

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/04/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135128	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2020
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LEWISTON			STREET ADDRESS, CITY, STATE, ZIP CODE 325 WARNER DRIVE LEWISTON, ID 83501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 000	<p>Initial Comments</p> <p>A COVID-19 Focused Emergency Preparedness Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on May 5, 2020 at Life Care Center of Lewiston.</p> <p>The facility was found to be in substantial compliance with 42 CFR §483.73 related to E-0024 (b)(6).</p> <p>Facility Resident Census 54 . Resident sample 6</p> <p>The CMS Team: Barbara Dagg RN, Health and LSC surveyor Federal surveyors can be reached at: US Department of Health and Human Services Centers for Medicare and Medicaid Services 701 Fifth Avenue Suite 1600 Mailstop 400 Seattle, WA 98104 206.615.2313 206.615.2088 (Fax)</p>	E 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/18/2020

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/04/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135128	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/05/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LEWISTON	STREET ADDRESS, CITY, STATE, ZIP CODE 325 WARNER DRIVE LEWISTON, ID 83501
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	<p>INITIAL COMMENTS</p> <p>A COVID-19 Focused Infection Control Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on May 5, 2020 onsite at Life Care of Lewiston with record review completed on May 17, 2020.</p> <p>The facility was found to be in substantial compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.</p> <p>Facility Resident Census 54. Resident sample 6</p> <p>The CMS Team: Barbara Daggy RN, Health and LSC surveyor</p> <p>Federal surveyors can be reached at: US Department of Health and Human Services Centers for Medicare and Medicaid Services 701 Fifth Avenue Suite 1600 Mailstop 400 Seattle, WA 98104 206.615.2313 206.615.2088 (Fax)</p>	F 000		
F 880 SS=E	<p>Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§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</p>	F 880		7/23/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 06/18/2020
---	-------	--------------------------------

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/04/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135128	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2020
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LEWISTON			STREET ADDRESS, CITY, STATE, ZIP CODE 325 WARNER DRIVE LEWISTON, ID 83501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	<p>Continued From page 1 diseases and infections.</p> <p>§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:</p> <p>§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;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <ul style="list-style-type: none"> (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: <ul style="list-style-type: none"> (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under 	F 880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135128	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2020
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LEWISTON			STREET ADDRESS, CITY, STATE, ZIP CODE 325 WARNER DRIVE LEWISTON, ID 83501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	<p>Continued From page 2 the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to implement facility policy and procedures to ensure hand washing/hand hygiene between glove changes and use of PPE for transmission-based precautions in accordance with guidelines established by Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) for the prevention of COVID 19 transmission. These failures placed residents on two of four units at risk for exposure to COVID-19 and other communicable illness.</p> <p>Findings include:</p>	F 880	<p>F880 Corrective Action:</p> <ol style="list-style-type: none"> 1. Staff member was re-educated regarding Life Care Center of Lewiston policy on hand hygiene. 2. Staff member was re-educated on not breaching the separation for the 400 hall by opening the cross-corridor doors. 3. Staff member was re-educated on the need to have a barrier on the isolation cart to place items that need to be cleansed prior to use. 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135128	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2020
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LEWISTON			STREET ADDRESS, CITY, STATE, ZIP CODE 325 WARNER DRIVE LEWISTON, ID 83501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	<p>Continued From page 3</p> <p>During the entrance interview on 5/5/20 the facility Administrator and the DON (Director of Nursing) said the facility currently had an outbreak of COVID-19 infection and all residents were tested. The administrator said the 400 hall was now clear with all residents asymptomatic for 17 days. The transitional care 200 hall was empty. The 400 Hall was a secured special care unit primarily for care of residents with dementia and was COVID-free. The 400 hall had dedicated staff with a separate entrance and break room. The 300 hall was used as the isolation wing. The DON identified 16 residents on isolation droplet precautions and residents who have resolved COVID and are considered recovered on the 300 hall. The DON identified 4 residents on the 400 hall and 1 resident on the 100 hall who recovered. The DON said CDC (Centers for Disease Control and Prevention) now required 10 days after last symptom to be considered recovered but the facility waits 14 days. DON said most of the residents are nearing the end of the 14 days.</p> <p>On 5/5/20 at 10:30 AM during observation on the 100 hall housekeeper HK1 exited resident room 116, placed soiled cleaning cloths in a bag on the housekeeping cart and removed his/her gloves. Without washing hands or using alcohol based hand rub (ABHR), HK1 put on new gloves, prepared a mop and re-entered room 116 to mop the floor. HK1 wore a facemask.</p> <p>At 10:45 AM observation revealed HK1 exited resident room 113 wearing the facemask and gloves. HK1 placed the cleaning cloths in the bag then while wearing the same gloves,</p>	F 880	<p>4. Facility staff were directed and re-educated to follow CDC guidelines posted at the entrance to isolation rooms regarding proper donning and doffing of PPE.</p> <p>Identification of Others at Risk:</p> <p>All residents are at risk due to this unmet requirement.</p> <p>Systematic Changes:</p> <ol style="list-style-type: none"> 1. Facility staff were re-educated on hand hygiene, to include return demonstration competencies. 2. Facility staff were re-educated to not open cross-corridor doors and to utilize designated entrance/exit only. 3. Facility staff were re-educated on PPE, to include utilization of a barrier when needing to place contaminated items down prior to cleansing. 4. Facility staff were re-educated on donning and doffing of PPE, to include return demonstration competencies. <p>Ongoing Monitoring:</p> <ol style="list-style-type: none"> 1. DON/Designee will conduct observation audits to verify staff are performing hand hygiene according to Life Care Center of Lewiston policy. Audits will include: 7 staff members/week 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135128	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2020
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LEWISTON			STREET ADDRESS, CITY, STATE, ZIP CODE 325 WARNER DRIVE LEWISTON, ID 83501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	<p>Continued From page 4</p> <p>reached into his/her pocket to get the keys for the housekeeping cart. HK1 got clean cleaning cloths from the cart then removed his/her gloves. HK1 applied new gloves without first washing hands or using ABHR between glove changes.</p> <p>At 10:47 AM HK1 took a garbage bag to the trash bin on the housekeeping cart. HK1 refreshed the mop in the mop bucket and wrung the mop with the wringer device on the bucket then went back into room 113. At 10:55 AM HK1 exited the room. HK1 spoke briefly with surveyor then went directly to room 111 to clean. HK1 put on new gloves without hand washing or ABHR.</p> <p>When HK1 exited room 111 he/she agreed to an interview. HK1 said he/she worked at the facility for only one week. HK1 said he/she received orientation and instruction regarding the job requirements including infection control. HK1 said he/she changed the mop water after about every four rooms but had to change the mop water after every room if they were isolation rooms. HK1 1 was asked if he/she washed hands or did wearing gloves replace hand washing. HK1 responded "I do have this" and showed a small bottle of ABHR that was on the housekeeping cart. Surveyor asked HK1 when he/she would use the hand sanitizer and HK1 said "I am not a fan of the sanitizer, it dries out my hands. I prefer to wash my hands. When asked if hand hygiene was required between glove changes HK1 said yes it was but he/she preferred to wash his/her hands. Surveyor informed HK1 that he/she was not observed to wash hands and HK1 responded "I have not" and further stated as he/she pulled back a glove "I can still smell it on my hands. I do not care for the</p>	F 880	<p>x 4 weeks; 5 staff members/week x 4 weeks; 3 staff member/week x 4 weeks.</p> <p>2. DON/Designee will conduct observation audits to verify staff are not opening the closed cross-corridor doors. Audits will be completed 3 times/week across various shifts x 4 weeks; once weekly across various shifts x 2 months.</p> <p>3. DON/Designee will conduct observation audits to verify staff are utilizing a barrier when needing to place contaminated items down prior to cleansing. Audits will include: 7 staff members/week x 4 weeks; 5 staff members/week x 4 weeks; 3 staff member/week x 4 weeks.</p> <p>4. DON/Designee will conduct observation audits to verify staff are following proper donning doffing procedures of PPE. Audits will include: 7 staff members/week x 4 weeks; 5 staff members/week x 4 weeks; 3 staff member/week x 4 weeks.</p> <p>Results of these audits will be brought to the facility QAPI committee for a period of 3 months, or until a lesser frequency is deemed appropriate.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/04/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135128	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2020
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LEWISTON			STREET ADDRESS, CITY, STATE, ZIP CODE 325 WARNER DRIVE LEWISTON, ID 83501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	<p>Continued From page 5</p> <p>sanitizer gel." When informed HK1 was not observed to wash his /her hands, HK1 said he/she had not. When asked where he would wash his/her hands HK1 said any bathroom or the staff breakroom. HK1 said he/she took four breaks a day so HK1 said he/she washed hands about 20 times a day.</p> <p>On 5/5/20 at 1:00 PM The DON (Director of Nursing) was informed of the observations and interviews with HK1 and RCM1. DON said she knew HK1 was new to the job but completed facility and job orientation and was expected to wash hands or use ABHR whenever indicated. DON confirmed hand washing or use of ABHR was required between glove changes. The DON said measures to address the COVID-19 spread were communicated to all staff. DON said she could not explain RCM1's interview responses. DON said RCM1 and re-educate if needed.</p> <p>At 11:25 AM licensed nurse (LN1) screened surveyor for re-entrance to facility at the 400 unit. LN1 pointed out the ABHR and directed that a face mask must be worn at all times. The 400 hall (dementia unit) was separated from the rest of the facility by closed cross-corridor doors. At 11:35 AM a staff member walked through the doors from the 300 hall. Nursing assistant (NAC1) immediately followed the staff down the hall and checked her temperature. Surveyor interviewed the staff member who said she was the Resident Care Manager (RCM1). When asked if she came from the 300 hall, RCM1 said she did. RCM1 said she was RCM for part of 300 hall and for the 400 unit and her office was on the 300 hall. When asked if it was OK to breach the</p>	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/04/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135128	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2020
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LEWISTON			STREET ADDRESS, CITY, STATE, ZIP CODE 325 WARNER DRIVE LEWISTON, ID 83501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	<p>Continued From page 6</p> <p>separation for the 400 unit by opening the cross-corridor doors, RCM1 said "I probably should have gone around to the courtyard entrance. RCM1 further said "It has just not been made clear what is expected." RCM1 said she wore a mask and did not routinely do direct care and wore PPE when she did.</p> <p>NAC1 said anyone who came onto the 400 unit from the 300 unit should put on a gown. NAC1 said the 400 unit was COVID-free.</p> <p>Observed care on 5/5/20 at 4:20 PM outside room 307 had signage indicating droplet precautions: facemask, eye protection, gown and gloves. Two signs posted inside the room indicated droplet precautions and enhanced barrier precautions. For enhanced barrier precautions staff must also wear gloves and a gown for the following high-contact resident care activities; dressing, bathing, transfers, and linen changes. The order to don (put on) was posted: gown, mask, goggles, gloves and to doff (remove) gloves, goggles, gown, and finally the facemask. A gown hung on a hook in the room labeled NAC.</p> <p>NAC2 put a surgical face mask on over the mask she already wore. Next NAC2 donned a gown. RCM2 brought goggles and face shields to the unit. NAC2 donned the face shield and finally gloves then entered the room 307. When NAC2 exited the room, she removed the outer mask and face shield, then the gown, and finally the gloves. NAC2 hung the gown in the room on top of the gown that hung on the hook and finally removed the gloves. Surveyor questioned and RCM2 cued NAC2 to discard both gowns in the</p>	F 880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135128	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2020
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LEWISTON			STREET ADDRESS, CITY, STATE, ZIP CODE 325 WARNER DRIVE LEWISTON, ID 83501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	<p>Continued From page 7</p> <p>room and directed staff to remove any gowns hanging in the rooms at the beginning of their shift to start with a clean gown. RCM2 explained that she was on the unit watching the staff to ensure compliance with transmission-based precautions (isolation/precautions) because the facility had new staff and had known COVID positive residents were recovering on the unit.</p> <p>At 5:00 PM on 5/5/20 observation revealed two isolation carts between resident rooms 115 and 117. As NAC2 doffed PPE to exit room 117 NAC2 removed the face shield and placed it in top of an open box of gloves on top of the isolation cart. NAC3 was preparing to enter the room next door and asked NAC2 if she was done with it (referring to the face shield). Nac2 said yes she was finished with it. When surveyor asked if it was sanitized, NAC2 said no it was not. NAC2 said she did not know NAC3 planned to use the face shield right at that time before she sanitized it. When asked where the face shield should be stored while awaiting sanitization, NAC2 said she should have placed a barrier on top of the cart first. NAC2 said she thought she contaminated the gloves too. NAC2 consulted RCM2 who directed to discard the opened box of gloves. NAC3 was observed to don gloves first then face shield and gown. When asked about the order to don PPE NAC3 said last week the corporate nurse instructed staff to don gloves first.</p> <p>In an interview at 5:15 PM on 5/5/20 the facility Infection Preventionist (IP) confirmed the prior week, the corporate nurse gave contradictory and confusing instruction to the staff regarding donning and doffing PPE. IP said staff should</p>	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/04/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135128	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2020
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LEWISTON			STREET ADDRESS, CITY, STATE, ZIP CODE 325 WARNER DRIVE LEWISTON, ID 83501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	Continued From page 8 don and doff PPE according to the posted instructions. IP said the posted instructions were consistent with the current CDC guidelines. At 5:25 PM the DON concurred with IP and told IP to direct staff to follow the instructions posted by the facility to don and doff PPE.	F 880			