STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135087	A. BUILDING _____ B. WING _____	06/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OWYHEE HEALTH & REHABILITATION CENTER	108 WEST OWYHEE HOMEDALE, ID 83628

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, and staff interview, it was determined the facility failed to ensure infection control prevention practices were 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. 1. The CDC guidance on Preparing for COVID-19 in Nursing Homes, the document the facility used as their policy for COVID-19 Infection Control, dated 5/19/20, documented to screen all staff at the beginning of their shift for fever and symptoms of COVID-19, have staff leave work if they are ill, and staff with a positive screening at entry were to leave the facility. The facility's staff screening and monitoring assessment tool, dated 4/30/20, directed staff to send employees home if they experienced a cough or shortness of breath or at least two of the following symptoms: * Fever (greater than 100 degrees Fahrenheit) * New loss of taste/smell * Repeated shaking with chills * Muscle pain * Headache * Sore throat * Chills The facility's Employee COVID-19 screening logs from 6/11/20 to 6/17/20, included columns with yes/no questions to be answered by individual staff as follows: * Temperature * SOB * Repeated shaking/chills * Gastrointestinal symptoms (Nausea/vomiting/diarrhea) * Muscle pain * Headache * Sore Throat * New loss of taste/smell * Contact outside of the facility with suspected or lab-confirmed COVID-19 * Traveled outside the state The last column on the screening log documented, Review screening answers. Recommend advanced screening by DON/ICP/Designees if yes to SOB, cough or temp (greater than) 100 or any two of the remaining symptoms. LN to sign. By signing you are indicating they are cleared to work. The facility's hourly employee timesheets from 6/11/20 to 6/17/20 were reviewed and compared with the employee COVID-19 screening logs from the same dates. The following inconsistencies were identified. a. Staff were identified who worked without being screened prior to the beginning their shift. * The screening logs and timesheets, dated 6/11/20, documented 2 CNAs, 1 NA and 1 LN were not screened prior to working their shifts. * The screening logs and timesheets, dated 6/13/20, documented 1 NA, 1 administrative staff, and 1 activities staff were not screened prior to working their shifts. * The screening logs and timesheets, dated 6/14/20, documented 7 CNAs, 3 NAs, 2 LNs, 4 activities staff, 2 housekeepers, 1 dietary staff, and 1 administrative staff were not screened prior to working their shifts * The screening logs and timesheets, dated 6/15/20, documented, 2 therapy staff, 3 CNAs, 2 NAs, 2 activities staff, and 1 administrative staff were not screened prior to working their shifts. * The screening logs, and timesheets, dated 6/16/20, documented 1 therapy staff and 1 activities staff were not screened prior to working their shifts. * The screening logs and timesheets, dated 6/17/20, documented 3 CNAs, 2 LNs, and 1 therapy staff were not screened prior to working their shifts. b. Staff who answered yes to 2 or more questions on the screening log did not have documentation they received further screening prior to beginning their shift. * On 6/11/20, CNA #1 answered yes to having a headache and sore throat. The column where the LN was to screen the staff member and sign was blank. Timesheet hours for 6/11/20, documented CNA #1 worked from 5:52 AM to 1:59 PM. * On 6/11/20, CNA #2 answered yes to having a headache and a sore throat. The column where the LN was to screen the staff member and sign was signed by CNA #2. Timesheet hours for 6/11/20 documented CNA #2 worked from 2:00 PM to 10:11 PM. * On 6/15/20, CNA #3 answered yes to having a cough and headache. The column where the LN was to screen the staff member and sign was signed by CNA #3. Timesheet hours for 6/15/20, documented CNA #3 worked from 9:47 PM to 6:07 AM. c. Columns on the staff screening logs were left blank, had a checkmark instead of answering the questions yes or no, or the screening log did not include the LN's signature. * On 6/12/20, CNA #2 left the column for temperature blank and the column where the LN was to screen the staff member and sign was signed by CNA #2. Timesheet hours for 6/12/20, documented CNA #2 worked from 2:03 PM to 10:34 PM. * On 6/12/20, 6 staff members' logs had checkmarks for responses to the screening questions instead of yes or no responses for the questions. * On 6/13/20, CNA #2 left the temperature column blank and the column where the LN was to screen the staff member and sign was signed by CNA #2. Timesheet hours for 6/13/20, documented CNA #2 worked from 2:02 PM to 10:15 PM. On 6/18/20 at 8:45 AM, in the entryway of the building was a sign on the wall which documented, Report any (signs and symptoms) to charge nurse before reporting to work station. RN #1 said staff screened themselves by documenting yes or no to the questions and taking their own temperature and recording it. She said if staff had a temperature or reported signs or symptoms on the log sheet they were to have a nurse screen them further. On 6/18/20 at 8:52 AM and 9:15 AM, the DON said staff screened themselves because she did not have enough staff to complete the screenings. She said facility staff knew to report any signs or symptoms to the charge nurse. The DON said she reviewed the screening logs several times a day to make sure they were accurate. On 6/18/20 at 10:10 AM, CNA #4 said he checked himself in at the front entryway, answered the questions on the screening log, and took his own temperature before each shift. On 6/18/20 at 10:18 AM, CNA #5 said she checked herself in at the front entryway, answered the questions on the screening log, and took her own temperature before each shift. On 6/18/20 at 10:32 AM, Housekeeper #3 said she checked herself in at the front entryway, answered the questions on the screening log, and took her own temperature before each shift. On 6/18/20 at 10:45 AM, Activity Assistant #1 said she came into the facility in the back of the building through the door next to the kitchen, used hand sanitizer, put on a facemask, and went through the dining room and hallway into the front entryway to check in before her shift. She said she checked herself in at the front entryway, answered the questions on the screening log, and took her own temperature before each shift. On 6/18/20 at 11:05 AM, the back door of the facility was unlocked. Just inside between the back door and the door leading into the dining room was a tray table with a box of surgical facemasks and a bottle of hand sanitizer. On the door leading into the dining room was a sign that documented, STOP Mask required to enter, 20 second hand sanitization required to enter. If staff came in through this door, they entered directly into the dining room and could either walk straight through the dining room into the main hallway and then into the front entryway or could come into the dining room and make an immediate right turn into a short hallway that connected to the main hallway. On 6/18/20 at 11:10 AM, Dietary Aide #1 said she came into the building in the back of the building through the door next to the kitchen, used hand sanitizer, put on a facemask, and went through the dining room and hallway into the front entryway to check in before her shift. She said staff walked to the front entryway, answered the questions on the screening log and took her own temperature before each shift. On 6/18/20 at 11:15 AM, the Van Driver sat in a chair by the front entryway. She said she was also a CNA and was asked to screen staff that morning. She said sometimes there was a staff member to check others in. The Van Driver said if there was not a staff member to check in staff, they checked themselves in at the front entryway, answered questions on the screening log, and took their own temperature before each shift. On 6/18/20 at 11:20 AM, the Business Office Manager said staff checked themselves in at the front entryway, answered the questions on the screening log, and took their own temperature before each shift. On 6/18/20 at 1:20 PM, the CDM said depending on where she parked in the morning, she entered the building either through the front or the back entrances. She said if she used the back entrance she sanitized her hands and put on a mask. She said she checked herself in at the front entryway, and answered the questions on the screening log and took her own temperature before each shift. On 6/18/20 at 2:15 PM, the DON said she expected staff to screen themselves, take their temperature, document the answers completely, and report any symptoms to the nurse on duty or to her. She said on 6/11/20,

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) CNA #1 was re-screened by the nurse on duty when CNA #1 reported she had a sore throat and headache and it was due to a pet allergy. She said there was no documentation regarding the re-screen and the nurse did not sign the column and it was blank. The DON said staff were probably confused about the signature area and how they documented their answers because the screening log was changed to a different format on 6/10/20. She said staff were familiar with the old form where the answer 'no' was a check mark instead of an 'N' and might have been confused with the new form. The DON said if staff presented to work with symptoms of COVID-19 they were sent home if it was not allergy related. She said the back door was unlocked because the laundry room was across the back alley way and laundry staff needed to come and go from there. The DON said very few staff entered the back door to begin their shift. She said staff who entered the back door were expected to use the hand sanitizer and masks before they walked through the building to screen themselves in the front entryway. On 6/19/20 at 1:35 PM, the Administrator said there were some questions on the screening logs missing a response and some staff had not documented they screened themselves. She said she expected staff to screen themselves before reporting to duty. She said everyone was responsible to make sure the screening logs were completed. 2. The facility's Infection Control Policy for Laundry Services, dated 11/2007, directed staff to perform hand hygiene after handling soiled linens and to keep linens clean. The facility's hand hygiene policy, dated 8/2014, directed staff to perform hand hygiene after coming in contact with contaminated objects. These policies were not followed. On 6/18/20 at 10:15 AM, CNA #5 was in the rehabilitation hallway and had a plastic bag of soiled linen in her right hand, which was bare. She opened the door handle of the soiled utility room with her left hand and then opened the lid of the soiled linen barrel with her left hand and threw the bag into the barrel. She then left the soiled utility room and did not perform hand hygiene. CNA #5 then used the key pad lock to open up the clean linen room door, grabbed the handle with her right hand and retrieved a clean washcloth. She handled the washcloth with both hands and then delivered the washcloth to Resident #2 who was in her room. On 6/18/20 at 10:18 AM, CNA #5 said she did not perform hand hygiene after disposing of the bag with the dirty linen. On 6/18/20 at 2:15 PM, the DON said staff were to perform hand hygiene after handling soiled linens and before handling clean linen. 3. The facility's Long Term Care Facility Assessment Tool for Infection Control, undated, documented the facility would place a sign for residents on transmission based precautions including required PPE that was clear and visible on their door or next to their door. This was not followed. On 6/18/20 at 9:06 AM, Resident #1's room was observed to have a PPE cart outside his room. There was no signage outside of Resident #1's room regarding when and what PPE to wear. A urine analysis report, dated 6/7/20, documented Resident #1 had Escheria coli, ESBL confirmed and next to it was a handwritten note isolation. On 6/18/20 at 1:10 PM, LPN #1 said Resident #1 had a urinary tract infection and was on contact precautions due to Extended Spectrum Beta-Lactamase (ESBL) in his urine. ESBL was an enzyme produced by certain bacteria causing a urinary tract infection that could spread by direct contact with an infected person's body fluids. The CDC website, accessed on 6/22/20, documented ESBL enzymes broke down and destroyed some commonly used antibiotics, and made these drugs ineffective which meant there were fewer antibiotics available to treat ESBL producing bacteria infection. LPN #1 said a facemask, gloves and a gown should be worn by staff when they provided direct care to Resident #1. LPN #1 said a PPE cart and Stop please see the nurse sign were placed at residents' doors when they were placed in isolation. The surveyor and LPN #1 then looked at Resident #1's door. LPN #1 said there was not a sign outside Resident #1's room. On 6/18/20 at 9:38 AM, Housekeeper #1 was inside Resident #1's room mopping the floor. Housekeeper #1 was not wearing a gown. On 6/18/20 at 10:15 AM Housekeeper #1 said she knew what was inside the PPE cart, when Beautician #1 then joined the surveyor and Housekeeper #1. Beautician #1 said Housekeeper #1 spoke mainly Spanish and she would interpret for the surveyor. Housekeeper #1 said via Beautician #1, she wore a gown when the infection was big. When asked what she meant by that, Housekeeper #1 said there would be a sign at the door to see the nurse and she asked the nurse if she needed to put a gown on before entering a room with a PPE cart outside of it. Beautician #1, Housekeeper #1 and the surveyor went to Resident #1's room. Housekeeper #1 said there was no sign to see the nurse at the door of Resident #1. On 6/18/20 at 1:45 PM, the ICP said a sign was placed outside the door for the residents in the COVID-19 quarantine unit. The ICP said for other residents in isolation, staff placed a PPE cart outside the room and an alert message would be sent to the staff through their electronic health system to inform them of the required PPE. The ICP said staff passed isolation information on between shifts and by their telephone system. The ICP said Standard Precaution signs were posted by the nurse's station. The ICP said it was not in the facility's policy to put a STOP please see the nurse sign outside the residents' door because it was a Health Insurance Portability and Accountability Act (HIPAA) violation unless the resident was in a quarantine unit. 4. The facility's Laundry Services policy and procedure, revised 11/2007, documented all clean linens should be stored and transported in carts used exclusively for this purpose. On 6/18/20 at 9:38 AM, the housekeeping cart was outside of Resident #1's room. The housekeeping cart had a clear plastic container on top of it containing folded clean washcloths. On 6/18/20 at 10:47 AM, the housekeeping cart was outside of room [ROOM NUMBER]. The plastic container on top of the housekeeping cart contained several clean washcloths and a black colored round material was observed at the bottom of the plastic container. When Housekeeper #1 stepped out of room [ROOM NUMBER], Housekeeper #1 was asked to open the plastic container and show what was inside the plastic container. Housekeeper #1 opened the plastic container, took all the washcloths out of the plastic container and there was one white pillow case in the container. Housekeeper #2 then joined the surveyor and Housekeeper #1 and said she would interpret for Housekeeper #1. Housekeeper #1 said via Housekeeper #2, the washcloths and pillow case were clean. Housekeeper #1 said she replaced the residents' washcloths by their sinks and changed the residents' pillow cases if she was asked to by the residents. At the bottom of the container were five 1.5 volt batteries, several pens and markers, clothes pins, one apple sauce container, a pad of paper and a butterfly pin. On 6/18/20 at 1:10 PM, the Housekeeping Supervisor said clean linen should be transported in a clean container and there should be nothing in the container except clean linen.