STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135144	A. BUILDING _____ B. WING _____	**08/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASCADIA OF NAMPA	**900 N HAPPY VALLEY RD NAMPA, ID 83687**

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 -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, 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. Findings include: 1. The facility's Transmission-Based Precautions policy, revised 7/1/20, directed staff to clean and disinfect equipment before it was used on another resident and to allow it to air dry. The Super Sani-Cloth germicidal wipe directions for cleaning and disinfecting stated to thoroughly wet the surface and allow to air dry for two minutes. This policy and manufacture directions were not followed. a. Resident #2's record documented she was on contact precautions and was being treated for [REDACTED]. The CDC website, accessed on 8/18/20, stated ESBL is an enzyme produced by certain bacteria causing a urinary tract infection that could spread by direct contact with an infected person's body fluids. On 8/17/20 at 3:00 PM, NA #1 was in Resident #1's room. NA #1 had a vital sign machine on wheels which contained a blood pressure cuff, a thermometer, and a pulse oximeter (oxygen level monitor). NA #1 placed the pulse oximeter on Resident #1's finger to measure their oxygen level. NA #1 did not disinfect it after it was used by Resident #1. At 3:05 PM, NA #1 left Resident #1's room and wheeled the vital sign machine to Resident #2's room. She performed hand hygiene and put on a gown and gloves. Resident #2's room door had a Contact Precautions sign which directed staff to wear a gown and gloves when in contact with the resident. At 3:07 PM, NA #1 placed the blood pressure cuff on Resident #2's left arm, used a disposable sleeve for the thermometer and took her temperature and then placed the pulse oximeter on her finger. After assisting Resident #2 in the bathroom, NA #1 took off her gloves and gown, performed hand hygiene, and took the vital sign machine out of the room and into the hallway. NA #1 did not disinfect the vital sign equipment after it was used for Resident #2. At 3:20 PM, Resident #3 was in her wheelchair in the hallway outside of her room and she requested NA #1 check her vital signs in the hallway. NA #1 used the thermometer and pulse oximeter from the vital sign machine for Resident #3 without disinfecting them prior to use. NA #1 did not disinfect the equipment after it was used. At 3:23 PM, NA #1 took the vital sign machine into Resident #4's room and used the blood pressure cuff, thermometer, and pulse oximeter on Resident #4 without disinfecting them prior to use. On 8/17/20 at 3:27 PM, CNA #1 retrieved the vital sign machine from NA #1, which was not disinfected, and took it into Resident #5's room. CNA #1 used a Sani-Cloth germicidal wipe and wiped down the blood pressure cuff and immediately placed it on Resident #5's left arm. On 8/17/20 at 3:38 PM, CNA #1 said after she wiped off the BP cuff with the Sani-Cloth, she did not wait the two minutes as directed on the label before placing it on Resident #5's arm. On 8/17/20 at 3:55 PM, NA #1 said she had not disinfected the vital sign equipment between the residents. She said she did not know she was supposed to wipe down the vital sign equipment between residents unless the residents were suspected of Covid-19 or had tested positive for Covid-19. On 8/17/20 at 4:05 PM, RN #1 said she expected staff to wipe down and disinfect the vital sign equipment after each use and especially after a resident who was on contact precautions. On 8/17/20 at 5:00 PM, the IP said he expected staff to disinfect the vital sign equipment between each use and expected staff to follow the contact times on the disinfectant's label. 2. The facility's policy for Indwelling Catheters, dated 11/28/17, stated The facility provides care for a resident with an indwelling catheter based upon current professional standards of practice, including but not limited to . insertion, ongoing care, and catheter removal protocols that adhere to professional standards of practice and infection prevention and control procedures. The Lippincott Manual of Nursing Practice, Tenth Edition (p. 782), stated the procedure for maintaining a closed urinary drainage system included keeping the drainage bag off the floor. This policy and guideline were not followed. On 8/17/20 from 1:55 PM to 2:54 PM, Resident #6 was observed sitting in her wheelchair in the hall across from her room. Resident #6 had an indwelling urinary catheter in place, and the tubing was hanging over the right side of the wheelchair. The urinary drainage bag was covered by a dark blue privacy cover, which was open across the bottom. The bottom of the urinary drainage bag was exposed, and it was resting directly on the floor underneath Resident #6's wheelchair. On 8/17/20 at 1:54 PM, RN #2 said Resident #6's urinary drainage bag should not be touching the ground. On 8/17/20 at 5:00 PM, the IP said the urinary drainage bag should be covered and hung so that it was kept off the floor.

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.