STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385228	A. BUILDING _____ B. WING _____	10/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PORTLAND HEALTH & REHABILITATION CENTER	**12441 SE STARK STREET PORTLAND, OR 97233**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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, interview and record review it was determined the facility staff failed to socially distance for 4 of 13 staff (#s 1, 2, 3 and 5) reviewed, failed to follow infection control procedures for cleaning resident care equipment (blood pressure cuff) for 1 of 1 staff (# 4) reviewed, failed to complete hand hygiene (HH) for 2 of 18 staff (#s 6 and 7) reviewed, failed to wear face shields or eye protection for 5 of 19 staff (#s 2, 3, 5, 8 and 9) reviewed. The facility failed to ensure gowns were used and stored appropriately for 6 of 6 resident rooms (#s 1, 5, 15, 17, 19 and 23) reviewed, failed to cohort residents for 2 of 6 rooms reviewed and failed to ensure equipment, personal items and protective equipment (PPE) were stored and/or discarded in 3 of 3 halls. This placed residents at risk for cross contamination and exposure to infectious agents. Findings include: 1. The 7/15/20 CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic guidance revealed for healthcare professionals (HCP) the potential for exposure to COVID-19 is not limited to direct patient care interactions. Transmission can also occur through unprotected exposures to asymptomatic or pre-symptomatic co-workers in breakrooms or co-workers or visitors in other common areas. Examples of how physical distancing can be implemented for HCP include: emphasizing the importance of source control and physical distancing in non-patient care areas, providing family meeting areas where all individuals (e.g., visitors, HCP) can remain at least 6 feet apart from each other, designating areas for HCP to take breaks, eat, and drink that allow them to remain at least six feet apart from each other, especially when they must be unmasked. On 10/5/20 at 12:18 PM Staff 1 (Administrator) and Staff 2 (DNS) were observed having a conversation in Staff 2's small office and were not socially distanced at six feet apart. On 10/6/20 at 3:08 PM Staff 3 (Medical Records) and Staff 5 (Corporate RN) were observed reviewing paperwork in a small office space. Staff 3 and Staff 5 were not socially distanced. On 10/6/20 at 3:10 PM Staff 5 indicated she was from the Corporate office, was new to the building helping out and had a recent negative COVID-19 test. Staff 5 indicated she was in an office and didn't need to wear a mask or face shield. On 10/6/20 at 4:20 PM Staff 1(Administrator) and Staff 2 (DNS) indicated they expected staff to adhere to social distancing guidelines. 2. The 2008 CDC Disinfection and Sterilization guidance revealed clean medical devices as soon as practical after use (e.g., at the point of use) because soiled materials become dried onto the instruments and clean in patient-care areas when these surfaces are contaminated or soiled. The 5/2015 EmpRes Healthcare Management infection control manual stated reusable resident care equipment are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment). On 10/5/20 at 11:38 AM Staff 4 (CNA) was observed at the nurses station cleaning a blood pressure (BP) cuff taken from a residents room who was on transmission based precautions (TBP). Staff 4 set the BP cuff on the desk without initially cleaning the desk area where she was going to clean the BP cuff, retrieved a pair of gloves, donned the gloves without prior hand hygiene. Staff 4 obtained a bleach wipe from a canister on the nurses desk, wiped down the BP cuff with the bleach wipe, retrieved a paper towel, and set the clean BP equipment on the paper towel. Staff 4 did not perform hand hygiene after cleaning BP equipment and returned BP equipment back to the Personal Protective Equipment (PPE) cart. On 10/5/20 at 11:38 AM Staff 4 indicated every TBP room has their own equipment and found the blood pressure cuff in one of the resident's rooms who was on TBP. Staff 4 indicated she should have performed hand hygiene after touching the dirty BP cuff and should have cleaned the nurses desk prior to setting the equipment on the desk and placed the dirty blood pressure cuff on a clean paper towel. On 10/6/20 at 4:20 PM Staff 1 (Administrator) and Staff 2 (DNS) indicated they expected staff to clean equipment before and after resident use. Staff 1 and Staff 2 stated they do not expect staff to put dirty BP cuffs on the nurse's desk while cleaning. 3. The 7/15/20 CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic guidance revealed healthcare professionals (HCP) should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process. On 10/5/20 at 11:38 AM Staff 4 (CNA) was observed at the nurses station cleaning a blood pressure (BP) cuff taken from a residents room who was on transmission based precuations (TBP). Staff 4 set the BP cuff on the desk, retrieved a pair of gloves and donned the gloves without prior hand hygiene. Staff 4 did not perform hand hygiene after cleaning BP equipment and returned BP equipment back to the Personal Protective Equipment (PPE) cart. On 10/5/20 at 11:40 AM Staff 6 (CMA) exited a room with ice water, doffed her gloves but performed no HH. On 10/5/20 at 12:00 PM no hand hygiene was offered to six residents in the dining room prior to staff providing drinks and food. On 10/5/20 at 12:10 PM and 12:20 PM Staff 7 (CNA) touched a mask on the table preformed no HH then salt, peppered and chopped up a resident's food. Staff 7 took off her scrub jacket, preformed no HH then assisted a resident with her/his drink. On 10/5/20 at 12:15 PM no hand hygiene was offered to residents prior to hall tray meal deliveries. In an interview on 10/5/20 at 11:38 AM Staff 4 indicated she should have performed hand hygiene after touching the dirty BP cuff. In an interview on 10/5/20 at 12:45 PM Staff 7 stated she did not realize she failed to perform HH but should have. In an interview on 10/6/20 at 4:21 PM Staff 1 (Administrator) and Staff 2 (DNS) expected staff to offer the residents HH prior to meals. Staff 1 stated he expected staff to perform HH after touching items, before helping with resident drinks and food and immediately after doffing PPE. 4. The 7/15/20 CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the COVID-19 Pandemic guidance revealed the following: put on eye protection (i.e., goggles or a face shield that covers the front and sides of the face) upon entry to the patient room or care area, if not already wearing as part of extended use strategies to optimize PPE supply. Protective eyewear (e.g., safety glasses, trauma glasses) with gaps between glasses and the face likely do not protect eyes from all splashes and sprays and HCP should wear a facemask at all times while they are in the healthcare facility, including in breakrooms or other spaces where they might encounter co-workers. On 10/5/20 at 12:18 PM Staff 1 (Administator) and Staff 2 (DNS) were observed having a conversation in Staff 2's small office. Staff 2 was not wearing a mask or eye protection. On 10/6/20 at 3:08 PM Staff 3 (Medical Records) and Staff 5 (Corporate RN) were observed reviewing paperwork in a small office and were not wearing a face mask or eye protection. On 10/6/20 at 3:10 PM Staff 5 indicated she was from the Corporate office, was new to the building helping out and had a recent negative COVID-19 test. Staff indicated she was in an office and did not need to wear a mask or face shield. On 10/5/20 at 12:07 PM and 12:29 PM Staff 8 (Dietary Aide) and Staff 9 (Dietary Manager) were observed not wearing face shields or eye protection. On 10/5/20 at 1:00 PM Staff 9 (Dietary Manager) was observed not wearing eye protection while working in the kitchen. In an interview on 10/5/20 at 12:29 PM and 1:00 PM Staff 9 (Dietary Manager) stated since kitchen staff could socially distance in the kitchen, they were not required to wear face shields or eye protection. Staff 9 stated the only time kitchen staff wore eye protection was during dishwashing. In an interview on 10/6/20 at 4:21 PM Staff 1 (Administrator) and Staff 2 (DNS) stated staff should wear a face shield or eye protection and masks. Staff 1 and Staff 2 indicated kitchen staff were provided eye protection and were expected to wear the eye protection while in the

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) facility. 5. The 10/9/20 CDC Strategies for Optimizing the Supply of Isolation Gowns revealed gown reuse was not recommended for coventional (measures consisting of engineering, administrative, and PPE controls that should already be implemented in general infection prevention and control plans) or contingency (measures that may be used temporarily during periods of expected isolation gown shortages. Contingency capacity strategies should only be implemented after considering and implementing conventional capacity strategies. While current supply may meet the facility's current or anticipated utilization rate, there may be uncertainty if future supply will be adequate and, therefore, contingency capacity strategies may be needed) strategies for PPE use.The reuse of gowns was only recommended during crisis strategy (strategies that are not commensurate with standard U.S. standards of care but may need to be considered during periods of known gown shortages. Crisis capacity strategies should only be implemented after considering and implementing conventional and contingency capacity strategies. Facilities can consider crisis capacity strategies when the supply is not able to meet the facility's current or anticipated utilization rate). Observations on 10/2/20 revealed the following: -At 10:40 AM three unlabeled gowns were observed draped directly on residents' closets in room five. Two of the three gowns were draped on top of each other; -At 11:49 AM gowns were on labeled hooks in room [ROOM NUMBER], two gowns were draped on top of each other; -At 11:53 AM in room [ROOM NUMBER] there was a used unlabeled gown hanging on a hook; -At 12:22 PM an unidentified staff used the same gloves and gown to pass three residents' meal trays in room five without changing the gloves and gown when she came into contact with environmental surfaces; -At 1:23 PM room one's entry way had unlabeled gowns hanging on hooks; -At 1:38 PM Staff 10 (Account Manager) hung up hooks for gown storage, but no labels were observed. Observations on 10/5/20 at 10:40 AM three hooks with gowns were on the closet doors in room five. In an interview on 10/2/20 at 11:02 AM Staff 2 (DNS) stated the facility was using a mix of conventional and contingency PPE. Staff 2 stated the facility was reusing gowns and had at least one week worth of gowns available. In an interview on 10/2/20 at 12:23 PM Staff 11 (CNA) stated the facility was reusing gowns, staff did not label their gowns because she knew which gown hers was due to the size. Staff 11 stated the facility did inform staff not to share PPE between the residents in room five. In an interview on 10/2/20 at 1:34 PM Staff 13 (CNA) stated they reuse gowns and when they are finished with the resident, they hang their gown up on the hook by the labeled job title (i.e. CNA, CMA, Nurse). Staff 13 acknowledged not all hooks had job title labels. In an interview on 10/2/20 at 1:38 PM Staff 10 (Account Manager) stated the staff should not hang gowns directly on residents' closet doors but sometimes putting hooks up fell through the rug. Staff 10 stated he placed the hooks so gowns would not touch and eventually were labeled with job titles. Staff 10 acknowledged labeled hooks were not in all rooms. In an interview on 10/2/20 at 1:51 PM Staff 14 (CNA) stated the facility was reusing gowns for the quarantine rooms. Staff 14 stated staff had labeled hooks for their gowns based on their job title. Staff 14 stated since there were no hooks in room five staff used the residents' closet doors and knew to keep track of which gown was theirs but did not label them. In an interview on 10/5/20 at 1:02 PM Staff 12 (RN/Infection Preventionist) stated the facility was in contingency status with gowns but were reusing gowns. In an interview on 10/6/20 at 4:21 PM Staff 1 (Administrator) and Staff 2 (DNS) stated there should be a consistent system in place if the facility was reusing gowns. Staff 1 stated gowns should not be draped on top of each other and staff should have a system to identify their own gown. 6. The 4/30/20 CDC Responding to COVID-19 in Nursing Homes guidance revealed Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19 .Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. Testing should not be required prior to transfer of a resident from an acute-care facility to a nursing home.New residents could be transferred out of the observation area or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g., date of admission). Testing at the end of this period could be considered to increase certainty. On 10/2/20 at 11:40 AM room five had contact/droplet precautions signs posted on the door and room seven had no signs posted. The toilet flushed in the shared bathroom connecting rooms five and seven. No resident exited the bathroom into room five. In an interview on 10/2/20 at 12:23 PM Staff 11 (CNA) stated the residents in room five were on quarantine for possible exposure to COVID-19 and shared a bathroom with the resident in room seven who was not on quarantine. In an interview on 10/2/20 at 1:23 PM Staff 14 (CNA) stated the residents in room five were on quarantine for possible exposure to COVID-19 but room seven was not on quarantine. Staff 14 stated two of the three residents in room five could use the bathroom with limited assistance or independently and the resident in room seven used the bathroom independently. Staff 14 stated the bathrooms were shared and only cleaned twice per day. In an interview on 10/2/20 at 1:38 PM Staff 10 (Account Manager) stated the housekeeping staff cleaned twice daily. In an interview on 10/2/20 at 2:27 PM Staff 1 (Administrator) stated no residents in the building tested positive for COVID-19, but the three residents in room five were on quarantine. Staff 1 stated he was not aware the residents were sharing a bathroom between quarantine (room five) and non-quarantined (room seven) rooms but should not share the bathroom. 7. The 2008 CDC Disinfection and Sterilization guidance revealed the following: disinfect (or clean) environmental surfaces on a regular basis and clean in patient-care areas when these surfaces are contaminated or soiled. Observations on 10/2/20 revealed the following: -At 11:46 AM a brown bag used to store staff masks, labeled(NAME)was sitting on the handrails outside room one. A resident with cognitive defcits was wandering in the hall; -At 11:49 AM in room [ROOM NUMBER] approximately five gloves and a tube of toothpaste sat on a clean, unused bed. An unlabeled face shield was on the nurse aide hook within the room; -At 11:53 AM in room [ROOM NUMBER] a glove and used gown was on the floor. A blood pressure cuff and two stethoscopes were on top of the nightstand near the empty but used urinal; -At 1:32 PM room [ROOM NUMBER] had a used glove and trash on the floor. Observations on 10/5/20 revealed the following: -At 10:48 AM a resident with cognitive deficits was wandering the halls in her/his wheelchair; -At 11:04 AM a used cup was sitting on the clean PPE storage container and a wad of issue was on the handrail outside room [ROOM NUMBER]. The resident with cognitive deficits was wandering near room [ROOM NUMBER] in her/his wheelchair; -At 11:23 AM a wad of tissue remained on the handrail; -At 11:42 AM inside room one there was an unlabeled face shield on the top of the closet. In an interview on 10/2/20 at 1:38 PM Staff 10 (Account Manager) stated the housekeeping staff cleaned twice daily and picked up items on an ongoing basis. Staff 10 stated nursing staff also cleaned as needed. In an interview on 10/6/20 at 4:21 PM Staff 1 (Administrator) stated they expected items to be cleaned, stored, contained and/or discarded to reduce the risk of cross contamination.