STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135081	A. BUILDING _____ B. WING _____	**07/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MINI-CASSIA CARE CENTER	**1729 MILLER AVENUE BURLEY, ID 83318**

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, nationally recognized professional standards of practice, 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 Novel Coronavirus (COVID-19) Control Plan, updated 5/7/20, documented residents, employees, and visitors were screened for symptoms of acute respiratory illness such as fever, cough, and difficulty breathing before they entered the facility. The facility's CDC Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19, dated 5/8/20, stated All HCP (including ancillary staff such as dietary and housekeeping and consultant personnel) are screened at the beginning of their shift for fever and symptoms of COVID-19 (actively records their temperature and documents they do not have fever, new or worsening cough, difficulty breathing, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell). The CDC website, accessed on 7/10/20, under Symptoms of Coronavirus, updated 5/13/20, stated people with COVID-19 have had a wide range of symptoms reported, ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to [MEDICAL CONDITION]. The website also stated people with the following symptoms may have COVID-19: * Fever or chills * Cough * Shortness of breath or difficulty of breathing * Fatigue * Muscle or body aches * Headache * New loss of taste or smell * Sore throat * Congestion or runny nose * Nausea or vomiting * Diarrhea. The facility did not screen HCP for all symptoms of COVID-19. On 7/8/20 at 10:17 AM, two surveyors were screened at the back entrance to the South Hall by CNA #2 before entering the facility. CNA #2 asked the surveyors if they had a fever, cough, sore throat, or shortness of breath. CNA #2 also asked the surveyors where they had been before coming to the facility. CNA #2 then checked the surveyors' temperatures and they were allowed to enter the facility. The facility's COVID-19 Staff Screening Tool included the following symptoms: * Fever * Cough * Sore Throat * Shortness of Breath The Screening Tool also included an area to document the employee's temperature. If the temperature was above 100, the tool stated, Access to the facility may be restricted. On 7/9/20 at 10:47 AM, the DON said when staff were screened for signs and symptoms of COVID -19, they were asked if they had a cough, shortness of breath, sore throat, or a fever, and their temperatures were checked before they entered the facility. The DON said the facility's screening form was last updated on 4/28/20. When asked if the staff and residents should be asked for other signs and symptoms of COVID-19 that were described on the CDC website, updated on 5/7/20, such as headache, body aches, diarrhea, and new loss of taste or smell, the DON said if the CDC had updated the signs and symptoms of COVID-19 then they should also ask their staff and residents about those signs and symptoms. 2. The facility's PPE and Hand Hygiene policies, revised September 2014, directed staff to use gloves when cleaning potentially contaminated items and to perform hand hygiene after removing gloves. The facility's Cleaning and Disinfection of Environmental Surfaces policy, revised September 2014, directed staff to use disinfectants according to the label's directions. The Virex II 256 disinfectant cleaner directions for cleaning and disinfecting hard nonporous surfaces stated to allow the surface to remain wet for 10 minutes and then wipe or allow to air dry. These policies and directions were not followed. a. On 7/8/20 from 10:30 AM to 11:06 AM, Housekeeper #1 was observed cleaning three dining rooms and the nurses' station in the North section of the facility. At 10:30 AM, Housekeeper #1 had on gloves and was in the dining room next to room [ROOM NUMBER] (Dining room [ROOM NUMBER]). She mopped the floor with a Velcro type mop and removed the mop cleaning pad, placed the pad in a dirty linen bag on her cart, took off her gloves, and did not perform hand hygiene. At 10:32 AM, Housekeeper #1 pushed her cart to the dining room across from the Resident Service Director's office (Dining room [ROOM NUMBER]). She put on new gloves and opened a locked compartment of the cart and retrieved the Virex disinfectant. She then sprayed the cleaner on two tables with vinyl table cloths and immediately wiped the tables off with a clean dry rag. Both surfaces appeared dry after she wiped the table cloths. She then dry mopped and swept the dining room floor. Housekeeper #1 then wrung out a wet mop pad, mopped the dining room floor and placed the pad in a dirty linen bag on her cart. After completing these tasks she took off her gloves and performed hand hygiene. At 10:40 AM, Housekeeper #1 moved her cart to the adjacent dining room which was next to the door that led to the outside smoking area (Dining room [ROOM NUMBER]). She placed a wet floor sign near Dining room [ROOM NUMBER]. She then put on new gloves without performing hand hygiene and opened the locked compartment of the cart and retrieved the Virex disinfectant. She sprayed and immediately wiped down four tables in Dining room [ROOM NUMBER]. After wiping the tables, the surfaces appeared to stay wet for 30 seconds before they dried. Housekeeper #1 placed the Virex disinfectant in the cart and disposed of the rag in the dirty linen bag. She then dry mopped and swept the dining room floor. Housekeeper #1 collected and disposed of a bag of trash from the dining room. She next wrung out a wet mop pad, mopped the dining room floor and placed the pad in a dirty linen bag on her cart. Housekeeper #1 then placed a dry mop pad on the mop and took off her gloves without performing hand hygiene. With her bare hands she mopped the floor with the dry mop pad, disposed of the mop pad and performed hand hygiene. Housekeeper #1 then placed a wet floor sign at the entrance of Dining room [ROOM NUMBER] and removed the wet floor sign from Dining room [ROOM NUMBER]. Housekeeper #1 opened the locked compartment of the cart, put on new gloves and retrieved the Virex disinfectant and a new dry rag. She sprayed the dry rag first and wiped down the counter in the North hallway nurses' station. The counter appeared to stay wet for five seconds before it dried. She then sprayed the rag and wiped down areas in the nurses' station including the hand sanitizer dispenser, paper towel holder, the employee bathroom door handles, the bathroom sink, and the toilet lid. She placed the Virex disinfectant in the cart and disposed of the rag, took off her gloves, and performed hand hygiene. On 7/8/20 at 11:50 AM, Housekeeper #1 said she was supposed to perform hand hygiene after removing her gloves and she did not. Housekeeper #1 said she was supposed to spray surfaces first and then wipe them down. She said she might have sprayed the rag instead of spraying the surfaces when she cleaned the nurses' station. b. On 7/8/20 at 2:10 PM, Resident #3's door had Contact and Droplet Precaution signs outside her door. Housekeeper #1 had on a facemask and was outside of Resident #3's room where she put on a gown, goggles and gloves before going into the room. Housekeeper #1 went into the room with Virex disinfectant and a clean dry rag. She sprayed Resident #3's bedside table top with the spray and immediately wiped it with the rag. The surface appeared dry after she wiped it off. On 7/8/20 at 2:20 PM, Housekeeper #1 said she sprayed the bedside table and immediately wiped it off with the rag. On 7/9/20 at 10:20 AM, the ICP said housekeeping staff were to perform hand hygiene after taking off their gloves. She said Housekeeper #1 did not perform appropriate hand hygiene several times during the observation. The ICP said she expected staff to know contact times for disinfectants and to follow those directions. She said Housekeeper #1 did not follow the 10 minute contact time for the Virex II 256 disinfectant cleaner spray. 3. The facility's Novel Coronavirus (COVID-19) Control Plan for residents with exposure to Coronavirus, updated 5/7/20, directed staff to wear appropriate personal protective equipment (PPE) including gloves, a gown, facemask, and eye protection when caring for the resident. This policy was not followed. On 7/8/20 at 2:20 PM, Resident #1's call light was turned on. NA #1 walked toward Resident #1's room. Resident #1's room had Contact and Droplet Precaution signs outside his door directing staff to put on a gown, gloves, facemask, and goggles or faceshield

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) before entering his room. Instructions directing staff how to put on and take off PPE and the PPE cart were also outside Resident #1's room. NA #1 was wearing a facemask and entered Resident #1's room. NA #1 did not put on a gown, gloves, goggles or a faceshield when she entered Resident #1's room. At 2:23 PM, NA #1 exited Resident #1's room and took a gown, gloves, and faceshield from the PPE cart and put them on. On 7/8/20 at 2:30 PM, NA #1 said she entered Resident #1's room without wearing a gown, gloves, and a faceshield. NA #1 said when she realized she was not wearing a gown she exited Resident #1's room and took a gown, gloves and faceshield from his PPE cart outside his door and put them on and went back into Resident #1's room. On 7/9/20 at 10:25 AM, the ICP said staff were expected to wear PPE when they entered a resident's room when they were under Contact and Droplet Precautions. 4. The facility's COVID-19 Staff Screening Tool, undated, directed staff not to shake hands, and not to touch or hug individuals in the facility. This was not followed. On 7/8/20 at 11:07 AM, the Infection Control Preventionist (ICP) was wearing a facemask and hugged Resident #2 who was also wearing a facemask and was sitting in her wheelchair in the South Hall by the nurses' station. Resident #2 hugged the ICP back. On 7/8/20 at 1:47 PM, CNA #1 was wearing a facemask and walked towards the nurses' station and greeted Resident #2 and put her left arm around Resident #2. On 7/8/20 at 2:55 PM, CNA #2 said she gave Resident #2 a hug because she reminded her of her mother. On 7/8/20 at 3:04 PM, the ICP said she greeted Resident #2 when she saw her earlier and gave her a hug. The ICP said she usually hugged Resident #2 because Resident #2 opened her arms when she saw her. The ICP said it was an emotional support for Resident #2. On 7/8/20 at 10:47 AM, the DON said it was not a good practice to hug residents in the facility especially during this time when COVID-19 was spreading in the community.