STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135105	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TEMPLE VIEW TRANSITIONAL CARE CENTER	660 SOUTH SECOND STREET WEST 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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, nationally recognized standards of practice, employee timesheets and screening log review, 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 Emerging Infectious Disease: Coronavirus Disease 2019 (COVID-19), revised 5/1/20, documented staff and visitors were screened for the following: international travel within the last 14 days to restricted countries, signs or symptoms of respiratory infection, such as fever, cough, chills, and gastrointestinal symptoms, and whether they had contact with someone who had or was under investigation for COVID-19. a. The employee screening logs and timesheets, dated 6/15/20 through 6/23/20, were reviewed for all employees of the facility. The following staff were not screened prior to working their shift: * Employee A worked on 6/21/20 from 6:54 AM to 12:58 PM, and from 1:45 PM to 2:45 PM. * Employee B worked on 6/21/20 from 4:30 AM to 6:00 AM, and from 10:23 AM, to 12:10 PM. * Employee C worked on 6/22/20 from 9:47 AM to 12:01 PM, and from 1:09 PM to 5:26 PM. The facility was unable to provide documentation Employee A, Employee B, and Employee C were screened prior to working on 6/21/20 and 6/22/20. On 6/23/20 at 6:15 PM, the DON said the facility could not account for all staff who were not on the screening logs and clocked in on the timesheets from 6/15/20 through 6/23/20. b. The screening logs were not actively screened for signs and symptoms of infection and were not reviewed to ensure each section was completed prior to employees starting their shift. The employee screening logs, dated 6/18/20 through 6/21/20, were signed by the IP. There was no date or time next to her signature. On 6/22/20 at 5:15 PM, CNA # 3 said when she came to work for her shift, she checked her temperature and answered some questions on a form. CNA #3 said if she had any symptoms she would go tell a nurse, and if she had a fever she would write it down and go to the charge nurse. CNA #3 said staff performed the screening themselves. On 6/22/20 at 5:20 PM, RN #3 said when she came to work for her shift, she checked her temperature and logged whether she had been out of state or had any symptoms of COVID-19. RN #3 said if she had any symptoms she would report it to the DON and leave the building. RN #3 said staff performed the screening themselves. RN #3 said at some point the IP took the screening information to the front desk and verified it. On 6/22/20 at 5:25 PM, CNA #4 said when he came to work for his shift, he checked his temperature, sanitized his hands, and answered a list of questions. CNA #4 said staff performed the screening themselves, and the screening information was looked at by a nurse approximately 10 minutes after the shift started. On 6/22/20 at 5:26 PM, CNA #1 said when he came to work for his shift, he checked his temperature, made sure he did not have symptoms, put a face mask on, and he filled out a log, and sanitized his hands. On 6/22/20 at 5:27 PM, CNA #2 said when he came to work for his shift he got a face mask, took his temperature, and answered questions about respiratory symptoms. He said he would inform the nurse if he had a temperature of 99.1 degrees Fahrenheit or above. CNA #2 said either the nurse would come to the nurses' station before shift change or the nurse would find him if his temperature was elevated. On 6/22/20 at 5:30 PM, CNA #5 said when she came to work for her shift, she checked her temperature, signed her name, and answered some questions. CNA #5 said staff performed the screening themselves, and once the shift started a nurse checked the screening information to see if anyone needed to be sent home. On 6/23/20 at 9:18 AM, LPN #1 said she checked into work at 5:30 AM and the other day shift staff came in at 6:00 AM. She said as staff walked down the hall she wrote down their names on a list and then went to check the screening log. She said she checked to see who was working from the timesheet list on the computer, and then checked the screening log. LPN #1 said she double checked with the head of the kitchen to make sure they completed their screening and reminded the maintenance staff member to complete the log when she saw him. She said on weekdays the IP completed the second audit after the RN, and on the weekends the second RN on shift completed the second audit. She said if the staff temperature was too high, staff knew not to go down the hall and called the RN for the second thermometer. LPN #1 said if the second temperature was still too high, the IP was called and assessed and directed them. She said if there were any questions the staff knew to go to the IP. On 6/23/20 at 9:20 AM, the IP said the staff screening logs were kept by her in a book, and she looked at them several times a day. The IP said staff would call her if they had a fever or questions. The IP said she looked at the screening logs first thing in the morning then again around 2:30-3:00 PM, and the nurse in the back hall looked at the screening logs after everyone was there for the shift, around 6:30 AM. The IP said the afternoon nurse also looked at the staff screening logs, the staff screened themselves, and they knew to stop if they had a fever or any symptoms. On 6/23/20 at 9:26 AM, RN #2 said when she came to work she entered the building from the parking lot door with a face mask on, signed in, took her temperature, sanitized her hands, and answered questions about fevers, chills, temperature, etc. She said if she had symptoms two RNs used separate thermometers to check her temperature. She said she was to text the RN and not go into the building with a high temperature. On 6/23/20 at 10:05 AM, Housekeeper #1 said when she came to work she signed in, put on a face mask, got her radio, and went to the floor. On 6/23/20 at 10:05 AM, Housekeeper #2 said when she came to work she signed in, put on a face mask, and got her radio. She said she did not wait for an RN, she went directly to the floor. On 6/23/20 at 10:20 AM, CNA #6 said when she reported for her shift she checked her temperature and wrote it down. CNA #6 said she also answered questions on the screening log and the nurse was supposed to look at the screening information after everyone arrived for the shift. CNA #6 said she went to her work station before the screening information was reviewed by the nurse. On 6/23/20 at 10:40 AM, CNA #7 said when she came to work she checked her temperature and made sure she had no symptoms. CNA #7 said if everything was normal, she went to the work station, and the screening logs were checked but she did not know when they were checked. CNA #7 said if anything was not normal, she would call the nurse, and report to the work station before the nurse reviewed the screening information. On 6/23/20 at 11:35 AM, LPN #1 said the aides entered the building at 6:00 AM and went to shift report at 6:05 AM, after they completed the screening log. She said she then went to check the screening logs. She said if she found a high temperature entry, everyone knew to call her. She said she had not found a high temperature recorded when she checked the screening logs, and most people called the IP if they come in with a concern. LPN #1 said the kitchen staff came in after the nursing staff and she checked their screening log 15 minutes after they came to work. She said she did not document when she checked the log. On 6/23/20 at 12:00 PM, the DON said employees were not actively screened when they came in for their shift, and they checked their temperature themselves. The DON said if a staff member had a fever, they were to contact the IP, then they were to go home and send their temperature readings to the facility for 3 days. The DON said if an employee had any symptoms during their shift, they talked to the nurse. 2. The facility's policy for the Infection Control Prevention and Control Program, revised September 2017, documented The program directs when and how isolation should be used for a resident; including type and duration of the isolation . a. On 6/22/20 at 3:06 PM, Resident #2's room had a rack hanging on the outside of the door, which held 1 box of examination gloves, 1 blue face mask lying loose in the rack that was soiled with makeup, and 1 yellow face mask lying loose on another section of the rack. There was no sign posted which indicated Resident #2 was on precautions or what type of precautions should be followed by staff. A small white sign was posted on the doorframe, which was approximately 2 inches by 3 inches,

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) and it was labeled PPE (personal protective equipment) Competency Checkoff. The sign stated staff were to gather supplies, perform hand hygiene, and apply a gown, face mask, eye protection, and gloves. The sign also stated before exiting the room and after completing cares, staff were to remove their gloves and gown, perform hand hygiene, remove eye protection, and remove their face mask. Staff were then directed to use the closest hand sanitizer. The sign did not state what type of precautions were to be observed for Resident #2. b. On 6/22/20 at 3:02 PM, Resident #3's door was closed. There was a rack hanging on the outside of the door, which held 2 boxes of gloves, some examination gloves laying loose in the rack, and a box of yellow face masks. There was no sign posted outside Resident #3's door which indicated he was on precautions or what type of precautions should be followed. A small white sign was posted on the doorframe, which was approximately 2 inches by 3 inches in measurement, and it was labeled PPE (personal protective equipment) Competency Checkoff and stated the steps to apply and remove PPE. The sign did not state what type of precautions were to be observed for Resident #3. c. On 6/22/20 at 3:05 PM, Resident #1's room had a 3-drawer cart outside of his room, which contained PPE. There was no sign posted outside Resident #1's door which indicated he was on precautions or what type of precautions should be followed. A small white sign was posted on the doorframe, which was approximately 2 inches by 3 inches, and it was labeled PPE (personal protective equipment) Competency Checkoff and stated the steps to apply and remove PPE. The sign did not state what type of precautions were to be observed for Resident #1. On 6/22/20 at 3:53 PM, CNA #8 said the small white sign on Resident #2's doorframe was so staff would know what order to put on PPE, and that Resident #2 was on precautions as a new admission for 14 days to make sure there were no signs or symptoms of COVID-19. On 6/22/20 at 4:00 PM, CNA #3 said Resident #2 was on special precautions to make sure he did not have any signs or symptoms of COVID-19. CNA #3 said she thought there should be a sign indicating what kind of precautions he was on. On 6/23/20 at 9:20 AM, the IP said new admissions were placed on precautions for 14 days, including contact and droplet precautions. The IP said she had signs she could place on the residents' doors, and there was a communication board that informed staff who the newly admitted residents were and when they could come off precautions. The IP said she did not place precaution signs on the residents' doors because the facility was not allowing visitors. 3. The CDC website, accessed on 6/30/20, documented the following on extended use of gowns: * Consideration can be made to extend the use of isolation gowns (disposable or cloth) if the same gown is worn by the same HCP when interacting with more than one patient known to be infected with the same infectious disease and the patients resided in the same location (i.e., COVID-19 patients residing in an isolation cohort). * Wearing the same gown by the same HCP could be considered only if there were no additional co-infectious [DIAGNOSES REDACTED]. * If the gown became visibly soiled, it must be removed and discarded. The facility provided two documents, undated, on the reuse and cleaning of gowns. The first document was from the CDC, which included the following: .risk from re-use of cloth isolation gowns without laundering among (1) single HCP (health care provider) caring for multiple patients using one gown or (2) among multiple HCP sharing one gown is unclear. The second document provided was the facility's instructions on how to clean a polyethylene (plastic) gown and included the following: * Spray the gown down with a CDC approved disinfectant while it hangs on a hook. * Use a bleach solution or another approved cleaner. * Let it drip dry for 10-15 minutes. The document did not include the manufacturer's instructions for cleaning gowns. The facility provided a document, undated, which included instructions for cleaning of eye protection which included face shields. The instructions stated to follow manufacturer guidelines and to perform the following: *With gloved hands, wipe inside, followed by outside of face shield or goggles with clean cloth saturated with neutral cleaner. *Wipe outside with clean water or alcohol to remove residue *Air dry or use clean absorbent towel * Perform hand hygiene The CDC guidance and facility provided instructions were not followed by staff, as follows: - On 6/22/20 at 3:40 PM, CNA #3 was in Resident #2's room and was wearing a blue plastic gown, gloves, and a face shield as she checked his vital signs. When she was finished, CNA #3 removed her gloves and blue plastic gown, hung the gown on a hook inside the room, performed hand hygiene, then removed her face shield. CNA #3 sprayed the face shield and outside of the gown with a bottle labeled alcohol. She did not wear gloves when using the disinfectant and did not follow the instructions for disinfection of the face shield. CNA #3 then removed her face mask, applied a new face mask, exited the room, and performed hand hygiene. - On 6/22/20 at 3:46 PM, CNA #8 entered Resident #1's room and donned a blue plastic gown, which was hanging on a hook in the room. CNA #8 next performed hand hygiene, put on a yellow face mask, a face shield, and then put on gloves. CNA #8 took Resident #1's temperature and oxygen level, then removed her gloves and performed hand hygiene. She next removed her gown and hung it on a hook in the room, removed the face shield and hung the face shield on a hook in the room, then sprayed the outside of the gown and face shield with a bottle labeled alcohol. She did not wear gloves when using the disinfectant and did not follow the instructions for disinfection of the face shield. CNA #8 then exited the room and performed hand hygiene. On 6/22/20 at 3:53 PM, CNA #8 said the staff were reusing the gowns, and the gown could be worn by anyone who came in the room and needed to wear it. CNA #8 said the gown could be used for a few days, unless it was ripped. On 6/22/20 at 3:55 PM, CNA #3 said everyone could wear the reused gown because the facility was in crisis mode with PPE. On 6/23/20 at 9:07 AM, the DON said the facility was in crisis mode for gowns because new admissions were under droplet precautions, which required gowns, face shields, gloves, and face masks. The DON said staff were sharing the same gown, and spraying them with 70% alcohol after use. The DON said the information from the CDC stated it was unclear whether it was acceptable for multiple staff to wear the same gown, so the facility was doing what it felt was safest. The DON said the facility had difficulty obtaining gowns. On 6/23/20 at 9:20 AM, the IP said staff were reusing isolation gowns for 3 days, unless something happened to the gown then they replaced it sooner. She said staff were to spray the gown with alcohol after use.