STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135090	A. BUILDING _____ B. WING _____	08/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHAW MOUNTAIN OF CASCADIA	909 RESERVE STREET BOISE, ID 83712

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.** Based on observation, policy review, and staff interview, it was determined the facility failed to ensure infection control prevention practices were consistently 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 Managing Outbreaks of Infection policy, revised 5/21/20, directed staff to clean and disinfect frequently touched surfaces with an appropriate disinfectant and to follow the manufactures' instructions regarding contact time. The manufacture's instructions for use stated for disinfecting hard nonporous surfaces to wipe the surface with the bleach solution and allow solution to contact surface for at least 5 minutes, then to rinse well and air dry. This policy and directions were not followed. On 8/10/20 at 10:00 AM, CNA #2 was in Resident #6's room, who was in the COVID-19 positive unit. CNA #2 sprayed the bleach solution on Resident #6's tray table and immediately wiped it off with a dry paper towel. The surface appeared dry after she wiped it off. CNA #2 then sprayed Resident #6's sink and counter top and immediately wiped it off with a dry paper towel. The surfaces appeared dry after she wiped them off. On 8/10/20 at 10:12 AM, CNA #2 was in Resident #7's room, who was in the COVID-19 positive unit also. CNA #2 sprayed the bleach solution on Resident #7's sink and counter top and immediately wiped it off with a dry paper towel. The surfaces appeared dry after she wiped them off. CNA #2 sprayed the bleach solution on Resident #7's tray table and immediately wiped it off with a dry paper towel. The surface appeared dry after she wiped it off. On 8/10/20 at 2:45 PM, the Administrator and the DON said staff were to follow the contact time for the bleach solution per the manufacturer's instructions. 2. On 8/10/20 at 9:35 AM, RN #1 prepared supplies for wound care at the wound care cart outside Resident #1's room. RN #1 placed the wound care supplies in a white plastic tray, then entered Resident #1's room. RN #1 placed the white tray on the counter near the sink. There was no barrier between the tray and the counter surface. RN #1 then washed her hands and closed the door. On 8/10/20 at 9:40 AM, RN #1 opened the door to exit Resident #1's room, and the white tray was in the same location on the counter near the sink. There was no barrier between the tray and the countertop. RN #1 washed her hands, exited the room with the white tray in her hands, and she placed the tray on top of the wound care cart. There was no barrier between the tray and the surface of the wound care cart. RN #1 then placed a disinfectant wipe inside the tray, wiped off a cell phone and a pair of scissors that were inside the tray, and wiped the inside of the tray with the disinfectant wipe. RN #1 did not wipe off the outside bottom surface of the tray, and she turned it upside down on top of the cart. RN #1 said there should have been a barrier between the white tray and the countertop in Resident #1's room. On 8/10/20 at 2:40 PM, the DON said when the nurse performed wound care, she should have disinfected the bottom outer surface of the tray that held the supplies when she completed the task and she should have used a barrier between the tray and other surfaces. 3. The facility's policy for Transmission Based Precautions, revised 7/1/20, stated the following: * For residents on Droplet precautions, staff and visitors were directed to put on a surgical mask, gloves and a gown when exposure is anticipated or within 6 feet of the resident's immediate environment. * For residents on Enhanced Droplet precautions staff were to use a respirator mask and follow all other droplet precaution directives. This policy was not followed. a. On 8/10/20 at 9:54 AM, RN #1 prepared to enter Resident #2's room to provide wound care. A sign was posted on the door which directed those who entered the room to don (put on) a gown, a surgical mask, eye protection, and gloves. On 8/10/20 at 10:00 AM, RN #1 entered Resident #2's room. She was wearing a gown, a surgical mask, and a face shield. RN #1 was not wearing gloves. Approximately 2 minutes later, RN #1 opened the door to Resident #2's room, and she stood in the doorway and called for a staff member to come and assist her. She was not wearing gloves inside Resident #2's room. b. On 8/10/20 at 10:10 AM, RN #2 prepared to enter Resident #3's room to administer medications. A sign was posted on the door, which directed those who entered the room to don a two-gown system, a respirator mask, eye protection, and gloves. RN #2 was wearing a dark blue gown, face shield, and a respirator mask. RN #2 was not wearing gloves. He donned a yellow gown over his blue gown, entered the room, and placed a cup of medications on Resident #3's dresser. RN #2 washed his hands, found there were no paper towels in the room, and called housekeeping for more paper towels. RN #2 then obtained a glove from a box of gloves near the sink, and he placed the glove on top of the sink faucet to turn off the water. RN #2 then administered the medications to Resident #3 without wearing gloves. Several minutes later, RN #2 washed his hands, removed the yellow gown, and exited the room. RN #2 said the sign on Resident #3's door indicated precautions were in place, and staff were to wear a gown, gloves, a respirator mask, and eye protection. RN #2 said he had removed his gloves and forgot to put them on before entering the room. On 8/10/20 at 2:40 PM, the DON said when staff entered a resident's room who was on precautions, they should put on gloves before entering the room. 4. The facility's Resident Hand Hygiene policy, revised 3/3/20, directed staff to assist residents to perform hand hygiene prior to dining. This policy was not followed. On 8/10/20 from 12:05 PM to 12:15 PM, lunch trays in the 300 hallway were served to residents. The following was observed: -At 12:05 PM, CNA #1 delivered and set up Resident #8's meal on his tray table in his room. CNA #1 did not offer hand hygiene to Resident #8 prior to eating his lunch. -At 12:08 PM, CNA #1 delivered and set up Resident #9's meal on his tray table in his room. CNA #1 did not offer hand hygiene to Resident #9 prior to eating his lunch. -At 12:10 PM, CNA #1 delivered and set up Resident #10's meal on his tray table in his room. CNA #1 did not offer hand hygiene to Resident #10 prior to eating his lunch. -At 12:11 PM, the Activity Director delivered and set up Resident #11's meal on his tray table in his room. The Activity Director did not offer hand hygiene to Resident #11 prior to eating his lunch. -At 12:13 PM, the SDC delivered and set up Resident #12's meal on her tray table in her room. The SDC did not offer hand hygiene to Resident #12 prior to eating her lunch. -At 12:15 PM, the Activity Director and CNA #1 delivered and set up Resident #13's meal on her tray table in her room. The Activity Director and CNA #1 did not offer hand hygiene to Resident #13 prior to eating her lunch. On 8/10/20 at 12:18 PM, Resident #11 said he was not offered hand hygiene before eating his lunch. On 8/10/20 at 12:20 PM, CNA #1 and the Activity Director said they had not offered residents hand hygiene when they delivered the meal trays. Both said they were not aware they were to offer residents hand hygiene before meals. On 8/10/20 at 12:38 PM, the SDC said she had not offered residents hand hygiene when she delivered the meal trays. The SDC said she should have offered residents hand hygiene. On 8/10/20 at 2:45 PM, the DON said staff were to offer residents hand hygiene before their meals. 5. The facility's policy for PPE donning (putting on) and doffing (removing), revised 7/21/20, directed staff to tie all the ties on the gown when donning an isolation gown. This policy was not followed. On 8/10/20 at 9:54 AM, RN #1 prepared to enter Resident #2's room to provide wound care. A sign was posted on the door, which directed those who entered the room to don a gown, a surgical mask, eye protection, and gloves. On 8/10/20 at 10:00 AM, RN #1 was wearing a surgical mask and a face shield, then donned a yellow gown. RN #1 did not secure the ties on the upper portion of the gown before she entered Resident #2's room. RN #1's upper back and upper chest area were exposed, due to the gown hanging down. RN #2 opened the door to Resident #2's room, and she stood in the doorway and called for a staff member to come and assist her. The upper ties of the gown remained untied as she was observed inside Resident #2's room., and her upper back and upper chest area remained exposed. On 8/10/20 at 10:18 AM, RN #1 said she realized her gown was not tied at the top after she had entered

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 -** Some	(continued... from page 1) Resident #2's room, so she washed her hands and tied the gown after she was observed with it untied. On 8/10/20 at 2:40 PM, the DON said when staff donned a gown, they should tie the ties at the back of the neck prior to entering the room.