STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135064	A. BUILDING _____ B. WING _____	**07/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRYSIDE CARE & REHABILITATION	**1224 EIGHTH STREET RUPERT, ID 83350**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, review of staff schedules and screening logs, and staff interview, it was determined the facility failed to ensure infection control prevention practices were 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 Coronavirus Surveillance, undated, documented visitors and staff were screened for the following: a) signs and symptoms of a respiratory infection (fever, cough, shortness of breath, or sore throat) b) whether there was contact in the past 14 days with someone who had confirmed COVID-19, was under investigation for COVID-19, or was ill with a respiratory illness c) international travel to countries with sustained community transmission of COVID-19 d) residing in a community where community-based spread of COVID-19 was occurring. The policy stated staff who had signs and symptoms of a respiratory infection would not report to work. The facility's Staff Screening Tool included 3 screening questions which included: * Contact with someone in the past 14 days who had a confirmed [DIAGNOSES REDACTED]. * Current signs of respiratory infection (fever, cough, shortness of breath, sore throat, loss of taste of smell, myalgia (muscle aches), or nausea and vomiting. * Traveled internationally in the past 14 days or had contact with persons who had travelled internationally. The Staff Screening Tool also contained a column to document the staff member's temperature, a column for initials, and a signature/date line at the end of the page for a nurse to sign the form. The facility's as-worked schedule and Staff Screening Tools, dated 6/29/20 through 7/6/20, were reviewed for all employees of the facility. There were inconsistencies between the as-worked schedule and the Staff Screening Tool. Examples include: a. The following staff were not screened prior to working their shift: * The screening tool and schedule, dated 6/29/20, did not include screening for 3 CNAs, 1 LPN, and the Administrator. * The screening tool and schedule, dated 6/30/20, did not include screening for 6 CNAs, 2 LPNs, 1 RN, the Administrator, the DON, the IP, and the Social Worker. * The screening tool and schedule, dated 7/1/20, did not include screening for 7 CNAs, 2 LPNs, 1 RN, the Administrator, and the IP. * The screening tool and schedule, dated 7/2/20, did not include screening for 4 CNAs, 2 RNs, 1 LPN, the Administrator, and the IP. * The screening tool and schedule, dated 7/4/20, did not include screening for 1 RN and 1 CNA. * The screening tool and schedule, dated 7/5/20, did not include screening for 1 RN. * The screening tool and schedule, dated 7/6/20, did not include screening for 1 CNA. b. The Staff Screening Tool had an area for staff to write their name. The Staff Screening Tools were reviewed from 6/29/20 to 7/6/20 and there were entries without a staff name, as follows: * One entry missing a staff name on 6/30/20, 7/3/20, 7/5/20, and 7/6/20 * Four entries missing a staff name on 7/2/20 c. The facility's policy for COVID-19 reporting, undated, documented staff screening logs and resident symptom logs were reviewed daily by the IP, or designee. The policy stated the data was reviewed for items that required reporting such as new-onset of respiratory symptoms, suspected/confirmed COVID-19, or a severe respiratory infection that resulted in hospitalization or death. The Staff Screening Tool, at the bottom of the form, had a line for the nurse signature and date it was signed. The Staff Screening Tool was not signed by the IP or a designee for each shift on 6/30/20, 7/1/20, 7/2/20, 7/3/20, 7/5/20, and 7/6/20. On 7/6/20 at 2:34 PM, the Physician was observed in Resident #1's room. The Physician was wearing a face mask and was conversing with Resident #1. After several minutes, the Physician exited the room. The Physician said he performed hand hygiene and donned a mask when entering the facility. He said the facility used to do temperature checks and ask screening questions, but he did not think they were doing that anymore. The Physician said he snuck in without being screened on that day. On 7/6/20 at 3:55 PM, CNA #5 said when she came to work she checked her temperature, showed it to the nurse, and wrote it in the Staff Screening Tool, which was in the employee break room. CNA #5 said she wrote down her temperature and the nurse made sure the staff signed their temperature. On 7/6/20 at 4:00 PM, the Ward Clerk said when she came to work she took her temperature and the nurse witnessed her temperature and initialed it. On 7/6/20 at 4:02 PM, LPN #1 said when he arrived for work he went straight to the break room and checked his temperature, the temperature was verified by another nurse, and there was a binder where the Staff Screening Tool forms were kept. LPN #1 said he and the other nurse for that shift looked at the screening logs prior to getting shift report and going to the resident care area. On 7/6/20 at 4:03 PM, CNA #1 said when she started her shifts, she donned a mask, went to the break room and an RN took her temperature and asked questions related to COVID-19 risk factors and wrote down the answers. CNA #1 said if she had symptoms she would call the CNA Supervisor, or the LPN, and they would find coverage for her shift. On 7/6/20 at 4:15 PM, Activities Aide #1 said at the start of her shift she went into the building with her mask on, went to the breakroom and clocked in, then went to the East Unit RN station where an RN took her temperature. She said she then washed her hands and started her duties. On 7/6/20 at 4:28 PM, CNA #2 said at the start of her shift she went to the breakroom where the RN took her temperature and asked questions related to COVID-19 risk factors. CNA #2 said she signed her own name to the Staff Screening Tool, the RN showed her the temperature reading and she, CNA #2, wrote it down and the RN initialed it. CNA #2 said she then began her duties. On 7/7/20 at 8:38 AM, Housekeeping Staff #1 said she entered the facility door near the laundry room west of the West Unit. She said the Housekeeping Supervisor took her temperature and watched while Housekeeping Staff #1 filled out the Staff Screening Tool, and if she did not have a fever she started her work day. She said if she felt sick at work she would tell her supervisor who would take her temperature. On 7/7/20 at 9:15 AM, LPN #2 said when she came to work she checked her temperature and the charge nurse verified it. LPN #2 said after her temperature was checked she was asked the screening questions. LPN #2 said the screening was done in the break room. On 7/7/20 at 9:50 AM, the IP said staff were screened after they entered the building through the back door and went to the break room. The IP said the staff had their temperature checked, it was verified by a nurse, and they were asked screening questions. The IP said the nurse verified the staff's screening by initialing the log, and she looked at the employee screenings when she arrived in the morning. The IP said the DON also keeps on top of it. The IP said she did not sign the Staff Screening Tool, and she should be notified if an employee had a temperature of greater than 100 degrees or if they answered yes to any of the screening questions. The IP said the Physician should go through the same process when he entered the building. On 7/8/20 at 10:24 AM, Prep Cook #1 said he entered the facility door near the laundry room west of the West Unit with a mask on. He said he went into the kitchen office, the kitchen supervisor took his temperature, and the same was done with vendors. Prep Cook #1 provided the Employee Screening Criteria log which included dates, employee names and departments, the temperatures taken, and the initials of the person taking the temperatures. 50% of the initials were observed missing from the log. Prep Cook #1 said if no one was in the office they asked the staff to screen their own temperature. Prep Cook #1 said no questions were asked regarding symptoms, and if they were not feeling well they did not work. He said the Director of Kitchen Operations was responsible for overseeing the kitchen staff screening process. On 7/7/20 at 10:25 AM, the DON said when staff arrived, they were to check their temperature, and have it verified, and they were to answer the screening questions. The DON said if any of the screening questions were answered yes or if the temperature was 100.4 or greater, the staff was sent home. The DON said most staff entered the building by the break room and were screened in the break room. The DON said the charge nurse

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 -** Many	(continued... from page 1) usually looked at the staff screening logs, and she had not personally reviewed them for quality assurance in a couple of weeks. The DON said it was up to the nurse working on the floor to ensure each staff had no symptoms of COVID-19 prior to entering the resident care area. The DON said some staff entered the building through the fireplace room, and sometimes the screening was done in the break room and sometimes it was done at the nurse's station. The DON said she realized the staff screening logs were missing signatures, and she did look at some of them, but it was usually the charge nurse who signed the logs. The DON also said she expected the Physician to follow the same precautions regarding COVID-19 and to be screened at the nurse's station. On 7/8/20 at 10:25 AM, when asked who was responsible to oversee the screening process of employees, the IP said either herself or the DON was helping her. The IP said the screening log book was close to the DON, so the DON checked on it. The IP said she was informed by the DON if there was missing information on the screening logs. On 7/8/20 at 10:38 AM, the Director of Kitchen Operations said she oversaw the kitchen screenings. She said the kitchen supervisor made a list of scheduled staff every morning before they started their shift. The Director of Kitchen Operations said she checked the temperatures every day and made sure they were not over the temperature limit. She said if their temperature was high, they contacted the IP in the (attached) hospital. She said she did not document that she looked at them. 2. The facility's policy Novel Coronavirus Prevention and Response, undated, stated to promote the easy and correct use of PPE by staff, signs were to be posted on the door or wall outside of the resident's room which clearly described the type of precautions needed and the required PPE. On 7/6/20 at 2:45 PM, carts or trays which contained PPE were placed outside the rooms of Resident #1, Resident #2, Resident #3, and Resident #4. There were no signs posted outside the residents' rooms which stated what precautions they were under or which PPE staff were required to wear prior to entering those rooms. On 7/6/20 at 3:06 PM, LPN #1 said Resident #1, Resident #2, Resident #3, and Resident #4 were on droplet precautions due to being on quarantine for 14 days per the facility's admission protocol. LPN #1 said prior to entering the room, staff should put on a new mask, a gown, gloves, and eye protection. On 7/6/20 at 4:30 PM, the IP said Resident #1, Resident #2, Resident #3, and Resident #4 were on droplet precautions, and staff were to wear the indicated PPE each time they entered the room. The IP said there were no signs posted near the residents' door which stated what kind of precautions or what PPE were required for staff to wear before entering the room. She stated there were no signs because she thought this was a potential dignity/privacy issue. 3. The facility's policy for Handling Clean Linen, undated, documented clean linens were transported by a method to ensure cleanliness and protection from dust and soil during intra-facility loading, transport and unloading. This included placing clean linen in a properly cleaned cart and covering the cart with disposable material or a properly cleaned textile material that could be secured to the cart. a. On 7/6/20 at 2:32 PM, CNA #2 was pushing a cart 48 inches tall, 18 inches wide, and 32 inches long with a blue vinyl cover from top to bottom. Linens were on shelves inside the covering and linens were placed on top of the cart with a sheet covering them. The cover had a 15-inch by 15-inch L-shaped cut or rip in the side on the front of the cart and the flap was hanging open exposing linens. CNA #2 said the linens must be covered. On 7/6/20 at 2:47 PM, CNA #2 was observed with a different linen cart that was the same size as the previous cart and had a different cover. This cover had a 6-inch rip along the seam on the upper side of the cart exposing linens down the side of the cart. On 7/7/20 at 10:20 AM, the DON said the linen cart was to be covered before walking it down the hall. b. On 7/6/20 at 3:04 PM, a laundry cart with residents' personal laundry was placed at the intersection of the East Unit and cross hallway near the East Unit nurses' station. The laundry was covered. CNA #8 unzipped the two side zippers of the cover and lifted the front of the cover and tossed it on top of the cart exposing residents' personal laundry, which was hanging and folded on the shelves below. CNA #1 removed clothing from the cart and delivered it to room [ROOM NUMBER] at the end of the East Unit hall. CNA #2 then removed clothing from the cart and walked it to room [ROOM NUMBER] at the other end of the East Unit hall. This was repeated until all the laundry was delivered. The laundry was exposed until the delivery was completed by CNA #1 and CNA #2. On 7/7/20 at 9:04 AM, the acting CNA Supervisor said staff were to take one set of clothing, close the cart cover, and then take the clothing to the resident's room. She said the CNAs should not take more than one or two sets of resident's personal laundry at a time to prevent cross-contamination by leaving it open. She said the CNAs could either take the cart down the hall to deliver laundry to each room or leave it in one place and the cover must always be closed.