STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135140	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MADISON CARRIAGE COVE SHORT STAY REHABILITATION	**410 WEST 1ST NORTH REXBURG, ID 83440**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** Based on observation, policy review, nationally recognized standards of practice, review of staff screening logs and timesheets, and staff interview, it was determined the facility failed to ensure infection control prevention practices were consistently implemented and maintained to provide a safe and sanitary environment. This failure created the potential for negative outcomes by exposing residents to the risk of infection and cross-contamination including COVID-19. Findings include: 1. The facility's policy for COVID-19 Reporting, dated 5/8/20, documented staff screening logs were reviewed daily by the IP or designee. The data was analyzed from triggers that warranted reporting, such as new-onset respiratory symptoms, suspected/confirmed COVID-19, or severe respiratory infection resulting in hospitalization or death. The facility's Employee Work Restrictions-Infectious Diseases policy, dated 8/15/19, documented employees were responsible to report the presence of any communicable or infectious disease to his or her supervisor. The facility's employee screening logs and timesheets for 6/15/20 through 6/24/20 were reviewed. The employee screening logs were not signed by the IP or designee prior to 6/25/20. On 6/24/20 at 11:25 AM, RN #2 said when she arrived at work, she checked her temperature and signed in. RN #2 said there was no one at the screening station that asked them questions and she did not fill out a screening log. On 6/24/20 at 11:30 AM, CNA #3 said when she arrived for work she waited for someone to open the door, a nurse checked her temperature, then she wrote it down and signed it. CNA #3 said there was an employee screening log that contained questions, and she checked off yes or no for each question. CNA #3 said the DON looked at the screening logs, but she did not know when he looked at them. On 6/24/20 at 11:43 AM, Housekeeper #1 said when she came to work she performed hand hygiene, put on a face mask, then the person behind the front desk took her temperature. Housekeeper #1 said she then answered yes or no questions and signed the screening log. She said if she did not feel good she informed her boss of her symptoms via text. She said she clocked in at the front desk on a computer and then went to the laundry room to start her shift. On 6/24/20 at 11:55 AM, RN #1 said when she came to work she got a face mask, had her temperature taken, completed the screening log questions, clocked in, and went to the nursing station. She said all staff arrived at the same time and took each other's temperature. She said there was no one at the desk when they arrived. She said the DON checked the screening logs. On 6/24/20 at 12:28 PM, Housekeeper #2 said a co-worker checked her temperature when she arrived for work, and she answered the questions on the screening log. Housekeeper #2 said no one asked her the screening questions when she arrived for work. On 6/24/20 at 12:30 PM, the Social Services Intern said when she arrived for work, staff members usually checked each other's temperature, and there was a sheet they signed. On 6/24/20 at 1:54 PM, the Social Worker (SW) said she entered the building, sanitized her hands, donned a face mask, found someone to take her temperature, signed and answered questions on the screening log, and then went to work in her office. She said if she had symptoms she would call in to the facility. On 6/24/20 at 2:10 PM, the Activities Assistant Intern said when she arrived at the facility, someone checked her temperature, then she opened the screening log book to the page where she previously answered the questions and signed to indicate the answers were the same. On 6/24/20 at 2:47 PM, the IP with the DON present, said the facility's staff were screened prior to their shift in the following manner: Staff entered the front door, sanitized their hands, put on a face mask, and had their temperature checked. Staff then wrote their temperature on the screening log and signed it. The IP said there was a questionnaire, and if any questions were answered yes or if the staff member had a fever, it would be brought to her attention by that staff member. The IP said if a question was answered yes, the screening partner held them accountable. She said the employees were to have a coworker screen them. The IP said she glanced through the screening log daily when she wrote in her name on the screening log. The DON said he reviewed the employee screening logs in a similar fashion. The IP said in the evenings the facility was more likely to have a receptionist at the desk. The IP said there was no receptionist at the front desk when staff arrived at 6:00 AM, so the staff screened each other. On 6/24/20 at 3:30 PM, the Administrator said employees were screened in the following manner: Staff entered the building, sanitized their hands, and had their temperature checked. The Administrator said there was an initial screening questionnaire staff completed, then they signed the screening log, indicating their prior answers were still the same. The Administrator said the person who checked the staff member's temperature notified the appropriate person if the staff member had a fever. The Administrator said that during off hours staff were screened by calling the nurse to come and check their temperature. The Administrator said the IP reviewed the employee screening logs, but he did not know when she reviewed them. The Administrator said he did spot checks of the employee screening logs, which he recorded in his own notebook. 2. The facility placed residents who were newly admitted under isolation precautions for 14 days to observe for potential signs and/or symptoms of COVID-19. These precautions included staff use of a cloth gown, eye protection, face mask, and gloves when entering the resident's room. On 6/24/20 at 11:12 AM, RN #1 stated the residents were on droplet precautions for two weeks when they were admitted to the facility. She stated staff wore goggles, gloves, gown, and a face mask when entering the newly admitted residents' rooms. On 6/24/20 at 11:29 AM, CNA #3 stated residents were on quarantine because they were in the facility for less than two weeks. She stated she was supposed to wear goggles, gloves, a face mask, and a gown when entering the residents' rooms. The facility provided documentation of training and competency verification of staff regarding donning (putting on) and doffing (taking off) of PPE. The training was from the CDC which included a step for removing a gown which stated Untie all ties (or unsnap all buttons). Some gown ties can be broken rather than untied. Do so in gentle manner, avoiding a forceful movement. Reach up to the shoulders and carefully pull gown down and away from the body. On 6/24/20 at 11:55 AM, RN #1 took goggles and gloves out of a set of plastic drawers outside Resident #4's door and entered the room before putting on PPE. When RN #1 came out of the room she did not have gloves or a gown on. When asked about her PPE, RN #1 said she went in the room and there were three gowns hanging on the wall inside Resident #4's door. RN #1 said she put on one of the gowns, then gloves and goggles. She said there were three reusable gowns hanging in the room only because sometimes more than one person goes in to help the resident. On 6/24/20 at 12:06 PM, CNA #4 entered Resident #2's room. Two yellow cloth gowns, with ties to secure the gowns in the back, were hanging on separate hooks in the room. CNA #4 put on one of the gowns without untying it by pulling it over her head. CNA #4 then put on goggles, performed hand hygiene, and put on gloves. CNA #4 delivered a meal tray to Resident #2 in his room then removed her gloves, removed the gown without untying it by pulling it over her head, and hung the gown back on the same hook. She then exited the room, removed her goggles and cleaned them with a disinfectant wipe, placed the goggles in the top drawer of the isolation cart outside the room, removed her face mask, sanitized her hands, and applied a new face mask. CNA #4 said the yellow cloth gowns were reusable, and staff took them to the laundry at the end of their shift. CNA #4 said the gowns were worn by anyone who came into the room, and after use the gown was hung back up on the hook. On 6/24/20 at 12:07 PM, the Administrator assisted with lunch tray distribution. He went into Resident #5's room and when handed the lunch tray he was wearing a yellow cloth gown, gloves, face mask, and goggles. After taking the lunch tray to Resident #5, he returned to the doorway and removed the gown by pulling it over his head without untying it, by the collar and turning it inside out. He hung the gown on a hook on the wall inside the room by Resident #5's door, next to another gown. On 6/24/20 at 12:17 PM, RN

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135140	A. BUILDING _____ B. WING _____	**06/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MADISON CARRIAGE COVE SHORT STAY REHABILITATION	**410 WEST 1ST NORTH REXBURG, ID 83440**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) #2 exited Resident #3's room. Two yellow cloth gowns were hanging on separate hooks in the room. RN #2 said she thought the yellow gowns were washed once a day, but she was not sure. RN #2 said other staff could use the same gowns when they went into the room. The CDC website, accessed on 6/30/20, documented the following on re-use of cloth isolation gowns In a situation where the gown is being used as part of standard precautions to protect HCP (healthcare personnel) from a splash, the risk of re-using a non-visibly soiled cloth isolation gown may be lower. However, for care of patients with suspected or confirmed COVID-19, HCP risk from re-use of cloth isolation gowns without laundering among (1) single HCP caring for multiple patients using one gown or (2) among multiple HCP sharing one gown is unclear. The goal of this strategy is to minimize exposures to HCP and not necessarily prevent transmission between patients. The facility also provided a document CDC/CMMS Recommendations, undated, which stated certain textile types of reusable gowns can be safely laundered according to routine procedures and reused, and Care should be taken to ensure that HCP do not touch outer surfaces of the gown during care. The document stated Laundry operations and personnel may need to be augmented to facilitate additional washing loads and cycles. The document also stated gowns should be prioritized for use during care activities where splashes and sprays are anticipated and during high-contact patient care activities which provide opportunities for cross-contamination of pathogens to the hands and clothing of healthcare providers. On 6/24/20 at 2:47 PM, the IP, with the DON present, said the facility used reusable cloth gowns for residents who were placed on droplet precautions due to their new admission status. The IP said droplet precautions required donning eye protection, face masks, gloves, and gowns. The IP said the gowns were changed out when linen changes were done, which was at least twice per week, or when the gown became soiled. The IP said the gowns were used by different staff for the same resident. The DON said the gowns were good for 75 washes, and laundry staff kept track of how many times the gowns were washed. The DON said if the resident had symptoms, then the staff would use disposable gowns. 3. The facility's policy for hand hygiene, dated 8/15/19, documented all staff performed proper hand hygiene to prevent the spread of infection. The policy directed staff to perform hand hygiene immediately after removing gloves. On 6/24/20 at 11:46 AM, Housekeeper #2 exited Resident #1's room and disposed of used cleaning rags into a plastic bag. Housekeeper #2 removed her gloves, did not perform hand hygiene, obtained the vacuum cleaner, and entered Resident #1's room with the vacuum cleaner and began vacuuming the floor. Housekeeper #2 touched several items in Resident #1's room with her bare hands, including a blanket on the foot of the bed and a large stuffed animal on the floor. Housekeeper #2 then picked up a water bottle from Resident #1's bedside table, using her bare hands, and handed the water bottle to Resident #1. Housekeeper #2 then touched Resident #1's bedside table with both of her hands and moved the table closer to Resident #1. Housekeeper #2 did not perform had hygiene before and after touching multiple items in Resident #1's room. On 6/24/20 at 11:50 AM, Housekeeper #2 said she should sanitize her hands when entering a resident's room, when exiting the room, and she should wash her hands when going into the biohazard room. Housekeeper #2 said after removing gloves, she should throw the gloves away and sanitize her hands for 30 seconds. Housekeeper #2 said she did not sanitize her hands after she removed her gloves and touched multiple items in Resident #1's room. On 6/24/20 at 2:47 PM, the IP said hand hygiene should be performed after removing gloves.