cooler and obtained cold roast
beef sandwiches from the cooler. Cook #1
proceeded to obtain a temperature for roast beef
sandwiches. The roast beef sandwiches were
assessed to be 53.5 degrees F. The CDM placed
the sandwiches into the freezer to cool down.

On 1/30/19 at 12:10 AM, Cook #1 was observed
obtaining chopped salads from the cooler and the
cold roast beef sandwiches from the freezer, and
placed them onto a cart to deliver them to the
serving area. Cook #1 assessed the temperature
of the cold roast beef sandwiches at 49 degrees
F. Cook #1 did not assess the temperature of the
chopped salads. The food was delivered upstairs
to the serving area for lunch.

On 1/30/19 at 12:17 PM, Cook #3 was observed
assessing the temperature of food items. Cook
#3 proceeded to obtain a temperature for roast
beef sandwiches. The roast beef sandwich was
assessed to be 49.4 degrees F. Cook #3 did not
obtain the temperature of the chopped salads
and continued with service. Cook #3 served the
roast beef sandwiches and the chopped salads
been updated by the Certified Dietary
Manager to clarify the correct Hand
hygiene practice.

Quality Monitoring:
An audit tool has been developed to
monitor staff are performing adequate
hand hygiene. Audit to be completed 3 x
weekly x 1 month, then 2 x weekly x 4
weeks then 1 x weekly x 4 weeks.

Responsible party: Certified Dietary
manager or designee.

Results on both audits will be reported to
the Interdisciplinary Committee on a
monthly basis for review and changes
made as necessary.
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On 1/30/19 at 12:37 PM, the CDM stated she did not feel right about serving the sandwiches, but the staff did so anyway. The CDM stated potentially hazardous foods should be at a temperature of less than 41 degrees F prior to service.

§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.
F 880

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, record review, and policy review, it was determined the facility failed to ensure infection control measures were consistently implemented as they related to laundry service practices, hand hygiene practices, and urinary catheter care. Failure to ensure staff processed and transported linens in a sanitary manner, had the potential to impact 12 of 12 residents (#1, #3, #4, #6, #7, #8, #9, #12, #13, #16, #18, and #72) reviewed who resided in the facility and the other 10 residents residing at the facility. Lapses in hand hygiene directly impacted 4 of 15 residents (#1, #6, #7, and #10) whose care was observed. Lapse in urinary catheter care directly impacted 1 of 1 resident (#9) reviewed who had a catheter. These deficient practices created the potential for harm by exposing residents to the risk of infection and cross contamination. Findings include:

1. The facility's Handwashing and Hand Hygiene policy, dated 9/3/17, documented staff should perform hand hygiene when they changed gloves and when moving from a unclean body site to a clean-body site during resident care. This policy was not followed. Examples include:

   a. On 1/28/19 at 11:15 AM, CNA #1 was observed providing peri care for Resident #7. After assisting Resident #7 with peri care CNA #1 removed her gloves but did not perform hand hygiene. CNA #1 continued to provide care for Resident #7 applying an incontinence pad, readjusting clothing, and transferring Resident #7 back to her recliner.

F 880 Infection Prevention and Control

Corrective Action#1:
An enclosed laundry cart for clean laundry is being purchased to meet the code requirement of laundry being covered properly. All clean laundry will be transported from laundry to the Extended Care Facility in the enclosed cart to prevent spread of infection.

Identification of other Residents:
All residents who reside in the Extended Care Facility (ECF) have the potential to be affected by this process.

Action Plan: All resident laundry will be transported in an enclosed linen cart to the resident care area. Patient care staff will ensure the cart cover is closed except while the laundry is being actively removed from the cart. Laundry staff will ensure the laundry is correctly placed into the carts and cover closed.

Systemic Changes:
Staff in-service provided to laundry staff and patient care staff on the correct process for linen handling and delivery of laundry to residents.

Quality Monitoring:
A quality improvement study will be conducted to ensure staff laundry is placed correctly in cart with covering in place daily x 1 month then 3 x weekly x 4
On 1/28/19 at 11:34 AM, CNA #1 stated she should have performed hand hygiene after removing her gloves, prior to touching other items.

b. On 1/28/19 at 1:15 PM, CNA #6 was observed assisting Resident #6 with peri care. CNA #6 was observed washing her hands and placing clean gloves onto her hands. CNA #6 retrieved clean supplies to change Resident #6's adult brief and prepared the supplies. CNA #6 began removing Resident #6's soiled pants and placed them into the dirty hamper. CNA #6 then looked around and grabbed the trash can with her hand and placed it next to her. CNA #6 removed Resident #6's soiled brief and threw it into the trash can. CNA #6 provided Resident #6 with peri care, applied a clean brief, placed pillows under and between Resident #6's contracted legs, and then removed her gloves. CNA #6 adjusted Resident #6's blanket and washed her hands.

On 1/28/19 at 1:27 PM, CNA #6 stated she forgot to perform hand hygiene after she assisted Resident #6 with peri care.

c. On 1/29/19 at 9:43 AM, CNA #5 and CNA #7 were observed assisting Resident #6 with peri care. CNA #5 washed her hands and placed clean gloves onto her hands. CNA #5 retrieved the clean supplies needed to assist Resident #6 with peri care. CNA #5 removed Resident #6's pants and soiled adult brief and began providing peri care. CNA #7 was assisting CNA #5 by holding Resident #6's contracted legs in place for peri care to be completed. CNA #5 stated she needed more wipes, removed her gloves, and left the room. CNA #5 returned with new wipes, weeks then weekly x 4 weeks.

Responsible Party: Environmental Services Manager
Audit of laundry delivery practices in the Extended Care Facility (ECF) will be conducted daily x 4 weeks, 3 x weekly x 4 weeks then weekly x 4 weeks.

The study results will be reported to the Interdisciplinary Quality Committee monthly for review and approval. Completion Date: 4/7/19

Corrective Action #2:
Resident #1, #6, #7 and #10 had no adverse effects from failure of staff to follow the Hand washing and Hand Hygiene Policy.

Identification of other residents who have the potential to be affected:
All residents have the potential to be affected by this deficit in practice. No other residents have shown any signs of adverse effects at this time.

Systemic Changes:
Staff education provided to all staff regarding proper Hand Hygiene practices before, during and after resident care. Education included need for hand washing when removing gloves, when going from a dirty task to a clean task and after completing peri-care for residents.

Quality monitoring:
F 880

Continued From page 13

opened the wipes, removed a few wipes, washed her hands, and placed clean gloves onto her hands. CNA #5 continued to assist with peri care and completed the task. After CNA #5 completed the task she placed a clean brief onto Resident #6 and placed pillows under and between her legs, and then removed her gloves and washed her hands.

On 1/29/19 at 9:53 AM, CNA #5 stated she forgot to complete hand hygiene after she assisted Resident #6 with peri care.

d. On 1/30/19 at 7:46 AM, CNA #3 was observed assisting Resident #10 with morning cares. CNA #3 cleaned Resident #10’s legs, arms, chest, and back with wipes and then assisted Resident #10 with sitting up. CNA #3 placed a clean shirt and clean pants up to Resident #10’s knees and rested an opened clean adult brief on the top of her pants. CNA #3 then stood Resident #10 up with the sit to stand, removed her soiled brief, and provided peri care. CNA #3 pulled up and fastened the clean brief, pulled Resident #10’s pants over the clean brief, and lowered her into her wheelchair. CNA #3 removed her gloves and washed her hands.

On 1/29/19 at 8:00 AM, CNA #3 stated she realized she did not change her gloves and perform hand hygiene after peri care was completed.

On 1/31/19 at 12:54 PM, the DNS stated staff should be washing their hands after removing gloves and the staff were educated constantly about this.

An audit of staff to ensure proper Hand washing and hand hygiene practices are being followed will be conducted weekly. We will complete 10 observations of staff weekly x 3 months.

The audit results will be reported to the Interdisciplinary Quality Committee monthly for review and approval.

Corrective Action #3:
Resident #9 catheter bag cover and tubing has been adjusted to ensure it is not on the floor.

Other residents that have the potential to be affected:
All residents with urinary catheters have the potential to be affected by this deficit.
No other residents with catheters residing here at this time.

Systemic Changes:
Staff education provided on proper catheter bag placement and management of tubing and bag to prevent it coming in contact with the floor.

Quality Monitoring:
An audit will be completed to ensure proper catheter bag and tubing placement 3 x weekly x 4 weeks, 2x weekly x 4 weeks then 1x weekly x 4 weeks.

Corrective Action #4:
Impervious gowns and protective face shields for sorting and handling laundry
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2. According the Centers for Disease Control and Prevention, Guidelines for Prevention of Catheter Associated Urinary tract infections, updated 2/15/17, states the urinary collection bag should not rest on the floor. This guideline was not followed. Examples include:

a. On 1/29/19 at 9:04 AM, Resident #9 was observed in the dining room, and he was stepping on his catheter tubing.

On 1/29/19 at 9:06 AM, CNA #4 was asked if Resident #9's catheter tubing should be on the floor and she stated no. CNA #4 was observed washing her hands, placing gloves on, and adjusting Resident #9's catheter tubing off the floor.

b. On 1/29/19 at 2:50 PM, Resident #9 was observed in bed and his catheter collection bag was inside a privacy bag and the privacy bag was resting on the floor.

On 1/29/19 at 3:01 PM, LPN #1 stated the catheter collection bag should be off the floor, and the privacy bag was permeable to germs. LPN #1 adjusted Resident #9's collection bag off the floor.

3. The facility's Environmental Services Department Laundry policy, reviewed 9/12/18, documented staff were to wear a gown and gloves when working in the sorting room and whenever handling soiled linen. The policy documented the clean linens should be covered. This policy was not followed. Examples include:

a. On 1/28/19 at 2:47 PM, CNA #2 was observed

were purchased, and received on 2/6/19. To protect all laundry staff while handling soiled laundry, the new policy and procedure is to wear impervious gowns and face shields at all times.

**Systemic Changes:**
All Environmental staff who work in the laundry area have been provided education on the policy and procedural changes of safe handling of soiled linen.

**Quality Monitoring:**
The Environmental Services manager will ensure a quality improvement study is conducted daily x 4 weeks, 3 x weekly x 4 weeks then weekly x 4 weeks. for to ensure staff remains in compliance. The study results will be reported to the Interdisciplinary Quality Committee monthly for review and approval.
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passing out clean clothes to different residents. The items were on two carts, one was a metal cart with shelves, and had the residents' names on the shelves, and one had hangers hanging from it. The cover for the metal cart was set on top of the cart and residents' undergarments were seen as the cart moved down the hall. The hanging cart's cover was thrown to the side and residents' clothes were seen as the cart moved down the hall.

On 1/28/19 at 3:00 PM, CNA #2 stated the laundry came from the laundry department covered and the staff uncovered it when it reached the floor, so residents' names could be seen.

b. On 1/31/19 at 2:25 PM, CNA #8 and CNA #9 were observed passing laundry with the covers off the carts. The DNS was present when the laundry was passed, and asked CNA #8 to please cover the undergarments with the covering. The covering on the metal cart was placed over the cart and the covering did not reach to the bottom of the cart, and half of the cart was still exposed. The DNS stated the cart needed a longer covering.

On 1/31/19 at 2:25 PM, the DNS stated the laundry should be covered for infection control reasons.

c. On 1/31/19 at 7:00 AM, Laundry Staff #1 stated when the staff sorted laundry in the dirty laundry room, they donned a protective jacket. The jacket used was a light weight porous material, not a moisture barrier type of material. Laundry Staff #1 stated the staff changed to a
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new jacket throughout the day, depending on the task, but always used the same type of jacket. She stated for example, the jacket was changed if residents' bowel movements were on linens. Laundry Staff #1 stated the jackets sometimes got wet. When they changed the jackets, they removed them and put them in with the laundry load and got a new jacket. Laundry Staff #1 stated she was responsible for sorting, washing, drying, and folding clothes. She stated she delivered the laundry to the floors. Laundry Staff #1 stated the staff did not normally wear goggles when sorting laundry, but they were available for use if they were needed.

On 1/30/19 at 7:30 AM, the Environmental Services Manager, stated the training she received was that the current jackets were the proper PPE (personal protective equipment) for laundry. She stated the laundry staff were to change jackets after every sort and the goggles were for when they worked with C-Diff. (Clostridium difficile, is a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon.)

On 1/31/19 at 11:31 AM, the Infection Control Preventionist stated the facility followed the Association for Professionals in Infection Control and Epidemiology (APIC) guidelines. She stated the guideline recommended wearing barrier gowns and safety glasses.

The 10/11/18 APIC Hygienically Clean Healthcare- Laundry Tour Planner for Healthcare Professionals guideline, posted on the APIC website on 10/11/18, documents employees should know what PPE was required in each
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function to guard against contamination and should be wearing barrier gowns, puncture resistant gloves, safety glasses/goggles, and face masks.

A document §1910.1030 Bloodborne pathogens, provided by the Infection Control Preventionist, which she said she had printed from the Centers for Medicaid and Medicare Website documented, PPE would be considered appropriate “only” if it did not permit blood or other potentially infectious material to pass through to or reach the employee's work clothes, skin, eyes, mouth, or other mucous membranes under normal conditions of use, and for the duration of time which the PPE would be used. The document was researched on the internet and found to be from the Occupation Safety and Health Association's Bloodborne Pathogens Standard (29 CFR 1910.1030), which prescribes safeguards to protect workers against health hazards related to bloodborne pathogens.