STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135092	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOOD SAMARITAN SOCIETY - IDAHO FALLS VILLAGE	840 EAST ELVA STREET IDAHO FALLS, ID 83401

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 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview, and record review, the facility failed to distribute and serve food in accordance with professional standards for food service safety when 1 of 3 dietary staff failed to wear a hairnet when in the kitchen during a meal service. This failure placed the residents at risk of food-borne illness. Findings include: The facility's policy, Employee Hygiene and Dress Code dated 7/1/2018 indicated under the Hairnets section that Hairnets or hair restraints and beard nets or beard restraints are used: a. When in the food preparation kitchen including the dish rooms and storage areas .Hair is to be covered completely. On 6/16/20 between 12:15 PM and 1:00 PM, observations were made of a meal service in the dining room: There was a sign posted on the door to the kitchen that read: Please put on a hairnet before coming into the kitchen. Hairnets are on the counter by the refrigerator or ask the cook for one. Thank You Management. During this observation time (12:15 PM - 1:00 PM) a Dietary Aide (DA) was seen doing a number of tasks associated with the meal service. At approximately 12:17 PM, the DA was observed to leave the dining room and enter the kitchen area without putting on a hairnet. The DA was observed going into the area behind the steam table, which was an area for food preparation. At 12:45 PM, the DA again was observed leaving the dining room and entering the kitchen area without putting on a hairnet. An interview was conducted with the Dietary Manager (DM) on 6/16/20 at 1:40 PM, The DM was asked about the use of hairnets in the kitchen. The DM stated that all the cooks wear hairnets. When asked about the dietary aides the DM did not have an answer. The DM did acknowledge the sign posted on the kitchen door as being the facility practice. An interview with the Administrator on 6/16/20 at 3:50 PM revealed that the Administrator expected all staff that entered the kitchen would wear a hairnet. The Administrator indicated that was the policy of the facility.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a process to: 1) monitor all residents for symptoms of COVID-19 (COVID-19 is an infectious disease by a new virus causing respiratory illness with symptoms including cough, fever, new or worsening malaise, headache, dizziness, nausea, vomiting, diarrhea, loss of taste and/or smell, and in severe cases difficulty breathing that could result in severe impairment or death) for 1 of 5 residents (Resident (R)5) reviewed for COVID-19 monitoring and, 2) ensure staff followed isolation precautions for residents in isolation for COVID-19 when 2 staff members entered isolation rooms without the appropriate use of personal protection equipment (PPE). The facility also failed to maintain an infection prevention and control program to provide a safe and sanitary environment to aide in the prevention and transmission of communicable disease and infections when a staff member failed to perform hand hygiene during the delivery of meals to residents in the dining room. Findings include: 1. The Centers for Disease Control and Prevention (CDC) indicated that Symptoms of Coronavirus (COVID-19) and What you need to know is that anyone can have mild to severe symptoms and that older adults and people who have severe underlying medical conditions like heart or lung disease or diabetes seem to be at higher risk for developing more serious complications from COVID-19 illness (https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html). The CDC indicates that those people who are at a higher risk for serious illness from COVID-19 are those at high-risk for severe illness from COVID-19 are: people aged [AGE] years and older, people who live in a nursing home or long-term care facility, people of all ages with underlying medical conditions, particularly if not well controlled, including: people with [MEDICAL CONDITION] or moderate to severe asthma, and people who have serious heart conditions (https://www.cdc.gov/coronavirus/2019-ncov/faq.html#People-at-Higher-Risk-for-Severe-Illness). The facility's policy entitled Emerging Threats-Acute Respiratory Syndromes Coronavirus (COVID)-Enterprise with a reviewed/revised date of 4/16/2020 indicated under the section for Long Term Care or Skilled Nursing Facility that Residents are screened at least daily for exposure and symptoms using the screening process. Resident 5 was admitted to the facility with [DIAGNOSES REDACTED]. During review of resident's (R1, R2, R3, and R4) medical records, Physician order [REDACTED]. Temp (temperature) greater than or equal to 100.4, and presence of cough INFORM MANAGEMENT ASAP. Review of R5's medical record revealed that R5 did not have a physician's orders [REDACTED]. The Director of Nursing (DON) was asked on 6/16/2020 at approximately 3:15 PM if full vital signs included an oxygen saturation reading (pulse oximetry is a test that measures oxygen saturation level. The pulse oximeter is a small, clip-like device that attaches to a body part, like a finger to detect how efficiently oxygen is being carried through the body), the DON indicated full vital signs included oxygen saturation readings. Review of R5's medical record revealed that other vital signs (temperature, pulse, and respirations) were taken three times a day since R5's admission (6/5/2020); however, oxygen saturations were only documented as being done on 6/9/2020, 6/10/2020 (twice), 6/11/2020, and on 6/16/2020 (4 days of the 11 days since admission). On 6/6/2020 at 4:05 PM, the DON explained that because the physician's orders [REDACTED]. The DON further explained that the facilities portable vital sign machines (ROSIE a vital signs machine with connectivity software that takes and records vital signs and records them in a resident's electronic health record) will record the oxygen saturations; however, the machines had not been working so R5's oxygen saturations were not completed as needed for COVID-19 monitoring. 2. The Centers for Disease control and prevention (CDC) indicated that long-term care facilities should Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown, which included the following guidance: Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP (Healthcare Professionals) should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission . https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html. The facility's policy entitled Emerging Threats-Acute Respiratory Syndromes Coronavirus (COVID)-Enterprise with a Reviewed/Revised date of 4/16/2020 indicated that the purpose of the policy was 1. to provide guidance to healthcare personnel working in healthcare settings who have the potential for exposure to patients presenting with an emerging respiratory threat including coronavirus. 2. To prevent the transmission from person to person of respiratory pathogens .LONG TERM CARE OR SKILLED NURSING FACILITY .Infection Prevention and Control Recommendations .The resident will be isolated in their room with the door closed .1. Limited only essential personnel to enter the room with appropriate PPE (personal protection equipment) and respiratory protection. PPE includes: Gloves, Gown, Eye Protection (goggles or face shield) On 6/16/2020 starting at 9:45 AM, observations were made in the hallway where the isolation rooms were located (Rooms 132,134, 135, 136, 137, and room [ROOM NUMBER]). These residents had potential exposure to COVID-19 due to their status as new admissions or the residents went

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 -** Some	(continued... from page 1) out of the facility on a regular basis for appointments (doctors, [MEDICAL TREATMENT], etc.). At 9:50 AM, the AD was observed entering resident room [ROOM NUMBER] (an isolation room). The only PPE utilized by the AD was a mask when entering the isolation room. Continual observation in the isolation unit revealed at 10:52 AM, the facility's transportation person (TP) entered resident room [ROOM NUMBER]. The TP only used a mask when entering the isolation room. An interview was conducted with TP on 6/16/20 at 1:35 PM, TP stated that he drives residents to their appointments. He indicated that staff gets the resident ready for the appointment and he then takes them to their appointment. TP stated he goes into the resident's room to get the resident. He indicated that he only wears a mask when he goes into the resident's room. An interview with the AD was conducted on 6/16/20 at 1:50 PM, the AD was asked about how she provides activities to those residents in isolation. The AD stated that she provided in room activities and that she does all the isolation residents at the same time. The AD explained that she puts on (dons) the PPE then visited each resident in their rooms. The AD indicated that once you go through the double doors you have to have on full PPE and that she did not need to change PPE between residents. On 6/16/20 at 4:00 PM during a meeting with the Administrator, Director Nursing, and the Infection Preventionist, the facility's isolation process was discussed. The facility administrative team indicated that they expected staff to don full PPE when entering the isolation rooms. 3. The facility's policy entitled Hand Hygiene and Handwashing with a reviewed/revised date of 4/14/20 indicated under the section, During Service of Meals that 2. Nursing and all other employees: a. Wash hands before meal service begins, when visibly soiled and whenever hands are contaminated by touching a resident, self or any surface (e.g., table, chair, counter) . On 6/16/20 at 12:15 PM, observations were made of meal service in the dining room. A dietary aide (DA) was assisting residents during the meals service. The DA failed to perform hand hygiene during these times: *At 12:28 PM, the DA was at the steam table (dining room side) looking at resident's dietary slips. The DA shuffled through the dietary slips and then took a number of them out to residents where the DA asked the resident what they would like for lunch. The DA would mark the dietary slips. After speaking with a number of residents the DA took the dietary slips back to the steam table and placed the dietary slips on top of the steam table. The DA then went back to providing drinks to the residents, this entailed getting cups/glasses, filling them and taking the prepared drinks to residents. The DA did not perform any hand hygiene during the process of filling out dietary slips and providing drinks to the residents. *At approximately 12:40 PM, the DA got a prepared plate from the top of the steam table and took the plate to a resident. He assisted the resident with set up. The DA then went back to the steam table and got another prepared plate from the top of the steam table and served another resident. The resident stated something to the DA. The DA removed the plate from in front of the resident, moving it to the other side of the table. The DA went back to the steam table and got a third plate and delivered it to a resident. Before the DA could set the plate in front of the resident, the DA had to move the resident's glass of water. The DA spoke with a resident and went to the steam table and wrote on a dietary slip. The DA then picked up another prepared plate and took the plate to a resident. No hand hygiene was preformed between these activities. At this time, there was only the DA and one Certified Nursing Assistant (CNA) who was seated and assisting a resident with eating and there were 14 residents in the dining room. An interview with the Administrator on 6/16/20 at 3:50 PM was conducted, the Administrator was told about the observations made during the meal service regarding the lack of hand hygiene. The Administrator acknowledged that staff should wash hands between residents and when they touch other surfaces.