STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385145	A. BUILDING _____ B. WING _____	04/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROBISON JEWISH HEALTH CENTER	6125 SW BOUNDARY STREET PORTLAND, OR 97221

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, interview and record review, the facility failed to properly prevent and/or contain COVID-19. COVID-19 is an infectious disease from by a new virus causing a respiratory illness with symptoms of a cough, fever, and in severe cases difficulty breathing and in some cases death. Facility staff failed to follow droplet transmission based precautions and wear personal protective equipment (PPE) goggles during care of 4 of 4 presumed COVID-19 positive residents (R) (R1, R2, R3 and R4) on the dedicated isolation Unit 600. Unit 600 is a separate area from other parts of the facility dedicated for new admissions/isolation for known and presumed/unknown COVID-19 residents. In addition, facility staff had misinformation on the COVID-19 status of residents on Unit 600. These failures increased the risks for the spread of COVID-19 to other residents and staff. Findings include: Record review of the facility's policy, COVID-19 Admission Procedure dated 4/2020, showed careful consideration is given to each potential admission to assure the needs of the individual can be met and to also assure the ongoing health and safety of existing residents and staff. DNS (Director of Nursing Services) to review documents for all potential admissions to assess health status/care needs. The policy referred to Table 1: Accepting Hospital Admission, dated March 30, 2020, which showed the following are potential steps that can be taken to reduce the spread of COVID-19 in your LTC (long term care) facility. Place in contact precautions per CDC guidance. If COVID-19 testing is not available, then the facility should assume the person is COVID-19 positive. During Entrance Conference interview on 4/28/20 at 11:00 AM Administrator and DNS stated that there were no presumed or confirmed positive COVID-19 residents. In addition, the facility was still admitting residents with DNS conducting preadmission screening. DNS stated all admissions have, at the minimum, at least one negative COVID-19 test result prior to admission and then placed in Unit 600 for 14 days. All staff on Unit 600 wear a N95 mask, face shield, gown and gloves when providing care and there was no concern with the availability of PPE (personal protection equipment) supplies. Observation on 4/28/20 at 12:15 PM showed four residents (R1, R2, R3, and R4) on Unit 600. Isolation carts were outside rooms but there was no isolation signs indicating type of isolation or type of PPE required. The kitchen area of the unit showed six face shields evenly spaced on top of paper towels as well as multiple plastic containers labeled with staff names which contained N95 masks in each container. One of the resident rooms was being used as a staff locker/break room with gowns hanging in the room. Observation on 4/28/20 at 12:20 PM showed Certified Nursing Assistant (CNA)1 enter R4's room with a surgical face mask and a N95 mask over surgical face mask, gown, gloves and no face shield or eye protection. R4 was overheard requesting assistance with calling someone on the phone. CNA1 entered room, closed R4's room door and exited R4's room several minutes later. No eye protection was worn by CNA1 while in R4's room. CNA1 called for Licensed Nurse (LN)1. A few minutes later LN1 entered R4's room. LN1 wore N95 mask, gown and gloves. No face shield or eye protection was worn by LN1 upon entry into R4's room. Observation on 4/28/20 at about 12:30 PM showed CNA1 enter R1's room. CNA1 had two masks on, gown and gloves but no eye protection. CNA1 removed meal tray from resident's room. During an interview on 4/28/20 at about 12:35 PM when asked about lack of eye protection when entering Unit 600 rooms, CNA1 stated, I have a face shield and I know I'm supposed to wear it as part of our PPE. Sometimes I do, I usually wear it when a resident is coughing or spitting. CNA1 stated that he only worked on Unit 600 and was on call status with facility as worked full time at the hospital. CNA1 stated that he only worked three times at the facility since COVID started, including eight hours yesterday and 16 hours today. CNA1 stated that only he and LN1 were on shift for Unit 600 today. During an interview on 4/28/20 at 1:10 PM LN1 stated that all four residents on Unit 600 were asymptomatic for COVID-19 and therefore none were tested for the coronavirus. LN1 stated that she only worked on Unit 600 and usually worked one day a week. LN1 confirmed surveyor's observation of LN1 going into multiple rooms on Unit 600 without eye protection used. LN1 stated that there is enough face shields available and she has her own eye goggles that she brought with her but the goggles fog up so she doesn't use it. CNA1 joined the conversation and both LN1 and CNA1 stated that use of goggles were up to individual staff whether they wanted to use it or not, CNA1 stated that goggle/face shield use on Unit 600 was based on staff preference and LN1 nodded her head in agreement. LN1 stated that all four residents on Unit 600 were admitted from either the hospital directly and indirectly as one resident stayed at hotel for a short period of time between hospital discharge and being admitted to the facility. During an observation on 4/28/20 between 2:55 PM and 3:30 PM LN1 was in R2's room with mask, gown, and gloves on. No eye protection was worn. LN1 entered R1's room with ipad on stand and stayed in room for about 10 minutes. LN1 did not wear eye protection. LN1 entered R3's room without any eye protection. During an observation on 4/28/20 between 4:00 PM and 4:35 PM CNA1 entered R2's room without eye protection. CNA1 took resident's vital signs and then exited R2's room. CNA1 and LN1 then entered R1's room. No eye protection was used by both CNA1 and LN1 when entering R1's room. CNA1 then entered R3's room without eye protection and proceeded to take R3's vital signs. Review of R1's Medication Administration Record [REDACTED]. Pre-admission COVID-19 test results could not be located. Review of R2's MAR indicated [REDACTED]. Pre-admission COVID-19 test results could not be located. Review of R3's MAR indicated [REDACTED]. Pre-admission COVID-19 test results could not be located. Review of R4's MAR indicated [REDACTED]. Pre-admission COVID-19 test results could not be located. During concurrent interview and record review on 4/28/20 at 5:15 PM DNS stated that all residents on Unit 600 had at least one negative coronavirus test result prior to facility admission and all test results were COVID-19 negative. When asked specifically about use of eye protection as part of transmission based precautions on COVID-19 admission/isolation unit, DNS stated that face shields/eye protection is available but not required, however later DNS stated eye protection was required. During review of facility's policy, COVID-19 Admission Procedure, Table 1: Accepting Hospital Admission, dated March 30, 2020, which showed place in contact precautions per CDC guidance. If COVID-19 testing is not available, then the facility should assume the person is COVID-19 positive, with DNS, DNS stated that all Unit 600 residents were COVID-19 negative. Reviewed with DNS of CMS COVID-19 Focused Survey for Nursing Homes showed for a resident with known or suspected COVID-19: staff wear gloves, isolation gown, eye protection and an N95 or higher-level respirator, if available. DNS reviewed Unit 600 residents' records, including history and physical, and could not locate current or negative COVID-19 test results. DNS stated R2 was a direct admission from RSM (Rose Schnitzer Manor at Cedar Sinai Park; assisted living section of campus) and therefore DNS was not involved in her preadmission process. DNS provided negative coronavirus test results for R4. Review of the Centers for Disease Control and Prevention (CDC) Preparing for COVID-19: Long-term Care Facilities, Nursing Homes webpage https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html accessed on 4/30/20 showed Dedicate space in the facility to care for residents with confirmed COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19. Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options may include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19 .All recommended PPE should be worn during care of residents under observation; this includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. Email communications, dated 4/29/20

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) at 4:14 PM, received from DNS showed R2 was admitted directly from RSM (Rose Schnitzer Manor at Cedar Sinai Park; assisted living section of campus) related to fall with back pain and the hospital declined to test resident while at the hospital stating resident was asymptomatic of any infectious process. For R1, the hospital declined three times for COVID-19 with multiple conversations with discharge planners regarding risks and all indicated resident was negative for symptoms, was not on a COVID unit nor in a COVID proximity. For R3, multiple conversations occurred with discharge planner at hospital who repeated resident was not in a COVID area of the hospital, testing was requested prior to admission but testing was declined due to lack of symptomatology. During Exit interview on 4/29/20 at 3:27 PM with Administrator and DNS, DNS stated that R2 refused to be tested for the coronavirus, was quarantined at home and was in the hospital for less than 36 hours, R4 had a negative coronavirus test result, R1 was discharged yesterday and R3 will be completing his 14 day observation period in Unit 600 on Friday, 5/1/20. DNS stated that she knows staff should be wearing face shields on Unit 600 and that is why they are provided. DNS stated that she has seen LN1 wear face shield in the previously and have seen other staff on Unit 600 with divots across their foreheads because of the abrasive plastic up against their foreheads and staff would put 2x2 or 4x4 pieces of gauze as cushion. DNS stated that she was surprised at the laissez-faire response when staff were asked why they were not wearing face shields for eye protection. Email communications, dated 4/29/20 at 8:46 PM, to DNS showed surveyor informing facility that further review of R4's negative coronavirus test results provided on 4/28/20 were not for the COVID-19 because the lab results were dated 7/26/18 and therefore, all four residents in the 600 hall did not have COVID-19 test results prior to admission and the CDC recommendations for full PPE, including eye protection, should have been worn by the nurse and aide on 4/28/20. Email communications, dated 4/30/20 at 2:09 PM, received from DNS showed posted signage on the entrance to the unit (600 unit) yesterday making it VERY CLEAR what PPE was required to enter any room on the unit. Email communications, dated 5/1/20 at 2:45 PM, received from DNS showed further research and calls for R4's COVID-19 test results did not result in any further information.