STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385136	A. BUILDING _____ B. WING _____	**07/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GLISAN CARE CENTER	**9750 NE GLISAN STREET PORTLAND, OR 97220**

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, interview and record review it was determined the facility failed to implement infection control practices to prevent the potential spread of COVID-19 Virus from 7/6/20 through 7/7/20 for 3 of 3 units. This failure resulted from multiple staff improperly using PPE (Personal Protective Equipment), staff not performing hand hygiene appropriately and staff not following infection control policies and procedures which exposed the residents to the risk of contracting the highly communicable COVID-19 Virus. Findings include: The Facility Policy Conservation Strategies, last revised 3/19/20, instructed HCW (Healthcare Worker) to take care not to touch their facemasks and to remove facemasks in a careful and deliberate manner. If the facemask was touched or adjusted, the HCW should immediately perform hand hygiene. The Facility Policy Coronavirus COVID-19, last revised 5/29/20, instructed all HCWs to wear surgical facemasks at all times during their shift. The Center for Disease Control (CDC) Coronavirus Disease 2019 (COVID-19), last revised 6/19/20, directed the facility to implement Universal Source Control which referred to facemasks to cover a person's mouth and nose to prevent spread of respiratory secretions when talking, sneezing or coughing. Because of the potential for asymptomatic and pre-symptomatic transmission, source control measures are recommended for all staff in the healthcare facility, even if they do not have symptoms of COVID-19. Healthcare providers should wear a facemask at all times while they are in the healthcare facility, including breakrooms or other spaces where they might encounter co-workers. Staff should be aware of the importance of performing hand hygiene immediately before and after any contact with their facemasks. Technical Assistance was provided by the State Survey Agency during the 5/12/20 and 6/3/20 Federal Focused Infection Control Survey on-site visits. Technical assistance included information regarding multiple staff improperly wearing facemasks and not completing hand hygiene after touching or adjusting facemasks. Multiple observations of staff improperly wearing facemasks and/or not completing hand hygiene after touching or adjusting their facemasks were made from 7/6/20 through 7/7/20 between the hours of 8:30 AM and 3:00 PM. Examples of observations include: -On 7/6/20 at 8:30 AM, Staff 4 (CNA) was observed walking from the reception desk, down the hallway towards the main nurse's station with her facemask around her chin, talking with staff as they passed by. No staff provided reminders. -On 7/6/20 at 9:53 AM, Staff 6 (CNA) exited room [ROOM NUMBER] without completing hand hygiene, walked down the hallway to the ice chest with her nose exposed, returned to room [ROOM NUMBER], entered and then exited the room with her nose still exposed. Staff 6 was provided technical assistance by surveyor. -On 7/6/20 at 10:18 AM, Staff 8 (LPN), while speaking with surveyor, dangled her facemask on her right ear, took a drink and replaced her facemask without completing hand hygiene. -On 7/6/20 at 11:10 AM, Staff 6 entered room [ROOM NUMBER] with her nose exposed. Staff 6 was talking with another staff member and resident in the room. Staff 6 exited the room and her nose continued to be exposed. No staff cued Staff 6 regarding her improperly donned mask and surveyor provided technical assistance. -On 7/7/20 at 12:03 PM, Staff 9 (Student) required technical assistance from surveyor to ensure facemask was properly donned due to her nose being exposed. -On 7/6/20 at 12:09 PM, Staff 5 (CNA) was at the tray cart on the back hall of the ICF unit, adjusted her facemask, did not complete hand hygiene, proceeded to remove a tray from the cart and took it to a resident. -On 7/6/20 at 12:31 PM, Staff 6 walked down the hallway with her nose exposed. Surveyor provided Staff 6 with technical assistance. -On 7/6/20 at 1:49 PM, Staff 6 was at the main nursing station with several other staff. Staff 6 adjusted her mask and did not complete hand hygiene. -On 7/6/20 at 2:00 PM, Staff 6 was at the main nursing station as evening shift staff were arriving. Staff 6 had her nose exposed and adjusted her mask without completing hand hygiene. At 2:03 PM, Staff 6 walked down the hallway with her mask around her chin towards the breakroom. Staff 6 exited the breakroom with her facemask on and her nose exposed and entered room [ROOM NUMBER] without completing hand hygiene. At 2:08 PM, Staff 6 exited room [ROOM NUMBER] with her nose exposed, walked toward the ICF back hall utility room with her nose exposed, placed a bag in the utility room, walked back down the hallway towards the main nursing station with her nose exposed, adjusted her mask and did not complete hand hygiene. -On 7/6/20 at 2:07 PM, Staff 5 walked in the ICF hallway with her nose exposed, adjusted her mask and did not complete hand hygiene. Surveyor provided technical assistance to Staff 5. -On 7/6/20 at 2:27 PM, Staff 7 (RN) was observed at the west hall nurse's station with several staff members not maintaining social distancing. Staff 7 had her facemask dangling from her right ear, drinking and talking with staff. -On 7/7/20 at 7:44 AM, Staff 14 (CNA) was at the west hall nurse's station. With multiple staff at the nurse's station and in the hallway surrounding the station, Staff 14 lowered her facemask to her chin, took a drink, placed the facemask back on and did not complete hand hygiene. -On 7/7/20 at 8:53 AM, Staff 9 was in the dining area with her mask under her chin, took a drink and was speaking with another student and her instructor prior to replacing her facemask. Staff 9 exited the area without completing hand hygiene. Surveyor provided technical assistance to Staff 9. -On 7/7/20 at 10:38 AM, Staff 7 was at the west hall nurse's station with her facemask dangling from her right ear, blowing her nose with another staff member present. In an interview on 7/6/20 at 2:08 PM, Staff 6 stated she was not supposed to wear her mask under her chin and was to have the facemask up and pinched at the nose. She stated she knew how to wear a facemask and acknowledged wearing her facemask improperly several times during the day. In an interview on 7/7/20 at 7:44 AM, Staff 14 acknowledged she did not properly remove the mask to take a drink. Staff 14 stated she was aware she needed to remove the mask using the strings and then complete hand hygiene but she did not follow the steps. In an interview on 7/7/20 at 8:53 AM, Staff 9 stated staff were supposed to take their masks completely off in the breakroom to take drinks. In an interview on 7/7/20 at 10:46 AM, Staff 2 (DNS) stated since the previous Federal Focused Infection Control Survey, she provided staff training on properly wearing facemasks including being sure staff do not have their noses exposed, not wearing facemasks under their chins, dangling from their ears or on top of their heads. Staff 2 stated she also provided staff training on not touching masks and, if touched, hands should be immediately sanitized. She reported managers were doing hourly rounds and checked staff to ensure facemasks were properly donned and hand hygiene was performed when necessary. She stated no managers had identified any concerns. In an interview on 7/7/20 at 11:15 AM, Staff 1 (Administrator), Staff 2 and Staff 3 (Infection Control Preventionist) were informed of the multiple observations of staff improperly wearing their masks and not completing hand hygiene when necessary. No further information was provided.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE