STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135140	A. BUILDING _____ B. WING _____	10/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MADISON CARRIAGE COVE SHORT STAY REHABILITATION	410 WEST 1ST NORTH 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)
E 0024 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Establish policies and procedures for volunteers.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, review of facility infection surveillance documents, and staff interview, it was determined the facility failed to ensure an emergency preparedness plan was developed and implemented for providing 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 residents and staff to be exposed to COVID-19 infection and experience negative outcomes to their health. The findings include: The facility's Emergency Management Plan Activation Evaluation Form, dated 3/13/20, stated the type of emergency was emerging infectious disease (COVID-19). The Emergency Management Plan stated As of 8:00am (sic) on 3/13/20 (sic) our facility went into full lockdown after receiving a letter from CMS (Centers for Medicare & Medicaid Services) to do so. Only employees are allowed in the building, a screening is to be done daily upon entering the facility, temperatures will be checked, questionare (sic) is to be done and hand sanitizing is to be done. We will stay in lock down until instructed to do otherwise. Under the Treatment Areas section of the Emergency Management Plan, it stated isolated to rooms/216 - 219 designated for isolation. The Emergency Management Plan 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. On 10/8/20 at 12:35 PM, the ICP stated the facility was following CDC guidance for mitigating staff shortages and to determine when positive staff could return to work. At 12:50 PM, the ICP provided the survey team with two CDC documents. The first CDC document was titled Strategies to Mitigate Healthcare Personnel Staffing Shortages, updated 7/17/20. The second CDC document was titled Criteria for Return to Work for Healthcare Personnel with [DIAGNOSES REDACTED]-CoV-2 (COVID-19) Infection (Interim Guidance), updated 8/10/20. The document titled Strategies to Mitigate Healthcare Personnel Staffing Shortages stated, If HCP (Health Care Personnel) are tested and found to be infected with [DIAGNOSES REDACTED]-CoV-2, they should be excluded from work until they meet all Return to Work Criteria. The guidance also stated the following: * 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 are 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. The document titled Criteria for Return to Work for Healthcare Personnel with [DIAGNOSES REDACTED]-CoV-2 (COVID-19) Infection (Interim Guidance) stated HCP could return to work when at least 10 days had passed since symptoms first appeared, and at least 24 hours had passed since their last fever without the use of fever-reducing medications, and symptoms (e.g., cough, shortness of breath) had improved. The facility's Emergency Staffing policy, dated 3/27/20, stated In an emergency situation, the Administrator and key staff .shall meet for briefing on staffing needs and develop an action plan .Staffing needs will be fulfilled in a step-wise fashion: a. On-duty staff and scheduled staff. b. Off-duty staff and on-call staff, including department managers . The Emergency Staffing policy did not include information related to having dedicated staff work only on the COVID unit. The facility's Novel Coronavirus Prevention and Response policy, dated 9/2/20, stated interventions to prevent the spread of respiratory germs within the facility included monitoring staff for fever and respiratory symptoms. The policy stated Restrict (staff) from work and follow current guidance about testing and returning to work (e.g., local health department, CDC). The guidance and facility policies were not followed. During an observation on 10/8/20, RN #1 stated at 10:05 AM, she was assigned to the North hall, to serve both the COVID-19 negative and COVID-19 positive residents. RN #1 stated 3 residents (#1-#3) were in the COVID-19 positive unit at the end of the North hall on the other side of the plastic barrier. RN #1 stated she crossed the plastic barrier to administer medications and completed assessments for the 3 residents on the COVID-19 positive unit and then crossed back through the plastic barrier to the COVID-19 negative unit to administer medications and completed assessments for the 12 residents that were negative for COVID-19. RN #1 stated she mainly stayed on the COVID-19 negative unit. COVID-19 test results and staff timecards, dated 9/14/20 - 10/7/20, documented the day staff tested positive and staff who returned to work prior to the 10-day criteria, as follows: - The BOM tested positive on 9/14/20 and worked on 9/23/20 (9 days). - CNA #1 tested positive on 9/25/20 and worked on 9/30/20 (5 days). - RN #1 tested positive on 9/28/20 and worked on 10/1/20, 10/2/20, and 10/5/20 (3 days). - CNA #2 tested positive on 9/29/20 and worked on 10/3/20 and 10/4/20 (4 days). - CNA #3 tested positive on 9/29/20 and worked on 10/3/20 and 10/4/20 (4 days). On 10/8/20 at 12:50 PM, the ICP stated the facility did not have enough nurses to work only the COVID-19 positive unit. On 10/8/20 at 1:03 PM, the DON stated the night nurse went back and forth between the COVID positive unit and the negative unit as the facility did not have enough nurses to staff both the positive and negative units. The facility failed to take actions to prevent the transmission of COVID-19 when staff and residents tested positive for COVID-19. The facility failed to ensure an emergency preparedness plan was sufficiently developed and implemented to provide dedicated staff for the COVID-19 positive unit to prevent further transmission to residents and staff who tested negative for COVID-19.
F 0684 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, it was determined the facility failed to ensure nursing staff followed 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 3 residents (#1, #2, and #3) 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, 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, and accessed on 10/13/20, 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

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 0684 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 1) 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 10/8/20 at 1:26 PM, RN #1 stated when she was scheduled on the COVID-19 positive unit on 10/1/20, 10/2/20, and 10/5/20, the nurses that worked the North hall, located outside of the COVID-19 positive unit, prepared the medications and delivered them to her in the COVID-19 positive unit to administer to the residents. RN #1 stated the medications were placed in medicine cups with the resident's room number handwritten on each medicine cup by the licensed nurse from the North hall. The medicine cups were placed on a bedside table located inside the COVID-19 positive unit. RN #1 stated she could not verify the medications were administered at the right dose, right medication, right resident, right time, and by the right route (e.g. oral, injection, rectal). RN #1 stated she did not sign in the Electronic Medical Record (EMR) for the medications she administered. RN #1 stated if a resident refused medications, she notified the licensed nurse working the North hall of the resident's refusal and that nurse documented the refusal in the resident's EMR. On 10/8/20 at 5:20 PM, RN #2 stated she worked the North hall and dispensed the medications of the 3 residents (#1, #2, and #3) on the COVID-19 positive unit into medicine cups, documented the medications as given in the EMR, and delivered the medication cups to RN #1 working in the COVID-19 positive unit. On 10/8/20 at 5:30 PM, the DON stated the licensed nurses scheduled to work the North hall on 10/1/20, 10/2/20, and 10/5/20 dispensed the medications, signed the EMR as given, and delivered the medications to RN #1 who was working in the COVID-19 positive unit for the residents there. The DON stated RN #1 was unable to verify the medications for each resident with the 5 rights (right dose, right medication, right time, right person, right route). The medications were not individually labeled and did not include sufficient information to identify which resident the medications were intended for. 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 Residents #1, #2, and #3 on the COVID-19 positive unit at imminent risk of significant medication errors resulting in serious harm, impairment, or death. On 10/8/20 at 7:18 PM, the facility Administrator, DON, and ICP were verbally informed of the Immediate Jeopardy (IJ) determination at F684 and written notification was emailed to the facility on [DATE] at 11:49 AM. On 10/9/20 at 1:45 PM, the facility provided a plan to remove the immediacy. The facility alleged the immediacy was removed on 10/8/20 at 10:00 PM. The removal plan was received on 10/9/20 at 12:42 PM and was accepted on 10/9/20 at 1:45 PM. The facility's IJ removal plan included: - Licensed nurses were scheduled to work the COVID-19 positive unit to administer and document medications for all shifts. A medication cart was delivered and accessible by the licensed nurses to administer medications for residents located on the COVID-19 positive unit. A laptop was accessible to document medications were dispensed and administered by the licensed nurse that was scheduled in the COVID-19 positive unit. Surveyors completed onsite verification on the removal of the IJ and confirmed the IJ was removed as of 10/8/20 at 10:00 PM. On 10/9/20 at 2:35 PM, the Administrator, DON, and the ICP were verbally informed the immediacy was removed based on onsite verification the IJ removal plan was implemented.
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** Based on observation, record review, and staff interview, it was determined the facility failed to ensure nursing staff with the appropriate competencies provided nursing and related services to 3 of 3 residents (Residents #1, #2, and #3) who resided on the COVID-19 positive unit. This deficient practice placed residents at risk of injury, lack of necessary services, and inappropriate care if staff did not have the knowledge and skills to perform them competently. Findings include: The facility's Nurse Aide Trainee Job Position documented, The primary purpose of your job position as a full-time staff member is to acquire the knowledge, skills, and certification as a Certified Nursing Assistant by participation in the facility's planned educational program consisting of classroom instructions, clinical practice, and on-the-job, supervised training, and to perform certain services for which you have been trained and found to be competent during the training period. The facility's Daily Nursing Staff Assignment, dated 10/8/20, documented the Medical Records/Receptionist was assigned to work as an NA in the COVID-19 positive unit. The staff person called in sick and the Business Office Manager (BOM) filled the position. The BOM was observed working in the COVID-19 positive unit on 10/8/20. The BOM was interviewed at 1:40 PM and stated in addition to being the BOM, he was an NA and Administrator in Training (AIT). He stated this was his first day working in the COVID-19 positive unit because the Medical Records/Receptionist called in sick. He reported he completed residents' vital signs and ADLs (Activities of Daily Living) and then informed a CNA, who was working the COVID-19 negative unit on the North hall, of the cares and assistance provided for Residents #1, #2, and #3 and that CNA entered the results in the residents' EMR. On 10/9/20 at 1:30 PM, the DON stated the BOM obtained vital signs and assisted residents with their ADLs, and then informed a CNA, who was working the COVID-19 negative unit on the North hall, who then entered the results in the residents' EMR. The DON stated the BOM did not have access to the EMR to document. On 10/9/20 at 2:35 PM, the DON stated there was no documentation of NA training or competencies for the Medical Records/Receptionist or the BOM. The DON stated the BOM used to be an NA and he would have to look for the documentation. The facility failed to ensure all staff providing nursing and related services to residents had the competencies and skills to do so.
F 0880 **Level of harm** - Immediate jeopardy **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, review of facility infection surveillance documents, 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 negative staff in the facility, and all 24 residents on the COVID-19 negative units in the facility, in immediate jeopardy of serious harm, impairment, or death related to COVID-19 infection. Findings include: 1. The facility did not have designated staff to work the COVID-19 positive unit each shift and ensure staff who tested positive worked on the COVID-19 positive unit only after meeting criteria to return to work. Examples include: a. The CDC website, accessed on 10/14/20, 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 included two halls, the North hall and the South hall. The North hall had a plastic barrier that covered floor to ceiling and wall to wall separating rooms 216-223 from the other rooms in the North hall. This area was identified as the COVID-19 positive unit. Residents #1, #2, and #3 tested positive for COVID-19 and resided in this unit. The facility's Daily Nursing Staff Assignment, dated 9/28/20 - 10/8/20, included nurse staffing assignments for the North and South halls, which were 12-hour shifts. The schedule documented one licensed nurse was assigned to the North hall for the night shifts, for both the COVID-19 negative and COVID-19 positive residents. The schedule documented one licensed nurse was assigned to the North hall for the day shifts on 9/28/20 - 9/30/20, 10/3/20 -10/4/20, and 10/6/20-10/8/20, to serve both the COVID-19 negative and COVID-19 positive residents. On 10/8/20 at 10:05 AM, RN #1 stated she was assigned to the North hall, to care for both the COVID-19 negative and COVID-19 positive residents. RN #1 stated Residents #1, #2, and #3 were in the COVID-19 positive unit at the end of the North hall on the other side of the plastic barrier. RN #1 stated she crossed the plastic barrier to administer medications and completed assessments for the 3 residents on the COVID-19 positive unit and then crossed back through the plastic barrier to the COVID-19 negative unit to administer medications and completed assessments for the 12 residents that were negative for COVID-19. RN #1 stated she mainly stayed on the COVID-19 negative unit. On 10/8/20 at 11:43 AM, RN #1 was observed crossing the plastic barrier from the COVID-19 negative unit into the COVID-19 positive unit with medications for Resident #1. On 10/8/20 at 12:03 PM, RN #1 was observed crossing the plastic barrier from the COVID-19 positive unit into the COVID-19 negative unit. On 10/8/20 at 12:09 PM, RN #1 was observed administering medications to Resident #6, who resided on the COVID-19 negative unit. On 10/8/20 at 5:15 PM, the DON stated there were shifts where the nurses' scheduled to work the North hall from 9/28/20 to present were crossing the plastic barrier and working both the COVID-19 positive unit and negative unit for both the day shifts and night shifts. On 10/8/20 at 5:45 PM, LPN #1 stated she was scheduled to work 12 hours on the night shift. LPN #1

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F 0880 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	(continued... from page 2) stated she had worked the North hall when the COVID-19 positive unit was initiated. LPN #1 stated she had crossed the barrier from the negative unit into the COVID-19 positive unit to pass medications, complete nurse assessments, and provided cares for the residents residing on the COVID-19 positive unit. b. On 10/8/20 at 9:25 AM, the DON stated staffing at the facility had not been at a crisis level. On 10/8/20 at 12:35 PM, the ICP stated the facility was following CDC guidance for mitigating staff shortages and to determine when positive staff could return to work. At 12:50 PM, the ICP provided the survey team with two CDC documents. The first CDC document was titled Strategies to Mitigate Healthcare Personnel Staffing Shortages, updated 7/17/20. The second CDC document was titled Criteria for Return to Work for Healthcare Personnel with [DIAGNOSES REDACTED]-CoV-2 (COVID-19) Infection (Interim Guidance), updated 8/10/20. The document titled Strategies to Mitigate Healthcare Personnel Staffing Shortages stated, If HCP (Health Care Personnel) are tested and found to be infected with [DIAGNOSES REDACTED]-CoV-2, they should be excluded from work until they meet all Return to Work Criteria. The document titled Criteria for Return to Work for Healthcare Personnel with [DIAGNOSES REDACTED]-CoV-2 (COVID-19) Infection (Interim Guidance) stated HCP could return to work when at least 10 days had passed since symptoms first appeared, and at least 24 hours had passed since their last fever without the use of fever-reducing medications, and symptoms (e.g., cough, shortness of breath) had improved. The facility's Novel Coronavirus Prevention and Response policy, dated 9/2/20, stated interventions to prevent the spread of respiratory germs within the facility included monitoring staff for fever and respiratory symptoms. The policy stated Restrict (staff) from work and follow current guidance about testing and returning to work (e.g., local health department, CDC). The facility did not follow the guidance from the CDC or their policy. i. On 10/8/20 at 10:05 AM, RN #1 stated she tested positive for COVID-19 on 9/28/20, and had symptoms of a fever, cough, sore throat, nausea, occasional diarrhea, and fatigue. RN #1 stated she was assigned to and worked the COVID-19 positive unit on 10/1/20, 10/2/20, and 10/5/20. RN #1 returned to work three days after testing positive for COVID-19 and while she had active symptoms. RN #1 stated today, 10/8/20, she was assigned to work both the COVID-19 negative and COVID-19 positive units on the North hall and was crossing the plastic barrier to administer medications to both the COVID-19 negative and COVID-19 positive units. On 10/8/20 at 10:47 AM, RN #1 stated she had nausea and occasional diarrhea on 10/7/20, but none yet so far today. RN #1 stated she did not have her taste and smell and was fatigued. RN #1 stated she answered the questions on the staff screening log and someone else took her temperature. RN #1 was observed with a flushed face and she stated her N95 mask and face shield made her warm. The facility's staff screening log, dated 10/8/20, documented RN #1 had marked, yes for cough, congestion, shortness of breath, or sore throat. RN #1 marked, no for nausea, diarrhea, or lack of taste or smell. The screening log documented RN #1's temperature was 97.7 Fahrenheit. On 10/8/20 at 11:28 AM, RN #1 stated she filled out the screening log and was not assessed by a nurse or the ICP regarding the questions she answered yes too. RN #1 stated she was told by the DON on 10/7/20 that she could return to work because her symptoms had decreased. ii. COVID-19 test results and staff timecards documented staff returned to work prior to the 10-day criteria, as follows: - The BOM tested positive on 9/14/20 and worked on 9/23/20 (9 days). - CNA #1 tested positive on 9/25/20 and worked on 9/30/20 (5 days). - RN #1 tested positive on 9/29/20 and worked on 10/1/20, 10/2/20, and 10/5/20 (2 days). - CNA #2 tested positive on 9/29/20 and worked on 10/3/20 and 10/4/20 (4 days). - CNA #3 tested positive on 9/29/20 and worked on 10/3/20 and 10/4/20 (4 days). On 10/8/20 at 5:22 PM, the DON stated the CDC was the facility's primary source of information related to positive staff returning to work. The facility failed to ensure they had designated staff assigned to the COVID-19 positive unit each shift, and staff who tested positive met criteria for return to work and did not provide cares for residents who were on the COVID-19 negative 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 10/8/20 at 7:18 PM, the Administrator, DON, and ICP were informed verbally of a determination of Immediate Jeopardy. The written notification was provided to the facility via email on 10/9/20 at 11:49 AM. On 10/9/20 at 12:42 PM, the facility provided a plan to remove the immediacy. The facility alleged the plan to remove the immediacy was implemented 10/8/20 at 10:00 PM. The plan was accepted on 10/9/20 at 1:45 PM. The facility's IJ removal plan included: -Designated staff had been placed into the COVID-19 positive unit and will not cross over to the barrier during their shift. -Staff who tested positive and are having active COVID-19 symptoms will not be assigned to work any shifts on the COVID-19 negative unit. Surveyors completed onsite verification on the removal of the IJ and confirmed immediacy was removed as of 10/8/20 at 10:00 PM. On 10/9/20 at 2:35 PM, the Administrator, DON, and the ICP were verbally informed the immediacy was removed based on onsite verification the IJ removal plan was implemented. 2. The facility's Coronavirus Surveillance policy, dated 9/2/20, stated heightened surveillance activities would be implemented to limit transmission of COVID-19, including staff. The policy stated staff were to be screened for 1) signs and symptoms of a respiratory infection, 2) whether staff had contact with someone with a confirmed [DIAGNOSES REDACTED]. The policy stated staff with signs and symptoms of a respiratory infection shall not report to work and staff that develop signs and symptoms while on the job will immediately stop work, put on a facemask, and self-isolate at home. The facility's screening form for staff, undated, stated all staff were required to answer the questions on the form prior to beginning each shift. The screening form also stated if a staff responded yes to having a fever they must put on a mask and call either the administrator, DON, or ICP and an action must be documented on the back of the form to determine if they were eligible to work. The screening form questions were: - Cough, congestion, shortness of breath or sore throat present? - Nausea, diarrhea, lack of taste of smell (sic)? - Contact with person with COVID-19 or under investigation? - Travel in the past 14 days to an area with community spread COVID? - Are you or do you intend to work anywhere outside this facility? The form also included a column for documentation of staff temperatures. The facility's daily staff screening forms, dated 9/13/20 - 10/8/20, did not include documentation of the action taken by the facility to determine work eligibility when staff answered yes to questions. There were also screening forms with no documentation of staff temperatures. Examples include: - 9/17/20: One staff member marked yes to the question nausea, diarrhea, and/or lack of taste or smell. There was no documentation on the back of the form related to the action taken by the facility to determine work eligibility. -9/21/20: No temperature was documented for 1 staff. - 9/22/20: No temperature was documented for 2 staff. - 9/23/20: No temperature was documented for 1 staff. - 9/24/20: No temperature was documented for 1 staff. - 10/1/20: Five staff members marked yes to the question Contact with person with COVID-19 or under investigation? One staff member answered yes to the question, Are you or do you intend to work anywhere outside this facility? There was no documentation on the back of the form related to the action taken by the facility to determine work eligibility. - 10/2/20: One staff member marked yes to the question Cough, congestion, shortness of breath or sore throat present? Four staff members marked yes to the question Contact with person with COVID-19 or under investigation? There was no documentation on the back of the form related to the action taken by the facility to determine work eligibility. - 10/3/20: Two staff members marked yes to the question Cough, congestion, shortness of breath or sore throat present? One staff member marked yes to the question Nausea, diarrhea, lack of taste of smell? One staff member marked yes to the question Contact with person with COVID-19 or under investigation? and marked yes to the question Are you or do you intend to work anywhere outside this facility? There was no documentation on the back of the form related to the action taken by the facility to determine work eligibility. - 10/6/20: One staff member marked yes to the question Nausea, diarrhea, lack of taste or smell? Seven staff marked yes to the question Contact with person with COVID-19 or under investigation? Two staff members marked yes to the question Are you or do you intend to work anywhere outside this facility? There was no documentation on the back of the form related to the action taken by the facility to determine work eligibility. - 10/8/20: One staff member marked yes to the question Cough, congestion, shortness of breath or sore throat present? Three staff members marked yes to the question Contact with person with COVID-19 or under investigation? Two staff members marked yes to the question Are you or do you intend to work anywhere outside this facility? There was no documentation on the back of the form related to the action taken by the facility to determine work eligibility. On 10/8/20 at 12:35 PM, the ICP stated if staff answered yes to screening questions, then their temperature would determine whether they could work. The ICP stated she reviewed the forms almost every day and the back of the screening forms were to be completed by those staff who answered yes. On 10/8/20 at 1:03 PM, the Administrator and DON stated staff were not screened on the COVID-19 positive unit because the staff were all positive anyway. 3. The CDC website, accessed 10/14/20, included a section titled, Using Personal Protective Equipment (PPE), dated 8/19/20, instructed healthcare personnel on How to Put on (DON) PPE Gear which stated when putting on an isolation gown to tie all of the ties on the gown. On 10/8/20 at 10:11 AM, RN #1 was observed donning a gown and entering Resident #5's room, without tying the gown at her waist. RN #1 administered oral medications and a nebulizer treatment (a fine mist of liquid medication to be inhaled) to Resident #5. RN #1 had her back, back side, and the back and sides of her legs exposed. RN #1 stated she should have also tied the gown at her waist. On 10/8/20 at 4:08 PM, the DON stated RN #1 should have tied the gown at her neck and

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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** - Many F 0886 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) waist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, review of facility infection surveillance documents, and staff interview, it was determined the facility failed to take actions to prevent the transmission of COVID-19 when residents and staff tested positive for COVID-19. This had the potential to impact all 24 residents and staff at the facility who were negative for COVID-19 to be exposed to COVID-19 and experience negative outcomes to their health. Findings include: During the entrance conference on 10/8/20 at 8:52 AM, the ICP stated the facility currently had 4 residents and 9 staff who tested positive for COVID-19. The ICP stated 1 of the 4 residents, Resident#4, was in the hospital. On 10/8/20 at 9:25 AM, the DON stated staffing at the facility had not been at a crisis level. On 10/8/20 at 12:35 PM, the ICP stated the facility was following CDC guidance for mitigating staff shortages and to determine when positive staff could return to work. At 12:50 PM, the ICP provided the survey team with two CDC documents. The first CDC document was titled Strategies to Mitigate Healthcare Personnel Staffing Shortages, updated 7/17/20. The second CDC document was titled Criteria for Return to Work for Healthcare Personnel with [DIAGNOSES REDACTED]-CoV-2 (COVID-19) Infection (Interim Guidance), updated 8/10/20. The document titled Strategies to Mitigate Healthcare Personnel Staffing Shortages stated, If HCP (Health Care Personnel) are tested and found to be infected with [DIAGNOSES REDACTED]-CoV-2, they should be excluded from work until they meet all Return to Work Criteria. The document titled Criteria for Return to Work for Healthcare Personnel with [DIAGNOSES REDACTED]-CoV-2 (COVID-19) Infection (Interim Guidance) stated HCP could return to work when at least 10 days had passed since symptoms first appeared, and at least 24 hours had passed since their last fever without the use of fever-reducing medications, and symptoms (e.g., cough, shortness of breath) had improved. The facility's Novel Coronavirus Prevention and Response policy, dated 9/2/20, stated interventions to prevent the spread of respiratory germs within the facility included monitoring staff for fever and respiratory symptoms. The policy stated Restrict (staff) from work and follow current guidance about testing and returning to work (e.g., local health department, CDC). COVID-19 test results and staff timecards, dated 9/14/20 - 10/7/20, documented the day staff tested positive and what staff returned to work prior to the 10-day criteria, as follows: - The BOM tested positive on 9/14/20 and worked on 9/23/20 (9 days). - CNA #1 tested positive on 9/25/20 and worked on 9/30/20 (5 days). - RN #1 tested positive on 9/28/20 and worked on 10/1/20, 10/2/20, and 10/5/20 (3 days). - CNA #2 tested positive on 9/29/20 and worked on 10/3/20 and 10/4/20 (4 days). - CNA #3 tested positive on 9/29/20 and worked on 10/3/20 and 10/4/20 (4 days). Additionally, the facility's Emergency Management Plan Activation Evaluation Form, dated 3/13/20, stated the type of emergency was emerging infectious disease (COVID-19). The plan stated As of 8:00am (sic) on 3/13/20 (sic) our facility went into full lockdown after receiving a letter from CMS (Centers for Medicare & Medicaid Services) to do so. Only employees are allowed in the building, a screening is to be done daily upon entering the facility, temperatures will be checked, questionare (sic) is to be done and hand sanitizing is to be done. We will stay in lock down until instructed to do otherwise. Under the Treatment Areas section of the 3/13/20 Emergency Management Plan, it stated isolated to rooms/216 - 219 designated for isolation. The Emergency Management Plan did not contain additional information related to dedicated staff working with residents isolated to Rooms 216 - 219. During an observation on 10/8/20, RN #1 stated at 10:05 AM, she was assigned to the North hall, for both the COVID-19 negative and COVID-19 positive residents. RN #1 tested positive for COVID-19 on 9/28/20 and returned to work on 10/1/20, three days later. RN #1 stated she crossed the plastic barrier to administer medications and completed assessments for the 3 residents on the COVID-19 positive unit and then crossed back through the plastic barrier to the COVID-19 negative unit to administer medications and completed assessments for the 12 residents that were negative for COVID-19. RN #1 stated she mainly stayed on the COVID-19 negative unit. The facility's Emergency Management Plan Daily Assessment Form, dated 9/15/20 - 10/2/20, documented a progression of residents and staff testing positive for COVID-19, as follows: - 9/15/20: Bi-weekly testing for employees starts today .Continue to encourage visiting with friends & family .Continue with plan in place (sic) Start testing. - 9/16/20: Because of a staff member testing positive for COVID-19 (sic) we are back in lockdown for 28 days as per public health (sic) requirements (sic) no visitors in the building (sic) checking with state to see if we can go 14 instead .Continue with plan in place. - 9/28/20: On 9/25/20 another staff member tested positive (sic) building remains on lockdown for 2 more weeks. On 9/26/20 we had our first resident test positive (sic) South Hall is on lockdown for 2 weeks .Continue with plan in place (sic) Limit access to 100 (south) Hall. - 9/29/20: Resident with positive case was moved to the end of the (200) North Hallway and plastic was put up to make that a quarantine area for positive cases (isolated from the rest of building) .Staffing for COVID area - we will be using staff who are asymptomatic or who have tested positive to work in this area if they choose to, this is on a volunteer (sic) only, if the need arises we will utilize staff from our other buildings, or a temp agency. - 9/30/20: 6 more staff members tested positive. Both Hallways are on lockdown. - 10/1/20: 3 residents confirmed positive. 11 total staff positive/9 still active. - 10/2/20: 4 residents confirmed positive. 11 staff total/9 active. There was no information why the resident who tested positive on 9/26/20, was not moved to the identified quarantine area until 9/29/20. There was no additional information related to dedicated staff being assigned only to the quarantine area. On 10/9/20 at 10:05 AM, the DON stated Resident #4 tested positive on 9/26/20 and the facility did not have dedicated staff to work only with Resident #4. The DON stated the COVID-19 unit was created on 9/28/20. On 10/8/20 at 12:50 PM, the ICP stated the facility did not have enough nurses to work only the COVID-19 positive unit. On 10/8/20 at 1:03 PM, the DON stated the night nurse went back and forth between the COVID positive unit and the negative unit as the facility did not have enough nurses to staff both the positive and negative units. The facility failed to take actions to prevent the transmission of COVID-19 when staff and residents tested positive for COVID-19.