| 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 _____ | 08/28/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| 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.

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| E 0024<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | **Establish policies and procedures for volunteers.**<br><br>Based on policy review, observation, review of nurse schedules, and staff interview, it was determined the facility failed to ensure it developed and implemented an emergency preparedness plan for how the facility would provide dedicated staff for the COVID-19 positive unit, who the staff would be, and how they would be scheduled. This failure created the potential for negative outcomes by exposing residents to the risk of COVID-19 infection. Findings include: The facility's Emergency Preparedness Plan, approved 1/15/20, documented the Policy Explanation and Compliance Guidelines, including the following: * The plan would address the facility's resident population and staff, including, but not limited to, the continuity of operations, including delegations of authority and succession plans. * The plan would identify which staff would assume specific roles in another's absence. * Policies and procedures would be developed to provide additional guidance on how to carry out the plan. The facility's COVID-19 Preparedness Plan, dated 4/22/20, did not include direction for staffing during a COVID-19 outbreak including dedicating staff to the COVID positive unit, who the staff would be, and how they would be scheduled. The CDC guidance Coronavirus Disease 2019 (COVID-19), Strategies to Mitigate Healthcare Personnel Staffing Shortages, found attached to the facility's Novel Coronavirus Prevention and Response policy, dated 6/10/20, provided by the facility, stated: * Healthcare facilities must be prepared for potential staff shortages and have plans and processes in place to mitigate staffing shortages, including communicating with HCP about actions the facility is taking to address shortages and maintain patient and HCP safety. * When staffing shortages were anticipated, healthcare facilities and employers, in collaboration with human resources and occupational health services, should use contingency capacity strategies to plan and prepare for mitigating the problem. *At baseline, healthcare facilities must understand their staffing needs and the minimum number of staff needed to provide a safe work environment and safe patient care. *Contingency capacity strategies included adjusting staff schedules, hiring additional HCP, and rotating HCP to positions that support patient care activities. These policies and guidance were not followed. The facility included two halls, the East Hall and the West Hall. The East Hall included both a Southeast Hall and Northeast Hall. On the Southeast Hall two resident rooms, 336 and 341, which were across the hall from each other, had been turned into an anteroom (a small outer room that leads to a larger room or area), one room was a breakroom and the other used to store clean supplies. To ensure separation of the anteroom the hall between the two rooms was covered on each side with a plastic barrier that covered floor to ceiling and wall to wall. The 5 residents (#1 - #5) who had tested positive for COVID-19 resided in the 4 rooms located beyond the barrier at the end of the Southeast Hall, rooms 337, 338, 339, and 340. This was the facility's COVID-19 positive unit. Residents who tested negative for COVID-19, and newly admitted residents who were in quarantine, resided on the other side of the plastic barrier on the Southeast Hall in rooms 333-336 and 342-345, the Northeast Hall, and the West Hall. The Nurses' Schedule, dated 8/23/20 - 9/5/20, documented nurse staff assignments for the Southeast Hall. The schedule documented 3 licensed nurses were scheduled to work on the dayshift on 8/26/20. The schedule documented one licensed nurse was assigned to the Southeast Hall, to serve both the COVID-19 negative and COVID-19 positive residents. On 8/26/20 at 2:40 PM, LPN #1 stated she worked the dayshift on the Southeast Hall on 8/24/20, 8/25/20, and 8/26/20. LPN #1 stated on 8/26/20 at approximately 11:00 AM, she was told to stay in the COVID-19 positive unit and to not go back and forth between the COVID-19 negative and positive units of the Southeast Hall. LPN #1 stated prior to 11:00 AM on 8/26/20 she worked both the COVID-19 negative and COVID-19 positive units on the Southeast Hall. On 8/26/20 at 3:45 PM, the DON stated since 8/23/20, the licensed nurses scheduled to work the Southeast Hall for the 12 hour dayshift were going through the COVID-19 barrier to pass medications and provide cares to Residents #1 - #5 on the COVID-19 positive unit and then came back through the plastic barrier to pass medications and provide cares to residents on the negative unit of the Southeast Hall. The DON stated licensed nurses scheduled to work the 12 hour nightshift worked on both sides of the Southeast Hall (COVID-19 positive and COVID-19 negative units), in addition to the Northwest Hall. On 8/26/20 at 6:15 PM, LPN #3 stated she was scheduled to work 12 hours on the Northeast Hall and Southeast Hall combined, including the COVID-19 positive unit. LPN #3 stated she had crossed the barrier from the negative unit into the COVID-19 positive unit to pass medications and provide cares on 8/24/20 and 8/25/20. LPN #3 stated she was scheduled to work a 12 hour nightshift on both the Northeast Hall and Southeast Hall, including the COVID-19 positive unit, that night (8/26/20). |
| F 0684<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | **Provide appropriate treatment and care according to orders, resident's preferences and goals.**<br><br>Based on observation, staff interview, and policy review, it was determined the facility failed to ensure, consistent with professional nursing standards of practice, medications were dispensed and administered by one licensed nurse in the COVID-19 positive unit. The facility's failure placed all 5 residents (#1-#5) in the COVID-19 positive unit at imminent risk of significant medication errors and subsequent serious harm, impairment, or death. Findings include: The Potter & Perry Fundamentals of Nursing, Eighth Edition, textbook, copyright 2013, under Professional Standards in Nursing Practice states under the section Legal Guidelines for Recording, nurses should only chart for themselves, are accountable for information they enter into a patient's chart, and nurses were never to chart for someone else. The Nurse.com website, dated 12/16/15, documents, One of the first general principles in medication administration that a nurse must adhere to is to personally prepare any medications properly ordered for a patient and to personally administer those medications. Although there may be instances in which more than one healthcare provider may be required to administer a single medication, such as in a code, it is not generally acceptable practice to prepare any type of medication for another person to administer. Nor is it acceptable practice to administer a medication that another has prepared. The reasons for this strict rule are numerous. First and foremost, because preparation and administration are fraught with potential for error, relying on another nurse to prepare a medication that you administer is dangerous at best. According to the Agency for Healthcare Research and Quality article, Medication Administration Errors, updated on 9/7/19, errors in medication administration can occur through failures in any of the five rights: right patient, right medication, right time, right dose, and right route. The article states such errors may be the result at the individual-level but may also result from system-level failures such as understaffing and poor process. On 8/26/20 at 2:40 PM, LPN #1 was observed working in the COVID-19 positive unit. LPN #1 stated five residents (#1 - #5) were in the COVID-19 positive unit located beyond a floor to ceiling and wall to wall plastic barrier toward the end of the Southeast Hall. On 8/26/20 at 2:45 PM, LPN #1 stated when the residents received routine medications or requested as needed medications, she notified the DON or the nurse working on the Northeast Hall, located outside of the COVID-19 positive unit, and one of them prepared the medications and delivered them to her in the COVID-19 positive unit to administer to the residents. LPN #1 stated the medications were placed in medicine cups with the resident's first name handwritten on each medicine cup by either the DON or the licensed nurse from |

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

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| F 0684<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Some | (continued... from page 1)<br>the other hall. LPN #1 stated she was unable to verify the medications were for the right resident and the resident received the correct medications. LPN #1 said she could not verify the medications were administered at the right dose, right time, and by the right route (e.g. oral, injection, rectal). LPN #1 stated she did not sign in the Electronic Medical Record (EMR) for the medications she administered. LPN #1 stated if a resident refused medications, she notified the DON or the licensed nurse working on the Northeast Hall of the resident's refusal and they documented the refusal in the resident's EMR. On 8/26/20 at 3:40 PM, LPN #2 stated the nurses that worked the Northeast Hall dispensed the medications of the 5 residents on the COVID-19 positive unit into medicine cups, wrote the resident's first name on the medicine cup, documented the medications as given in the EMR, and delivered the medication cups to the licensed nurse working the COVID-19 positive unit. On 8/26/20 at 3:45 PM, the DON stated she worked the COVID-19 negative side of the Southeast Hall at approximately 11:00 AM that day, and dispensed and pre-poured the medications for the 5 residents in the COVID-19 positive unit and documented in the EMR that she administered the medications to the 5 residents. The DON stated she delivered the medications to LPN #1 to administer to each of the 5 residents. The DON stated one licensed nurse should have been dispensing, administering, and documenting the medications as given to the 5 residents on the COVID-19 positive unit. The medications were not individually labeled and did not include sufficient information to identify which resident the medications were intended for. In addition, the licensed nurse who received the medications on the COVID-19 positive unit did not verify the medications or the resident they were intended for prior to administering them. These negative facility practices placed the 5 residents on the COVID-19 positive unit at imminent risk of significant medication errors resulting in serious harm, impairment, or death. On 8/26/20 at 6:20 PM, the facility Administrator and DON were verbally informed of the Immediate Jeopardy (IJ) determination at F684 and the IJ template was emailed on 8/27/20 at 1:15 PM, which provided written notification of the IJ. On 8/27/20 at 1:30 PM, the facility provided an acceptable plan to remove the immediacy. The facility had implemented the removal plan prior to submitting it for approval. In the removal the facility alleged the immediacy was removed as 8/27/20 at 6:30 AM. The facility's IJ removal plan included: - Medication Pass: A workstation on wheels (WOW) was to be placed in the COVID-19 positive unit so the licensed nurse in the unit may document medication administration. A licensed nurse would retrieve the medications from the Pyxis (medication storage and retrieval machine) and place them in a cup marked with the resident's name. The licensed nurse in the COVID-19 positive unit would then scan the resident barcode and scan the medication barcode for verification and administer the medications. Surveyors completed onsite verification of the removal of the IJ and confirmed the IJ removed as of 8/27/20 at 4:05 PM. On 8/27/20 at 4:57 PM, the facility Administrator, along with the DON from the attached critical access hospital, were verbally informed the immediacy was removed based on onsite verification the IJ removal plan was implemented. |
| F 0880<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Many | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review, review of nurse schedules, staff interview, and policy review, it was determined the facility failed to ensure infection control prevention practices were implemented and maintained to prevent and contain COVID-19 infections. The facility's failure to implement and maintain infection control measures to prevent transmission of COVID-19 placed all staff in the facility, and all residents on the non-COVID units in the facility, in immediate jeopardy of serious harm, impairment, or death related to COVID-19 infection. Findings include: 1.The facility's Coronavirus Surveillance Policy, dated 6/10/20, documented the facility monitored the status of the COVID-19 outbreak through the CDC website, and monitored the website for changes in prevention, treatment, isolation, or other recommendations. The CDC website, accessed on 8/27/20, included a section titled Responding to Coronavirus in Nursing Homes, which documented facilities were to assign dedicated healthcare professionals (HCP) to work only on the COVID-19 positive unit. The website also included Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, which documented dedicated means that HCP are assigned to care only for COVID-19 positive patients during their shift. The facility's policy and CDC guidelines were not followed. The facility included two halls, the East Hall and the West Hall. The East Hall included both a Southeast Hall and Northeast Hall. On the Southeast Hall two resident rooms, 336 and 341, which were across the hall from each other, had been turned into an anteroom (a small outer room that leads to a larger room or area), one room was a breakroom and the other used to store clean supplies. To ensure separation of the anteroom the hall between the two rooms was covered on each side with a plastic barrier that covered floor to ceiling and wall to wall. The 5 residents (#1 - #5) who had tested positive for COVID-19 resided in the 4 rooms located beyond the barrier at the end of the Southeast Hall, rooms 337. 338, 339, and 340. This was the facility's COVID-19 positive unit. Residents who tested negative for COVID-19, and newly admitted residents who were in quarantine, resided on the other side of the plastic barrier on the Southeast Hall in rooms 333-336 and 342-345, the Northeast Hall, and the West Hall. The facility's COVID-19 symptom and tracking form, dated 8/24/20, documented 5 residents (#1 - #5) tested positive for COVID-19 on 8/23/20. The Nurses' Schedule, dated 8/23/20 - 9/5/20, documented nurse staff assignments for the Southeast Hall. The schedule documented 3 licensed nurses were scheduled to work on the dayshift on 8/26/20. The schedule documented one licensed nurse was assigned to the Southeast Hall, to serve both the COVID-19 negative and COVID-19 positive residents. On 8/26/20 at 2:40 PM, LPN #1 stated she worked the dayshift on the Southeast Hall on 8/24/20, 8/25/20, and 8/26/20. LPN #1 stated on 8/26/20 at approximately 11:00 AM, she was told to stay in the COVID-19 positive unit and to not go back and forth between the COVID-19 negative and positive units of the Southeast Hall. LPN #1 stated prior to 11:00 AM on 8/26/20 she worked both the COVID-19 negative and COVID-19 positive units on the Southeast Hall. On 8/26/20 at 3:45 PM, the DON stated since 8/23/20, the licensed nurses scheduled to work the Southeast Hall for the 12 hour dayshift had been going through the COVID-19 barrier to pass medications and provide cares to the 5 residents on the COVID-19 positive unit and then came back through the plastic barrier to pass medications and provide cares to residents on the negative unit of the Southeast Hall. The DON stated licensed nurses scheduled to work the 12 hour nightshift worked on both sides of the Southeast Hall (COVID-19 positive and COVID-19 negative units), in addition to the Northwest Hall. On 8/26/20 at 6:15 PM, LPN #3 stated she was scheduled to work 12 hours on the Northeast Hall and Southeast Hall combined, including the COVID-19 positive unit. LPN #3 stated she had crossed the barrier from the negative unit into the COVID-19 positive unit to pass medications and provide cares on 8/24/20 and 8/25/20. LPN #3 stated she was scheduled to work a 12 hour nightshift on both the Northeast Hall and Southeast Hall, including the COVID-19 positive unit, that night (8/26/20). On 8/26/20 at 6:20 PM, the DON stated the nurses scheduled to work the Southeast Hall on the 12 hour dayshift and the nurses scheduled to work the 12 hour nightshift were crossing the plastic barrier and working both the COVID-19 negative unit and positive unit during their shift. 2. On 8/26/20 at 3:00 PM, CNA #1 stated at the end of her shift, she exited the COVID-19 positive unit on the Southeast Hall back into the COVID-19 negative unit of the Southeast Hall wearing a surgical mask and walked through the COVID-19 negative unit of the Southeast Hall. LPN #1, also present during the interview, and CNA #1, both stated they stopped and talked with other staff members at the East Hall nurse's station, which was located between the Northeast Hall and Southeast Hall, prior to walking through the dining room to exit the facility near the West Hall. The facility failed to ensure designated staff were assigned to work the COVID-19 positive unit each shift, and staff who worked on the COVID-19 positive unit had separate exit/entrance to the unit. These deficient practices placed staff and residents who had tested negative of COVID-19, at imminent risk of COVID-19 infection and subsequent serious harm, impairment, or death, related to the infection. On 8/26/20 at 6:30 PM, the facility Administrator and DON were informed verbally of a determination of Immediate Jeopardy for F880. The Immediate Jeopardy (IJ) template was provided to the facility via email on 8/27/20 at 1:15 PM, which provided written notification of the IJ. On 8/27/20 at 1:30 PM, the facility provided an acceptable plan to remove the immediacy. The facility alleged the plan to remove the immediacy was implemented August 27, 2020 at 6:30 AM. The facility's IJ removal plan included: *Staff had been placed into the COVID-19 positive unit, a nurse and a CNA, and they do not come out of the COVID-19 positive unit during their shift. *An anteroom was placed at the entrance into the COVID-19 positive unit, located at the end of the Southeast Hall, so staff could enter the unit from outside the facility. On 8/27/20 at 2:45 PM, the survey team was onsite at the facility to confirm implementation of the above IJ removal plan. However, changes initiated by the facility to correct the above IJ, resulted in a practice that continued to place residents' health and safety in IJ. This IJ is described below. The CDC website, accessed on 8/27/20, included a document dated 5/22/20, titled Responding to Coronavirus in Nursing Homes. The document stated healthcare providers must wear eye protection and an N95 or higher-level respirator at all times while on the COVID-19 positive unit. On 8/27/20 at 2:45 PM, the ICP stated the COVID-19 positive unit had its own entrance and exit area and staff were screened by the licensed nurse at the COVID-19 positive designated entrance. On 8/27/20 at 3:07 PM, LPN #5 was observed wearing a surgical mask, gown, booties, and gloves in the newly established anteroom located at the end of the Southeast Hall, at the |

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| F 0880<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Many | (continued... from page 2)<br>outside entrance into the COVID-19 positive unit. LPN #5 was not wearing an N95 or higher-level respirator mask and a face shield. LPN #5 stated the COVID-19 positive unit hallway was the warm zone marked with 2 parallel strips of red tape in the center of the hallway. LPN #5 stated staff were instructed by the ICP to wear a surgical mask and face shield in the warm zone. LPN #5 stated the warm zone was identified with the 2 strips of red tape approximately 3 feet wide apart in the middle of the COVID-19 positive unit hallway. The strips of red tape were approximately 2 feet from rooms [ROOM NUMBERS] on the right side and rooms [ROOM NUMBERS] on the left side of the COVID-19 positive unit hallway. While walking through the COVID-19 positive unit hallway warm zone, the doors to rooms 338-340 were open. Resident #2 was observed reclined in a recliner and both Resident #3 and #5 were lying in bed. LPN #5 stated the residents' rooms were the hot zone and full PPE was required to be donned when in them. LPN #5 stated full PPE included a gown, booties, gloves, and an N95 mask and a face shield or a powered air purifying respirator (PAPR) and the PPE was to be worn while providing resident care. LPN #5 stated full PPE was located in the previously established anteroom utilizing rooms [ROOM NUMBERS] which were across the hall from each other. On 8/27/20 at 3:22 PM, LPN #5 walked through the positive unit hallway and entered the anteroom in rooms [ROOM NUMBERS]. The doors to the clean supply room and the staff breakroom/charting room were open. LPN #5 stated the doors remained closed unless used by a staff member. LPN #5 stated no one was in either room and the doors should have been closed. LPN #5 stated staff donned and doffed their PAPR or N95 mask and face shield in that anteroom. The facility failed to ensure staff assigned to work the COVID-19 positive unit wore an N95 or higher-level respirator and eye protection at all times, which placed staff and residents who had tested negative of COVID-19 at imminent risk of COVID-19 infection and subsequent serious harm, impairment, or death, related to the infection. On 8/28/20 at 3:00 PM, the facility Administrator, LSW, CNA Supervisor, Activities Director, Facility's Emergency Management Director, and DON, as well as, the Administrator of the attached critical access hospital, were notified via phone of the continued Immediate Jeopardy at F880. The IJ was not removed prior to the exit conference.<br><br>3. On 8/26/20 at 10:55 AM, the Administrator said the first COVID-19 positive resident was detected on 8/20/20 and was transferred to the hospital. The Administrator said five more residents tested positive on 8/23/20 and were moved and cohorted in the Southeast Hall. On 8/26/20 at 11:25 AM, the ICP said she was instructed by the ICP of the attached hospital to implement droplet precautions for all residents who were not COVID-19 positive residing in the facility. a. The CDC guidance Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated July 15, 2020, stated HCP should continue to adhere to standard and transmission-based precautions, including use of eye protection and/or an N95 or equivalent or higher-level respirator based on anticipated exposures and suspected or confirmed diagnoses. The facility's Novel Coronavirus Prevention and Response, dated 6/10/20, documented to promote easy and correct use of PPE by posting signs on the door or wall outside the resident room that clearly described the type of precautions needed and the required PPE. This policy and guidance was not followed. The West Hall and Northeast Hall only had four resident rooms with two signs on their door. These residents were identified as under quarantine because they were newly admitted to the facility. One sign instructed individuals to see the nurse before entering, and the second sign stated Droplet precautions (in addition to Standard Precautions) were in use with instructions for the required PPE. The sign for droplet precautions stated staff were to wear eye protection with respiratory symptoms and use eye protection, a gown, and gloves if contact with secretions was likely to occur. The instructions on the sign for droplet precautions for what PPE to wear, and under what circumstances, differed from what was observed and what staff stated they needed to wear when they entered a resident's room. There were no signs posted elsewhere in the facility or on resident doors to identify the type of precautions needed when entering resident rooms. On 8/26/20 at 11:40 AM, CNA #2 was wearing a surgical mask and a face shield on the West Hall when going into resident rooms. CNA #2 said the signs on the resident doors were used for newly admitted residents who were on quarantine for 14 days. She said she was to perform hand hygiene, put on a gown and gloves in addition to the face mask she was wearing, before assisting the residents who were on quarantine. CNA #2 said for rooms without signs, nursing staff were to put on all PPE only if they were going to touch the resident. On 8/26/20 at 12:30 PM, Housekeeper #1 was observed entering a resident's room to adjust the exterior window at the resident's request after putting on a surgical mask, face shield, gown and gloves. There were no signs on the resident's door stating they were on precautions. Housekeeper #1 said she was instructed yesterday morning to wear a surgical mask, face shield, a gown, and gloves into all the rooms on the Northeast Hall. On 8/26/20 at 12:35 PM, the CNA Supervisor stated all the residents residing on the East Hall were on droplet precautions. The CNA Supervisor stated the facility's droplet precautions instructed staff to wear a surgical mask, a face shield, a gown, and gloves. On 8/26/20 at 3:35 PM, CNA #3 said every resident was on airborne, standard, and droplet precautions. She said she was informed of what to wear by the RNs, the signs posted, and by what was in the PPE supply carts. CNA #3 said they did not have supplies or signs for every room and she did not know why, and she was doing what the CNA Supervisor instructed her to do. She said she came to work on Tuesday, 8/25/20, and the droplet precautions were in place. On 8/26/20 at 3:45 PM, CNA #4 said an RN informed them on Tuesday, 8/25/20, to start using the droplet precaution protocol, and they were to wear all the PPE, including a face mask, face shield, a gown, and gloves into all resident rooms. CNA #4 said those residents on quarantine had a PPE supply cart and signs at their door. CNA #4 said the newly admitted residents were placed on quarantine for two weeks and staff were required to wear full PPE in their rooms. On 8/26/20 at 4:00 PM, CNA #6 said the doors of the newly admitted resident rooms had signs indicating hand hygiene, a face mask, goggles, a gown, and gloves were required whenever staff went into those rooms. CNA #6 said since Monday or Tuesday the staff were to use droplet precautions in every resident room, as indicated on the signs. On 8/26/20 at 4:10 PM, CNA #5 said the Northeast Hall residents were all on droplet precautions since Tuesday, 8/25/20. On 8/26/20 at 4:25 PM, LPN #4 said the sign on the door meant a newly admitted resident was on quarantine for 14 days, and staff were to put on a gown, gloves, and a face shield; the staff already had on a face mask. LPN #4 said other residents without signs also required staff to wear gowns in their rooms. It was unclear what PPE was to be worn and when PPE was to be worn in resident rooms who were on quarantine or who had tested negative for COVID-19. b. The facility's COVID-19 Preparedness Plan, dated 4/22/20, stated the ICP will have the responsibility to educate staff on proper use of PPE, handwashing, and isolation precautions. This policy was not followed. On 8/26/20 at 3:10 PM, the ICP said the residents on the East and West Halls were on droplet precautions starting on 8/25/20. The ICP said the staff were trained one on one when they came in to start their shift. Facility staff were not consistently and appropriately trained and educated on the changes in required PPE once there was an outbreak of COVID-19 infection. Examples include: - On 8/26/20 at 3:35 PM, CNA #3 said every resident was on airborne, standard, and droplet precautions. She said she was informed of what to wear by the RNs, the signs posted, and by what was in the PPE supply carts. - On 8/26/20 at 3:45 PM, CNA #4 said an RN informed them on Tuesday, 8/25/20, to start using the droplet precaution protocol, and they were to wear all the PPE, including a face mask, face shield, a gown, and gloves into all resident rooms. - On 8/26/20 at 4:00 PM, CNA #6 said during report on Tuesday, 8/25/20, the charge nurse informed her the new PPE protocol, including surgical masks, were to be followed. CNA #6 said when the COVID-19 lock down started in March they received PPE use training from the ICP or the charge nurse. When the facility learned of the first COVID-19 positive resident CNA #6 said she was trained by another CNA on how to put on disposable booties and the Powered Air-Purifying Respirator (PAPR) hood for the COVID-19 positive unit. - On 8/26/20 at 4:25 PM, LPN #4 said when she came in to work on Monday morning, the night shift nurse informed her the droplet precautions were in place. 4. The facility's Coronavirus Surveillance Policy, dated 6/10/20, stated: * Heightened surveillance activities would be implemented to limit the transmission of COVID-19. These included, but were not limited to, screening residents. * Residents would be monitored for signs and symptoms of coronavirus illness: fever, cough, shortness of breath. Some older adults may exhibit subtle or atypical symptoms of COVID-19, such as new or worsening malaise, change in appetite, dizziness, diarrhea, or change in mental status or behavior. And, considerations for managing residents with suspected or confirmed COVID-19 infection include: * Increase monitoring of resident for development of more severe symptoms or other changes in condition. * Increase monitoring of all other residents when COVID-19 is suspected or confirmed. The CDC guidance for Responding to Coronavirus (COVID-19) in Nursing Homes, accessed 8/27/20, stated to increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infections. And, to consider increasing monitoring of asymptomatic residents from daily to every shift to more rapidly detect any residents with new symptoms. The facility's COVID-19 Resident Symptom Tracking Log, dated 8/24/20, instructed to check vital signs and assess residents for symptoms of COVID-19 illness and to document them in the medical record. Vital signs included oxygen saturation, respiration, temperature, blood pressure, and |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
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| F 0880<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Many | (continued... from page 3)<br>pulse. Six residents tested positive for COVID-19 illness, the first on 8/20/20 and five on 8/23/20. Nurse Progress Notes which included COVID-19 symptom screening and a Vital Signs Roster from 8/22/20 through 8/26/20, documented for the five residents who tested positive on 8/23/20, the following: * Residnt #2 was not screened for symptoms on 8/22/20, 8/23/20 and 8/24/20, and was not screened for vital signs on 8/25/20. * Resident #5 was not screened for symptoms on 8/22/20 and 8/2320, and was not screened for vital signs on 8/25/20. * Resident #4 was not screened for symptoms on 8/23/20 and 8/24/20, and was not screened for vital signs on 8/25/20. * Resident #3 was not screened for symptoms on 8/22/20, and was not screened for vital signs on 8/25/20. * Resident #1 was not screened for symptoms on 8/23/20, and was not screened for vital signs on 8/25/20. On 8/26/20 at 3:10 PM, the IPC said they assessed the residents every shift, they took their temperatures, and documented symptoms by exception (meaning if they had symptoms then they were documented in the record, if no symptoms were exhibited then there was no documentation). |