STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135125	A. BUILDING _____ B. WING _____	08/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CREEKSIDE TRANSITIONAL CARE AND REHABILITATION	**1351 WEST PINE AVENUE MERIDIAN, ID 83642**

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 -** Immediate jeopardy **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, review of policies, and record review the facility failed to implement and maintain an effective infection control program to contain and prevent facility transmission of COVID-19 in accordance with Centers for Disease Prevention and Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines and requirements. The facility failed to ensure infection control standards related to resident and staff hand hygiene and use of personal protective equipment were implemented and maintained for randomly observed residents on the 100, 200, and 300 halls. The facility failed to ensure dental staff while providing services in the facility and family members during a [MEDICATION NAME] visit used appropriate PPE and practiced social distancing. The facility failed to ensure staff donned, doffed, and used PPE (personal protective equipment) in accordance with accepted standards of practice to prevent contamination of PPE intended for reuse when caring for R1 who had COVID-19. The facility failed to ensure staff used all recommended PPE in accordance with CDC guidelines for new and readmitted residents to prevent facility-transmission of COVID-19. The facility failed to implement appropriate transmission-based precautions during the 14-day period following admission for R10 and R 16. On 8/12/20 the facility was made aware 5 of 25 residents on the 100 hall (R1, R4, R5, R6, and R10) tested positive for COVID-19. Although the facility moved the five residents to the COVID unit; the facility failed to identify the 20 remaining 100 hall residents and 100 hall assigned or float staff as persons under investigation for COVID-19. The facility failed to implement use of full PPE for care of all residents on the 100 hall, failed to implement immediate separation of the 100 hall from the rest of the building and failed to ensure dedicated staff to contain COVID-19 to the affected unit (100 hall) and prevent spread to other areas of the facility. Two days later 10 additional COVID positive residents were identified on the 100 hall. The facility failed to implement a system to ensure accurate and timely identification of residents and staff exposed to COVID-19, with unknown COVID status, and with positive COVID-19 status. Accurate and timely information is necessary to ensure implementation of transmission-based pre-cautions, isolation of staff and residents, cohorting of residents, and assignment of staff. The facility failure to maintain infection control measures to prevent facility-transmission of COVID-19 placed staff and 96 residents on the non-COVID units in immediate jeopardy and at risk for serious illness and death related to COVID-19. Immediate action was required to prevent further spread of COVID-19 to other areas of the facility. The facility administrator was informed of the determination of immediate jeopardy verbally on 8/12/20 at 2:00 PM, verbally on 8/13/20 at 4:00 PM, and in writing by email on 8/13/20. Findings include: The facility administrator and the facility Infection Control Officer (IP, infection preventionist) were interviewed on 8/12/20 at 9:30 AM. The administrator reported a resident census of 106. IP said the facility had a dedicated COVID unit (700 hall). The COVID unit was self-sustaining with a separate entrance and exit, dedicated staff who worked only on the COVID unit and did their own housekeeping with meals delivered to the unit in disposable plates and utensils. IP reported the current census on the COVID unit was 10 and the facility staffed for 10 but could staff for a surge on the COVID unit. IP said the staff on the COVID unit used full PPE including washable gowns. The administrator reported the facility had adequate PPE and expected a delivery of N95 masks that day. IP said the 500 hall was designated for new admissions and readmissions for 14-day observation/quarantine before moving to other units in the facility. IP described the 400 hall as the step-down unit for residents under investigation for COVID and for residents who come out of the COVID unit to allow for an additional two weeks observation. IP said one resident, (R1) was in isolation at the end of the 400 hall because he was symptomatic and waiting for COVID test results. IP said the facility was open to visitors for a short time and had a fair amount of visitors but was again closed to visitors due to some positive COVID tests. IP said all residents were tested on admission and placed on isolation for 14 days. The facility conducted universal testing (testing all including those with no signs or symptoms of COVID) for staff and residents. IP said in July 2020; five staff tested positive for COVID-19 and were from different units. Documentation of facility surveillance and tracking of persons under investigation for COVID-19 such as persons with symptoms, known exposure, and new admissions, was requested. IP provided a spreadsheet that showed universal COVID testing of residents on 6/26/20 with no positive results and testing on 7/23/20 with COVID positive results identified for two residents on the 400 hall. When asked for all information regarding infection surveillance, IP provided a spreadsheet titled Admit Cohort Tracking Log. The log had seven columns: resident name, admit to, admitted , 1st test, results, 2nd test, results, and OFF ISO. The log included 28 resident names admitted to rooms on the 500 and 700 halls. The log covered dates from 5/11/20 through 6/30/20. IP said he was behind in updating the infection surveillance logs. IP provided a third spreadsheet titled, COVID Unit. The log had seven columns; name, positive test date, moved to unit, symptoms onset, symptoms, clear date, and discharged to. Fourteen resident names were entered. The log indicated R11 with a positive test date of 7/31/20 admitted to the unit on 8/5/20 with symptom onset 8/11/20 of shortness of breath and [MEDICAL CONDITION] symptoms. The clear date column indicated; continue to monitor if improved reeval (reevaluate) on 8/21/20. In an interview on 8/13/20 at 10:20 AM, IP said the facility moved the COVID unit from the 400 hall to the 700 hall around July 22, 2020 so the dates on the log may be skewed. When asked about the log entry for R11 with positive test on 7/31/20 and not moved to COVID unit until 8/5/20, IP said it probably took that long to get the test results back. When asked if R11 was in isolation while waiting test results, IP replied Probably so but IP said he did not include residents under investigation or waiting for test results and did not include staff in his surveillance data. IP said he recently passed his RN boards and although he completed the CDC course for infection control he was new to his role as infection control officer (infection preventionist) and did not yet have a coordinated and comprehensive system set up to document tracking and trending for surveillance during infection outbreaks such as COVID-19. IP said the facility based policies and procedures on CDC guidelines and he was not aware of tools available through CDC to assist LTC facilities to detect, characterize, and investigate outbreaks of respiratory illness such as COVID-19. A separate universal testing spreadsheet showed staff testing 6/26/20 identified two licensed nurses and one central supply staff who tested positive. Staff testing between 7/8/20 and 7/27/20 indicated two licensed nurses, two nursing assistants, and one physical therapist tested positive for COVID-19. The staff test spreadsheet did not indicate where the staff worked in the building, did not indicate if known exposure or presence or absence of COVID-19 symptoms, and did not indicate interventions or disposition. IP said the COVID positive staff worked on all units including the 100 hall. When asked to describe the measures taken to prevent facility spread of COVID-19 after positive staff were identified in July 2020, IP said, There was nothing to be done because we already required universal masking and face shields for all staff. IP stated the facility was trying to conserve PPE (personal protective equipment) and required gowns be worn with only the highest risk residents. IP said he only required isolation gowns be used with transmission-based isolation precautions for COVID positive residents, roommates of COVID positive residents, those exposed to COVID, or those residents on the same HVAC (heating ventilation and cooling) system as COVID positive residents. IP explained that the HVAC system was segmented with one system covering about three resident rooms. IP said he determined who required transmission-based precautions based on the HVAC system. IP said the facility did not implement a PPE reuse strategy for gowns due to an

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135125	A. BUILDING _____ B. WING _____	08/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CREEKSIDE TRANSITIONAL CARE AND REHABILITATION	1351 WEST PINE AVENUE MERIDIAN, ID 83642

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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) increased risk for error with re-use. IP said the facility did not require staff wear gowns for transmission-based precautions for residents on the 500 hall for 14 day observation following admission or readmission. IP said the decision regarding not using gowns was based on crisis capacity for PPE and CDC's ever changing guidance. However, during the initial interview, the administrator reported the facility had an adequate PPE supply. IP did not provide evidence the facility was at crisis capacity for PPE. IP provided an undated, 3-page facility document titled Creekside Testing Plan Section 5. New Admit Testing and screening read in part; *All new admits will be tested three times prior to removal of isolation/quarantine. Testing will be completed with 3 spaced out intermittent testing prior to removal of isolation protocol. Ongoing review of burn rate of PPE completed to determine PPE utilization and level of isolation precautions. *All new admits are placed on modified isolation precautions (standard plus droplet utilizing (gloves, face shield, or goggles) until 3 negative tests are returned. *After completion of 14 days of isolation with no s/sx (signs or symptoms) of COVID-19, resident is discontinued from droplet isolation. The facility policy titled; Infection Control and Prevention Policy; Emerging Infectious Disease (EID): Coronavirus 2019 (COVID-19), revised 6/12/20 identified four steps to take to minimize the spread 1. Isolate 2. Minimize contacts with all residents 3. Increase transmission-based precautions 4. Increase monitoring of residents and staff. On page 7 of 13, the policy read in part: Increase transmission-based precautions: As of June 11th, 2020 the facility PPE process is universal masking for all health care workers in the building. Residents are to be placed on droplet+ standard reaction (face shield, universal mask and gloves) until they have 2 negative COVID-19 nasal swabs. These tests are to be performed on day one and day four of admission. They are then moved to standard precautions and a third nasal swab will be performed on/around the 12th day of their stay. Test may vary depending on available supplies and resident wishes. The facility policy and practice was not consistent with CDC guidelines which required full PPE to include facemask, eye shield or goggles, gown, and gloves when caring for residents during the 14-days following admission. Medical record review revealed R16 admitted to the facility (500 hall) on 7/14/20. A swab was obtained for COVID testing on 7/15/20. MDS note dated 7/19/20 at 11:20 noted post admission on 7/18/20 R16 was found to be COVID positive and placed on strict isolation precautions. The note read in part; on 7/19/20 she had and elevation of temperature of 99.9. She has [MEDICAL CONDITION] (breathing machine for sleep apnea) at bedtime. Prior to going into isolation she was seen by PT (physical therapy) who worked with her on bed mobility, exercises, and transfers. She was seen by OT on 7/15/20 for functional ADL (activities of daily living) requiring moderate to maximum assist. The MAR indicated [REDACTED]. R16 received respiratory treatments, physical, occupational therapy, and nursing care for six days following admission without appropriate transmission-based precautions. A progress note written by the Director of Nursing Services on 7/18/20 indicated R16 was moved to the 400 COVID hall COVID unit due to the positive result of her COVID test that was performed on the 13th and facility was called with the positive results last night. A telehealth note written by the nurse practitioner on 7/21/20 indicated R16 tested positive for COVID-19 on 7/17/20. The COVID Unit surveillance log indicated R16 tested positive for COVID on 7/17/20, moved to the COVID unit on 7/17/20 and discharged to the hospital on [DATE]. Review of the medical record review revealed R10 admitted to the facility on [DATE] from a separate assisted living facility located on campus. R10 admitted directly to the 100 hall room [ROOM NUMBER]A. R10 was not placed on transmission-based precautions or isolation at the time of admission. Six days after admission, a nasal swab was collected on 7/23/20 for COVID testing. A progress note dated 8/12/20 noted R10 was New COVID positive, asymptomatic (no symptoms). Isolation, droplet precautions were ordered 8/13/20 at 6:00 PM. In an interview on 8/13/20 at 2:00 PM the DNS confirmed R10 was admitted directly to the 100 hall and was not placed on 14-day new admission observation or droplet precautions until R10 tested positive. The DNS said she did not consider R10 to be a new admission because she came from the Assisted Living Facility on campus. In a telephone interview the corporate clinical nurse (CNN) stated she was not aware IP changed the facility policy to not require gowns for droplet precautions. CCN concurred the changed facility policy was not consistent with CDC guidelines which required gowns. 400 Hall observations: PPE and transmission-based precautions On 8/12/20 at 12:10 PM resident room [ROOM NUMBER] had a caddy hanging on the door that held one yellow gown, a box of gloves, and a container of disinfectant wipes. No signage was present to indicate to staff if R1 required precautions (aka; isolation) or what specific PPE was required to enter the room to care for R1. LN1 and NAC1 wore face masks and face shields. LN1 and NAC1 stepped inside room [ROOM NUMBER] and donned gowns that hung in the room and gloves then entered the room. A few minutes later, LN1 stood just inside the doorway and removed the gloves and then the gown. LN1 touched the front of the gown with both bare hands to feel for the waist tie. LN1 untied the gown and then pulled on the front of the gown pull it off her torso, then pulled the sleeves off by holding the cuffs. LN1 hung the gown on a hook on the wall. The gown hung with the outside of the gown facing outward and the gown touched another gown that hung nearby. The hooks and gown were not labeled. LN1 used ABHR (alcohol based hand rub) immediately after exiting the room. A few minutes later, NAC1 stood near the doorway and removed gloves and then gown. NAC touched the outside front of the gown with bare hands then contaminated the gown as she held the inside of the gown and hung the gown on top of a gown already hanging on a hook (stacked two gowns on one hook). In an interview upon exiting the room, LN1 said the gowns were to be reused due to conservation mode. LN1 said each staff had their own gown for the room. When mentioned the gowns were not labeled, LN1 said No, you just remember which is yours. When asked if they were hung correctly to prevent contamination when reused, LN1 replied probably not, you should be able to put your arms right into the sleeves without touching the outside. On 8/12/20 at 12:25 PM IP was informed of the observation of gowns doffed improperly and stored improperly for reuse. IP said LN1 informed him about her response to questions about use of gowns for room [ROOM NUMBER]. IP said LN1 gave the surveyor inaccurate information. IP said the disposable gowns were not intended for reuse. The disposable gowns were one-time use to be discarded after use. IP said all staff were educated regarding use of disposable gowns. IP said LN1 was a unit manager and should know the expectations. IP was asked about R1's medical condition and any required transmission-based precautions. IP said R1 was moved from the 100 hall to the 400 hall on 8/11/20. IP said R1 had a negative COVID test but had persisting gastrointestinal symptoms so the facility was re-testing him. IP said he moved R1 to the 400 hall until the test results come in. IP said the facility followed CDC guidelines so R1 was on droplet plus precautions. Regarding no signage to indicate the type of precautions and the required PPE to enter room [ROOM NUMBER]; IP said, ideally the room should have signage, IP added But the iso (referring to isolation) caddy was a visual clue that iso was needed. During an interview on 8/12/20 at 12:30 PM the DNS agreed there should be signage on room [ROOM NUMBER] regarding transmission-based precautions. DNS added But staff use the door-hung supply caddy or the small cart next to the room as a visual clue. The DNS acknowledged there were different types of transmission-based precautions (aka, isolation) and the staff could not discern the required type of isolation or the specific required PPE from the caddy or cart. Observation on 8/12/20 at 12:35 PM revealed isolation caddies hung on two empty room doors on the 400 hall. Additionally a cart placed between resident rooms [ROOM NUMBERS] was not labeled to indicate which room if any required isolation precautions. IP placed signage on room [ROOM NUMBER] door indicating droplet plus contact precautions required and, dispose of gowns after use. The signage read: Droplet and Contact Precautions. Bed ___. Families and visitors STOP. Please report to staff before entering. Clean hands before entering and when leaving room. Graphic images of ABHR (alcohol based hand rub) and handwashing with text; clean hands with A. hand foam/gel or B. soap and water. Staff: KEEP SIGN POSTED UNTIL ROOM CLEANED. HOUSEKEEPER will remove sign after Discharge cleaning. POINT of CARE Risk Assessment. Gown and Gloves. Procedure mask with eye protection-when within 2 metres of patient. Keep 2 metres between patients. The sign indicated it was produced by PICnet, (provincial network of British Columbia), a program of the Provincial Health Services Authority. When asked why the facility did not use resources and signage available through CDC, in a written response, IP wrote that he felt the PICnet signs better encompassed our infection control protocols IP's response indicated the PICnet signage matched the CDC recommended guidelines. IP wrote: My rationale was that it is more complete and easy to edit in the case of adding a N95 (for example) to the precautions as recommendations have changed over the course of the COVID-19 season. IP further wrote; Droplet plus contact precautions signs are used for the COVID unit (because it includes the N-95 mask) while Contact-Plus is used upon admit residents, and the point of care assessment can be over ruled due to the fact that surgical mask or higher and face shield is required center wide. The PICnet Contact Plus Precautions sign directed; Contact Plus Precautions-Used for [MEDICAL CONDITION] Infection (CDI) Only. [MEDICAL CONDITION] is a bacterium that causes severe diarrhea. Contact Plus sign showed a picture of a person wearing gown and gloves but no facemask or eye shield. And directed Staff: Required gown and gloves. The sign read; Point-of-Care-Assessment. When there is a risk of splash or spray, wear face and eye protection. The facility policy titled Infection Control and Prevention Policy- Emerging Infectious Disease (EID): Coronavirus Disease 2019, revised 6/12/20 read in part; Procedure: 1. Minimize Chance for Exposures interventions included *Identify, stock, and staff separate designated areas of the building to room:-diagnosed COVID-19 positive resident(s) or suspected

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135125	A. BUILDING _____ B. WING _____	08/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CREEKSIDE TRANSITIONAL CARE AND REHABILITATION	1351 WEST PINE AVENUE MERIDIAN, ID 83642

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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) (symptomatic residents -Suspected COVID-19 positive resident (post exposure) pending test results and -New admissions to the building for 14 days (observation) may include [MEDICAL TREATMENT] residents (potential community exposure). *Ensure rapid safe triage and isolation of patients with symptoms of suspected COVID-19 or other respiratory infection. 2. Adhere to Standard and Transmission-Based Precautions. Read in part; Attention should be paid to training and proper donning (putting on), doffing (taking off), and disposal of any PPE. Personal Protective Equipment; HCP (health Care professional) must receive training on and demonstrate an understanding of: when to use PPE, what PE is necessary, how to properly don, use, and doff PE in a manner to prevent self-contamination, how to properly dispose of or disinfect and maintain PPE, and the limitations of PPE. The facility policy and procedure regarding transmission-based precautions, the PICnet signage, and directions for precautions were not consistent with the CDC guidelines which required an N95 mask, eye protection, gown, and gloves for care of residents suspected to have COVID-19, known COVID positive, and during the 14 day observation period following admission or readmission. From CDC website at www.cdc.gov. Preparing for COVID-19 in Nursing Homes Updated June 25, 2020 Because of the higher risk of unrecognized infection among residents, universal use of all recommended PPE for the care of all residents on the affected unit (or facility-wide depending on the situation) is recommended when even a single case among residents or HCP is newly identified in the facility; this could also be considered when there is sustained transmission in the community. Residents with known or suspected COVID-19 should be cared for using all recommended PPE, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown. Cloth face coverings are not considered PPE and should not be worn when PPE is indicated. Signage on the use of specific PPE (for staff) is posted in appropriate locations in the facility (e.g. outside of resident's room, wing, or facility-wide). Review of Centers for Disease Control and Prevention (CDC) cases and deaths by county, https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/county-map.html showed Ada County, where the facility is located, had 2,104 cases per 100,000 which indicated high community COVID-19 activity. [MEDICATION NAME] visit Review of R5's medical record revealed a medical provider note dated 7/28/20 noted R5 has been isolating in her room currently with her spouse (R6) as he has been having a fever and is 'not feeling well'. Review of R6's medical record revealed a physician order [REDACTED]. The order did not specify what type of precautions and did not specify the reason for precautions. No directions were specified for the order and the order was not entered onto the medication or treatment record. The record did not reflect whether the precautions were implemented on 7/18/20 and the daily charting did not document isolation precautions. Progress notes written 7/27/20 noted R6 had elevated temperature at 101.1 and abnormal lung sounds. A progress note dated 7/30/20 noted R6 continued on antibiotics for pneumonia and was on gown isolation. Observation conducted on 8/12/20 from 1:18 PM to 1:25 PM revealed no signage to indicate precautions for R5 and R6's room [ROOM NUMBER]. NAC2 said room [ROOM NUMBER] was not on isolation. NAC2 was asked to identify persons in room [ROOM NUMBER]. NAC2 identified a family member, a hospice nurse and social service staff. NAC2 said it was a [MEDICATION NAME] visit for hospice. The family member at R5's bedside did not wear a facemask. The hospice nurse wore a facemask and eye protection but no gloves and no gown and leaned on the overbed table. Several staff came and went from the room at various times wearing face mask and eye shield but no gown or gloves. Hospice nurse, family, and facility staff engaged in comforting behaviors such as rubbing R6's back and patting shoulders, no hand hygiene was performed following such comfort measures. Social distancing was not maintained. Four hours later, positive COVID test results were reported for R5 and R6 at 5:40 PM on 8/12/20 and both were transferred to the COVID unit. Potentially contaminated intravenous fluid available for use On 8/12/20 at 11:45 AM a bag of 0.9% NACL (Normal saline) hung on a pole in the 400 corridor outside room [ROOM NUMBER]. The bag was spiked (bag punctured to attach tubing). The IV solution label had no date to show when it was opened (spiked) and no resident name or room number. LN1 exited room [ROOM NUMBER] and was asked about the IV solution. LN1 said she did not know anything about it, no resident on the hall needed IV fluids. On 8/12/20 at 11:47 AM, when shown the IV solution hanging on the pole, IP confirmed no current resident required IV fluid and said he would investigate. IP returned at 12:30 PM and reported he thought staff got the IV fluid ready to give to R2, but R2 went out to the hospital so they probably did not have time to start the IV. IP said R2 went to the hospital around the 4th or 5th. IP said the IV solution should have been labeled with the date and time it was spiked and the resident's name. IP said the IV solution was not safe, because it could be contaminated with bacteria. IP said IV fluid should be used within 24 hours after it is opened or spiked, but added he doubted anyone would use it. IP discarded the IV solution. Outside Professional Provider On 8/12/20 at 12:06 PM observed personnel P1 in room [ROOM NUMBER] as she washed her hands. P1 wore a face mask, face shield, and a gown. When asked about PPE requirements in the facility, P1 responded that she did not know because she was not facility staff. P1 explained she came into the facility with the dentist to provide dental exam and dental treatment to residents, and added, We wear this gown when we are working on residents. IP was called to the 400 hall. When IP was asked if the dentist and his staff were screened and instructed in the use of PPE, facility restrictions/process regarding movement of residents in the facility, where treatment would be provided, and which residents would be treated; IP said he did not know the dentist was in the building, IP said only essential services were to be allowed in the building and he should have been consulted before the dentist came into the facility. IP concurred dental treatment would be considered aerosol generating procedure (AGP) with increased risk for transmission of COVID-19. When asked the facility expectation for dental examination and treatment in the facility, IP said the dental staff would need full PPE including N95 facemask, face shield, gowns, and gloves due to the increased risk with AGP. IP said he obtained more information and reported the dentist came to the facility because two residents had pain. IP said both residents had negative COVID tests. IP said the dentist brought his own reusable washable gown which the dentist reported he wore. IP said he placed disposable gowns in room [ROOM NUMBER] and instructed the dentist and his staff to use disposable gowns, one gown per resident. IP said the dentist stated last Thursday (6 days prior) he was in a skilled nursing facility that had COVID-19. When asked about screening of the dentist for facility entry; IP said the screening should have identified that the dentist was in a COVID positive building 6 days earlier and either he (IP) or the DNS should have been informed to review the screening information and to provide direction regarding allowing access to the residents. IP reported social services set up the dental visit and the DNS was also unaware the dentist was in the building. Resident hand hygiene Observed distribution of lunch trays on 8/12/20 from 12:46 PM to 12:58 PM on the 300 hall. Transportation staff TS1 and maintenance staff MS1 assisted. TS1 delivered a meal tray to room [ROOM NUMBER] and set up the tray on the overbed table. TS1 did not perform hand hygiene when exiting the room. TS1 got a tray from the tray cart which he delivered to room [ROOM NUMBER] with no hand hygiene when entering or exiting the room. Observed trays delivered by various staff to rooms, 306, 308, 311, 313, and others with no pre-meal hand hygiene provided or offered to the residents. Similarly on the 100 hall NAC2 delivered and set up trays in rooms 106, 108, 114, and others without providing or offering the residents pre-meal hand hygiene. Observation of the evening meal on 8/12/20 from 5:00 PM to 5:25 PM revealed NAC4 delivered trays on the 200 hall to residents in rooms 205, 201, 203, 209, and 212. Residents were not provided or offered hand hygiene prior to the meal. The meal included sloppy joes, French fries, and vegetables. Residents ate the sloppy joes and French fries with their fingers. Evening meal observations conducted on the 300 hall revealed similar findings of no hand hygiene offered or provided by NAC3, unit manager, or Staff 1 to residents in rooms 308, 311, 312, and 313. CMS State Operations Manual: If residents need assistance with hand hygiene; staff should assist with washing hands after toileting, before meals, and use of ABHR or soap and water at other times when indicated. Observations 8/13/20 On 8/13/20 at 8:40 AM R3 stood at the door in room [ROOM NUMBER] and requested assistance. Social service staff SS sat in an office nearby and was informed of the request. SS did not perform hand hygiene before she donned a facemask and face shield that sat on her desk. SS went to room [ROOM NUMBER] and donned gloves and then a gown and entered the room. SS said last night R3 moved to 408 from another unit. SS said R3 did not test positive for COVID-19 but she was exposed so she had to move to a new room. Signage on the door indicated droplet plus contact precautions. IP confirmed R3 was a relative and had close personal contact with two residents who tested positive for COVID-19. R1 was no longer in room [ROOM NUMBER]. Review of the census log for 8/13/20 revealed the facility made eight room changes overnight; R1 moved from 412B to the COVID unit, R4, R5, R6, and R10 moved from the 100 hall to the COVID unit and R7, R8, and R9 moved out of the COVID unit to the 400 hall. The census log did not reflect R3's move from 110A to 408. Observation of the 100 hall at 10:00 AM revealed five resident rooms (109, 110, 112, 113, and 114) had signage indicating droplet precautions required. No rooms on the 100 hall required droplet precautions on 8/12/20. NAC5 said she was not told of concerns at 6:00 AM report, but then at 9:00 AM she noticed the isolation signs were up. NAC5 said she thought one resident was positive. NAC5 said she was informed it was precautionary, a roommate came back so be aware of that, watch for symptoms, wash hands, gown up and put on gloves and face shields and have resident wear a mask. In an interview on 8/13/20 at 10:30 AM IP said two employees who worked on the 100

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135125	A. BUILDING _____ B. WING _____	**08/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CREEKSIDE TRANSITIONAL CARE AND REHABILITATION	**1351 WEST PINE AVENUE MERIDIAN, ID 83642**

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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) hall tested COVID-19 positive around July 27, 2020 so the facility conducted COVID testing of all residents on the 100 hall. IP said the facility received a call last evening at 5:40 PM with the first results confirming COVID positive test results for 5 of 25 residents on the 100 hall (R1, R4, R5, R6, and R10). Test results for 20 residents were still pending. When asked to describe the measures the facility implemented to contain the outbreak on the 100 hall, IP said R1 was moved to the 400 hall on 8/11/20 because he spiked a temperature. IP said he was going under the assumption that R1 was negative when he moved him, but he (R1) turned up positive. IP said R10 was moved to the 400 hall on 8/12/20 because she was exposed through close contact (regular visits) with two positive residents. When asked why residents in only five 100 hall rooms were identified for droplet precautions and shouldn't all residents on the 100 hall be isolated. IP said he based his decision on the HVAC system. IP said he did not consider it necessary to lock down or quarantine the entire 100 hall. Discussed CDC guidelines that all recommended COVID 19 PPE should be used during care of all residents on the affected unit or facility. IP said it was not necessary and it was not in the facility plan to isolate an entire unit. IP said closing the unit would have been pr