STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385241	A. BUILDING _____ B. WING _____	04/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE OAKS AT SHERWOOD PARK	4062 ARLETA AVENUE NE KEIZER, OR 97303

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, interview, and record review, in 2 of 6 observations of care the facility failed to ensure handy hygiene and use of personal protective equipment in accordance with CDC guidelines. These failures placed residents at risk for transmission of infection from one resident to another. Findings include During the entrance interview on 4/8/20 at 9:15 AM the facility administrator reported the facility currently had an outbreak of COVID-19 infection. The Administrator reported five residents who tested positive were in the hospital and one resident was hospitalized but returned to the facility. Of five staff tested , four results were negative. All staff in the building were observed wearing N95, cloth, or surgical face masks throughout the survey. The Director of Nursing (DON) reported on 4/2/20 the facility tested seven asymptomatic (had no symptoms of COVID-19) roommates of the residents who tested positive for COVID-19. The first of these test results was reported to be positive on 4/5/20. The Administrator said the facility designated the west wing as an isolation wing or (COVID Unit) and began moving residents onto the isolation wing on 4/6/20. The Administrator stated the isolation wing was a self-contained unit with dedicated staff, a break room with meals provided to staff and a separate entrance/exit leading directly outdoors. The DON said criteria for placement on the isolation wing included residents who tested positive for COVID-19 or were roommates of residents who tested positive. The DON said the staff used full droplet precautions with N95 masks for the care of all residents on the isolation unit. All staff wore facemasks and face shields in other areas of the facility and added gowns and gloves for entry to resident rooms or resident contact. The RCM (resident care manager) escorted surveyor to the west wing (isolation wing) on 4/8/20 at 9:40 AM. Observation revealed cross-corridor doors (smoke/fire doors) were closed physically separating the west wing from the remainder of the facility. The RCM opened the separating door and entered the isolation wing. The resident census on the isolation wing was 10. A licensed nurse and two nursing assistants provided care on the isolation wing. Three resident room doors were open. When interviewed, LN1 said the doors were kept closed for the symptomatic residents and some residents did not like the door closed. On 4/8/20 at 10:40 AM observed nursing assistant (Staff 1) doff (remove) PPE (personal protective equipment) when exiting isolation wing room [ROOM NUMBER]. The isolation gown was tied loosely at the neck. While still wearing gloves Staff 1 reached behind her head and pulled the tied neck string over her head and hung the gown on a hook in the room near the door. Next Staff 1 removed the face shield and then the N95 mask, touching the mask ties and placed the mask in a paper bag for re-use. Staff 1 still wore the gloves and handled the paper bag and the surface the bag sat on. Staff 6 removed the gloves last and performed hand hygiene. Staff 1 then donned (put on) a face shield and surgical mask. The posted signage directed staff to first remove gown and gloves, then goggles or face shield, mask or respirator and then wash or sanitize hands. RCM who was present during the observation concurred the gloves were considered contaminated and Staff 1 could potentially contaminate the N95 mask, the face shield, and the gown while doffing the PPE still wearing the gloves. On 4/8/20, at 10:55 AM, laundry staff 2 pushed a linen cart from the laundry through the isolation wing, opened the cross corridor doors and pushed the linen cart into the non-COVID area of the building. The RCM stopped Staff 2 as she left the isolation unit and reminded her to wash her hands. When asked why she pushed the linen cart through the isolation unit and not out the exit next to the laundry room door, Staff 2 said the linen was covered and the linen cart would not fit through the exit door, it was too tall. The RCM said the facility chose the West Wing as the COVID unit because it could be separated by closing the fire/smoke doors. RCM said it was unfortunate that laundry happened to be on the West Wing. The findings were shared with the facility administrator on 4/8/20 at 11:00 AM, the administrator said she thought the droplet precaution signage directed to remove gloves first. The administrator said the signage that should be posted for re-use of PPE should direct to remove gloves and perform hand hygiene then remove the gown, face shield, and mask. The administrator immediately located a CDC (Centers for Disease Control) poster that directed staff to remove gloves first and requested staff change the postings in the building. The administrator said she was not aware the linen carts were wheeled through the COVID Unit and not out the exit near the laundry room. The Administrator said the facility was still in the process of setting up the isolation unit policies and would evaluate and implement measures to ensure the laundry staff and linen carts did not travel through the isolation unit to reach the remainder of the nursing home. On 4/8/20 at 3:45 PM surveyor observed from the corridor on the non-COVID area of the facility, resident room [ROOM NUMBER] door was wide open. A resident in the room called for assistance. Nursing Assistant Staff 5 wore a facemask and a faceshield. A gown hung on a hook just inside room [ROOM NUMBER]. Staff 5 donned (put on) the gown and then gloves. Staff 5 provided assistance to the resident in the bed nearest the window. Staff 5 removed her gloves and used alcohol based hand rub (ABHR). Staff 5 went into the resident's bathroom without gloves. Staff stepped out of the bathroom and took something from the resident and threw it in the trash can. Staff 5 went directly to the resident in the bed by the door and without performing hand hygiene or wearing gloves, Staff 5 checked the resident's blood pressure (B\P) and pulse. Staff 5 placed the B\P cuff on the resident's overbed table then lifted her gown above her waist exposing Staff 5's clothing. Staff 5 reached in her pockets for pen and paper. Staff 5 wrote on the paper, again lifted her gown and returned the pen and paper to her pocket. Staff 5 exited room [ROOM NUMBER] and went directly to resident room [ROOM NUMBER]. Staff 5 removed the gown from the hook and carried the gown through the room to the bed by the window, then donned the gown. Staff 5 donned the gloves at the bedside to check a B\P. Staff 5 laid the B\P cuff and stethoscope on the bed without a barrier. After checking the B\P, Staff 5 again raised up her gown and reached into her pockets with gloved hands. As she left the room, Staff 5 placed the B\P cuff and stethoscope on the overbed table for the bed closest to the door. Staff 5 removed the gown and hung it on the hook. It was not turned and hung on the hook in a manner to facilitate re-use donning without contamination. Staff 5 removed the gloves last. On 4/8/20 the facility Infection Preventionist (IP) was not available for interview due to quarantine. In a telephone interview on 4/15/20 at 1:00 PM, the IP said the facility utilized CDC guidelines as a reference for the infection control program. IP said resident room doors for droplet precautions and all on the isolation wing should be kept closed at all times. The IP said staff that worked on the isolation wing were assigned only to the isolation wing and were educated on the procedures that included closing resident room doors. IP said the facility staff were supposed to enter and exit the isolation wing through the door at the end of the isolation wing that led directly outdoors. The care observation findings were shared with the IP. IP stated all staff were trained in donning and doffing PPE and in transmission-based precautions. IP confirmed Staff 5 had multiple infection control breeches regarding donning and use of PPE including gowns and gloves. Staff 5 committed breeches in hand washing and hand hygiene. IP stated the facility took disciplinary action with Staff 5 regarding the infection control breeches.

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