STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135019	A. BUILDING _____ B. WING _____	08/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ORCHARDS OF CASCADIA, THE	404 NORTH HORTON STREET NAMPA, ID 83651

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 -** Immediate jeopardy **Residents Affected -** Few	**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, the facility failed to properly prevent and/or contain COVID-19. COVID-19 is an infectious disease by a new virus causing respiratory illness with symptoms including cough, fever, new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death. Two of seven Certified Nursing Assistant (CNA1 and CNA2) did not utilized full personal protective equipment (PPE), specifically eye protection, during cares and interactions within six feet of nine non-masked residents (R5, R7, R8, R9, R10, R11, R12, R13, and R14). Both CNAs worked on Hall 200 where R2 tested positive for COVID-19 eight days prior. The facility was located in a county with a high level of community transmission. The facility also failed to conduct [DIAGNOSES REDACTED]-CoV-2 (severe acute respiratory syndrome coronavirus 2), [MEDICAL CONDITION] that causes COVID-19, testing of all residents and all staff who previously tested negative when the facility had a COVID outbreak. After R17 tested positive for COVID-19, 11 of 12 residents (R14, R9, R2, R13, R11, R12, R18, R19, R5, R10 and R6) on Hall 200, who previously tested negative, should have been tested but were not. R2 later tested positive for COVID-19 on [DATE] after becoming symptomatic requiring transfer to the hospital. After R2 tested positive for COVID-19, 9 of 11 residents (R14, R9, R13, R11, R12, R18, R19, R10 and R6) on Hall 200, who previously tested negative for COVID-19, should have been tested but were not. In addition, 5 of 10 staff (CNA4, CNA5, CNA6, LN3 and LN4) who worked on Hall 200 and previously tested negative for COVID-19 should have been tested but were not. The facility failure to maintain infection control measures to prevent transmission placed all residents and staff in the facility in immediate jeopardy for risk for serious illness and/or death related to COVID-19 and required immediate action. On [DATE] at 4:20 PM the Administrator was informed and emailed Immediate Jeopardy (IJ) determination for 42 CFR 483.80 (F880). On [DATE] at 10:26 AM Administrator was informed of determination that immediacy was removed based on onsite verification that IJ removal plan was implemented. Findings include: During an interview on [DATE] at 8:00 AM Administrator and Director of Nursing (DON) stated that the facility census was 60. The facility currently had 8 COVID-19 positive residents who resided in Hall100 (COVID-19 unit). The facility did not have any resident presumed positive or under investigation outside of the COVID-19 unit. Facility had sufficient inventory of PPE (personal protective equipment) and all staff were required to wear full PPE comprised of mask (N95 on COVID unit and KN95 on non-COVID unit), eye protection, gown and gloves. Full PPE use started on [DATE] when facility had first COVID positive case. The most recent resident who tested positive for COVID was R2. R2 was residing on Hall 200 and became lethargic on [DATE]; therefore, R2 was transferred to hospital and tested positive for COVID-19 on [DATE]. Review of Centers of Disease Control and Prevention (CDC) cases and deaths by county, https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/county-map.html, updated [DATE], accessed [DATE], showed Canyon County (the county where the facility was located) had 2,768 cases per 100,000 indicating a high level of community COVID-19 activity. *CNA1 not wearing PPE Observation on [DATE] between 10:00 AM and 11:00 AM showed CNA1 on Hall 200 entering R9's room. CNA1 wore gown, KN95 mask and glasses but no goggles or face shield. CNA1's glasses were small to medium measuring about 1.5 inches x 2 inches covering the front of her eyes but nothing covering or protecting the sides of her face or eyes. CNA1's glasses were not PPE eye protection. CNA1 stood less than 6 feet away from R9, resident did not wear mask, as the pulse oximeter was placed on R9's finger. After exiting R9's room, CNA1 entered R10's room. CNA1 was not wearing eye protection and stood less than 6 feet from R10, resident did not wear mask, to wrap blood pressure cuff around resident's arm. CNA1 exited R10's room and approached Licensed Nurse (LN)1 at the medication cart. LN1 and CNA1 spoke briefly with CNA1 obtaining hand cuff from LN1. LN1 did not mention to CNA1 that CNA1 was not wearing eye protection. At 10:05 AM, CNA1 entered R8's room with no eye protection and closed the door. After about 15 minutes, CNA1 exited R8's room with two bags of trash and linen. At 10:35 AM, CNA1 stated that she was passing water and ice to all residents on Hall 200. CNA1 still was not wearing eye protection as CNA1 entered several resident rooms. CNA1 entered R7's room and stood less than 6 feet from R7, wiping down bedside table and passing water and ice. R7 did not wear a mask. CNA1 entered R8's room and stood less than 6 feet from R8. R8 did not wear a mask. During interview on [DATE] at 10:40 AM, CNA1 stated that about 30 minutes ago, she changed R8's brief, provided pericare and repositioned resident and she did this before and after breakfast today. CNA1 entered R11's room and stood less than 6 feet from R11 as she passed water and ice and conversed with R11 about misplaced clothing. R11 did not wear a mask. CNA1 entered R12's room and stood less than 6 feet from resident as CNA1 passed water and ice and conversed with resident. Resident did not wear a mask. While in the R12's room, CNA1 asked LN1 to tie the top of her gown and LN1 stood right next to CNA1 and tied gown. LN1 did not mention to CNA1 that CNA1 was not wearing eye protection as both staff were in resident's room. CNA1 then entered R13's, R9's, and R14's room without eye protection and stood less than 6 feet from these residents while passing water and ice and conversing with residents. None of these residents wore a mask. CNA1 stood less than 6 feet from R14, about a foot next to resident, and both were talking for longer than 10 minutes. Observation on [DATE] at 11:40 AM showed CNA1 and CNA2 in R5's room. R5 was sitting in wheelchair and CNA1 stated that plan was to transfer R5 back into bed with hoyer (mechanical) lift, check and change resident's brief and then transfer resident back to wheelchair. CNA1 was not wearing eye protection. R5 had his mouth open about two inches wide and continued to make audible grunting and moaning noises while within 2 feet of both CNA1 and CNA2. R5 then began coughing loudly, cough was moist sounding. CNA1 and CNA2 transferred R5 to bed with hoyer lift. CNA1 was less 6 inches from R5's open mouth and was face-to-face with resident. After R5 was in bed, R5 was rolled onto his side with his face next to CNA1. As R5's brief was changed and pericare was performed, R5 grunted loudly and frequently. After brief change, R5 was transferred back to wheelchair where CNA1 was again face-to-face, about one feet away, from R5's face. R5 laughed in response to conversation with CNAs. R5 could also be heard gurgling with moist sounds and open mouth breathing. CNA2 did not mention to CNA1 that CNA1 was not wearing eye protection and should wear eye protection. During an interview on [DATE] at 11:50 AM CNA1 stated that R5 is high risk for aspiration and we have to make sure he is straight up during feeding. He tends to gurgle a lot and always has his mouth open and grunts often. CNA1 stated that she started shift at 6:00 AM today and provided personal cares to R7, R8 and R9 which involved direct cares as all three residents' required total assistance with personal cares, dressing, mobility, and positioning. CNA1 also stated that she gave a shower to R6 and R7. CNA1 stated that she used the shower hose to spray R6 body and back during shower and washed R6's back and legs during shower. CNA1 stated that she works full time assigned to Hall 200. When asked about COVID amongst residents in Hall 200, CNA1 stated that R2 had COVID and is now in the COVID unit, resident had no symptoms except for diarrhea for ,[DATE] days but no temperature. This happened recently. R3 and R4 also had COVID and went to the COVID unit with R3 just returning back to Hall 200. When asked about use of eye protection such as goggles or face shield, CNA1 stated I'm supposed to wear goggles but it fogs up. I tried the face shield but I couldn't see. When asked if any staff has mentioned to CNA1 that she should be wearing eye protection, CNA1 stated that Administrator told her two weeks ago that she should be wearing goggles. When asked if CNA1 has been wearing goggles since Administrator spoke to her two weeks ago, CNA1 shook her head no and stated that she rarely wears goggles. When asked when

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 -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) CNA1 started her shift, CNA1 responded 6AM. When asked if CNA1 wore eye protection since the start of her shift (6 hours ago) CNA1 said, No. CNA1 did not wear eye protection for the first six hours of her shift on [DATE] (until interview with surveyor) and stated that she rarely wears eye protection despite providing direct resident care within 6 feet of residents on Hall 200 non-COVID unit. Since [DATE], a month ago, 8 residents on Hall 200 tested positive for COVID-19 and the facility did not conduct testing of all residents and all staff after each resident or staff tested positive for COVID-19. In addition, 8 days ago, R2, who resided on Hall 200, tested positive for COVID-19. CNA1 is supposed to wear eye protection and her lack of wearing eye protection consistently for two weeks or more, increased the risk that serious harm or death from COVID-19 is likely to occur. *CNA2 not wearing PPE Observation on [DATE] at 9:23 AM showed CNA2 exit R10's room with goggles on top of her head and not covering her eyes. CNA2 did not have any eye protection. CNA2 held thermometer and pulse oximeter (device to check oxygen level) and began cleaning devices. CNA2 then entered R5's room and stood less than 2 feet away from resident's open mouth, while resident gurgled, grunted and moaned. Resident had device on that supplied oxygen. CNA2 applied pulse oximeter (device to check oxygen level) and scanned resident's forehead with thermometer. CNA2 continued to have goggles on top of her head and did not have any eye protection. CNA2 exited R5's room and cleaned devices and then moved cart with devices to another resident's room, looked at surveyor and then repositioned goggles from top of head to over her eyes. During an interview on [DATE] at 12:10 PM with Infection Preventionist (IP) and DON, when asked about staff providing direct care in close contact with residents without eye protection and the risk of COVID transmission to residents, IP stated that staff would have risk of contracting COVID but if staff was wearing mask and performing hand hygiene, the risk of transmitting COVID to residents are low. When asked to confirm risks are present for transmitting, IP nodded her head. When asked if staff are 100% in hand hygiene and other infection control practices, IP didn't respond. IP and DON stated that they have received from staff texts and reports of staff not wearing PPE. When asked how residents on non-COVID unit are protected from positive COVID staff working, IP stated that if staff are COVID positive they are quarantined for 10 days or they could work on the COVID unit. When asked if COVID positive staff could work on the non-COVID unit, IP stated no. When asked if staff working on non-COVID unit are not wearing eye protection and increasing their risk of getting COVID, how did that differ from not allowing COVID positive staff to work on non-COVID unit, IP stated that the difference was knowing or deliberating knowing COVID positive staff was working with non-COVID unit residents. During an interview on [DATE] at 1:00 PM Administrator stated that he recalled conversation with CNA1 about not wearing eye protection while working. Administrator stated that it was about two weeks ago and he immediately made sure CNA1 put on eye protection. During an interview on [DATE] at 3:10 PM DON stated that eye protection protects staff but when staff wears mask, they are preventing transmission to residents, DON asked how would it get to the residents. When asked if COVID positive staff working in non-COVID unit could transmit COVID to other staff in the break room, if there was a lapse in infection control such as respiratory hygiene, not washing hands appropriately, touching eyes or mouth and not washing hands and then touching resident, resident environment or shared equipment or common area shared by staff or residents, DON responded by stating that eye protection protects staff and not the resident. During an interview on [DATE] at 3:43 PM with DON and Administrator, DON stated that she spoke with CNA1 about not wearing eye protection and CNA1 confirmed that she wears eye protection about 25% of the time and takes eye protection on and off because she can't see and afraid she might fall because she can't see. CNA1 stated that she wants residents to be safe and doesn't feel it's safe to be using hoyer lift if she can't see. DON stated that CNA1 has been suspended today and matter will be investigated before CNA1 can return to work. DON stated that CNA1 did not raise problem of not wearing eye protection because of issues with not seeing and therefore, there was no opportunity to problem solve about alternative eye protection options or other solutions. Administrator and DON stated that it is important that residents need to be protected and safe, staff need to wear PPE. CNA1 knows she's in the wrong and CNA1 apologized for not wearing eye protection. During concurrent interview and record review on [DATE] at 4:04 PM with DON and Administrator, records showed CNA1 received donning and doffing training. DON reviewed facility's policy, Screening and Management of Coronavirus COVID-19, revision date [DATE], with DON confirming that PPE use for staff in Hall 200 was applicable under b. General Population: iv. White Zone: Facility Exposure continuous wear protection: 1. Gown or long sleeve scrub, KN95/respirator, eye protection, and gloves. During an interview on [DATE] between 4:20 PM and 5:30 PM DON and Administrator stated that they would not allow a COVID positive staff to work in non-COVID unit and staff are screened daily but also stated that asymptomatic COVID positive staff could pass the screening process. It was also stated that lack of eye protection increases CNA1 risk of getting infected with COVID-19. CNA1 last COVID-19 test was on [DATE] with negative results. When asked if CNA1 could be asymptomatic COVID positive and working on non-COVID unit, Administrator stated Yes, but that could be the same for any staff. When asked if CNA1 could have been COVID-19 positive but not shedding [MEDICAL CONDITION] enough to yield a positive result on [DATE] or currently COVID positive, Administrator stated it was possible. When asked if mitigation strategies such as staff screening, no visitation, and use of PPE is to keep COVID out of building, Administrator stated Yes. During an interview on [DATE] at 5:45 PM IP stated that CNA1's behaviors of not wearing eye protection puts CNA1 at risk for COVID and want to prevent COVID in non-COVID unit. CNA1 could be asymptomatic with COVID and they could be breaches in infection control. During an interview on [DATE] at about 10:10 AM LN1 stated that she worked primarily on Hall 200 and was not aware CNA1 was not wearing eye protection yesterday. When informed that yesterday CNA1 was observed wearing glasses and not eye protection, LN1 stated that she didn't know CNA1 wore glasses and stated that I just didn't notice, I wasn't aware. Review of facility's LTC (Long Term Care) Respiratory Surveillance Line List, dated [DATE], showed during time period of [DATE] to [DATE], 16 residents and 21 staff tested positive for COVID-19. Out of this total number of residents and staff who tested positive for COVID-19, 7 residents (R4, R15, R8, R16, R3, R17 and R2) resided on Hall 200 and 3 staff member (LN1, LN2, CNA3) was primarily assigned to work on Hall 200. Review of CDC's Preparing for COVID-19 in Nursing Homes, https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, updated [DATE], accessed [DATE], showed Given their congregate nature and resident population served (e.g., older adults often with underlying chronic medical conditions), nursing home populations are at high risk of being affected by respiratory pathogens like COVID-19 and other pathogens . Because of the higher risk of unrecognized infection among residents, universal use of all recommended PPE for the care of all residents on the affected unit (or facility-wide depending on the situation) is recommended when even a single case among residents or HCP (health care personnel) is newly identified in the facility; this could also be considered when there is sustained transmission in the community. Review of CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html, updated [DATE], accessed [DATE] showed HCP working in facilities located in areas with moderate to substantial community transmission are more likely to encounter asymptomatic or pre-symptomatic patients with [DIAGNOSES REDACTED]-CoV-2 infection . .They should also: Wear eye protection in addition to their facemask to ensure the eyes, nose, and mouth are all protected from exposure to respiratory secretions during patient care encounters. 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. Review of CDC's Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19, https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html, updated [DATE], accessed [DATE], showed Health care personnel (HCP) who had prolonged close contact with a patient, visitor, or HCP with confirmed COVID-19 who were not wearing eye protection if the person with COVID-19 was not wearing a cloth face covering or facemask should be exclude from work for 14 days after last exposure as well as advise HCP to monitor themselves for fever or symptoms consistent with COVID-19. Review of CDC's Responding to Coronavirus (COVID-19) in Nursing Homes Considerations for the Public Health Response to COVID-19 in Nursing Homes, https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html, updated [DATE], accessed [DATE], showed Resident with confirmed COVID-19 .HCP should use all recommended COVID-19 PPE for the care of all residents on affected units (or facility-wide if cases are widespread); this includes both symptomatic and asymptomatic residents .Maintain Transmission-Based Precautions for all residents on the unit at least until there are no additional clinical cases for 14 days after implementation of all recommended interventions. Review of facility's policy, Screening and Management of Coronavirus COVID-19, revision date [DATE], showed COVID-19 infection can spread very rapidly. Healthcare institutions .are particularly at-risk for outbreaks because of increased person-to-person contact Asymptomatic staff with unprotected

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) exposure to COVID-19 positive individuals, may be excluded from work for 14 days after last exposure. Section 30. Use of Personal Protection Devices showed b. General Population: iv. White Zone: Facility Exposure continuous wear protection: 1. Gown or long sleeve scrub, KN95/respirator, eye protection, and gloves. Review of facility's policy, Transmission-Based Precautions Conventional Plan, revision date [DATE], showed Droplet Precautions: 3. Staff and visitors don a medical mask, gloves and gown when exposure is anticipated or when within 6 feet of the resident's immediate environment. If substantial spraying of respiratory fluids is anticipated, wear goggles or face shield. Review of letter to residents and family members of COVID-19 status, dated [DATE], showed The Orchards has already developed an infection treatment and containment plan to specifically address COVID-19. Our plan contains stringent protocols which were immediately implemented. The protocols include .direct care staff utilizes medical masks, face shields, and gowns for personal protection during care for all residents Record review of R2's progress notes and care plans showed resident was admitted [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. On [DATE] at about 8:00 PM, resident was very fatigued, minimally responsive, and unable to swallow medications or drink fluids and had sporadic jerking movements. Resident was transferred to the emergency room . At the emergency room , on [DATE], resident tested positive for COVID-19. Record review of R5's progress notes and care plans showed resident was readmitted [DATE] with [DIAGNOSES REDACTED]. Resident required total assistance with grooming, dressing/ undressing and bathing, [MEDICAL CONDITION] cares and incontinence care, oral care after each meal, staff to have resident up and out of bed for all meals, and required and had suction machine at bedside. Record review of R7's progress notes and care plans showed resident was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident required two person assistant using sit to stand and staff assistance with pericare after each incontinence episode. Record review of R8's progress notes and care plans showed resident was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident required extensive assistance to use the toilet. Record review of R9's progress notes and care plans showed resident was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident required extensive assistance with incontinence care. Record review of R10's progress notes and care plans showed resident was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident required assistance every two to three hours for incontinence care. Record review of R11's progress notes and care plans showed resident was admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of R12's progress notes and care plans showed resident was admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of R13's progress notes and care plans showed resident was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident required one staff supervision/participation in bathing, personal hygiene, oral care and incontinence care. Record review of R14's progress notes and care plans showed resident was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident required staff participation with incontinence care, bathing, dressing and mobility. *Testing Review of facility's LTC (Long Term Care) Respiratory Surveillance Line List, dated [DATE], showed during time period of [DATE] to [DATE], 16 residents and 21 staff tested positive for COVID-19. Out of this total number of residents and staff who tested positive for COVID-19, 7 residents (R4, R15, R8, R16, R3, R17 and R2) resided on Hall 200 and 3 staff member (LN1, LN2, CNA3) was primarily assigned to work on Hall 200. Record review of R4's progress notes, lab reports, and respiratory surveillance line list showed resident was admitted on [DATE], resided on Hall 200, was almost [AGE] years old, and had symptoms consistent with COVID-19 on [DATE] and tested positive for COVID-19 on [DATE]. Record review of R15's progress notes, lab reports, and respiratory surveillance line list showed resident was admitted on ,[DATE], resided on Hall 200, was over [AGE] years old, and had symptoms consistent with COVID-19 on [DATE] and tested positive for COVID-19 on [DATE]. Record review of R8's progress notes, care plans, lab reports, and respiratory surveillance line list showed resident was admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of R16's progress notes, lab reports, and respiratory surveillance line list showed resident was admitted on [DATE], readmitted on [DATE], resided on Hall 200, was over [AGE] years old, and had symptoms consistent with COVID-19 on [DATE] and tested positive for COVID-19 on [DATE]. Record review of R3's progress notes, lab reports, and respiratory surveillance line list showed resident was admitted on [DATE], resided on Hall 200, was over [AGE] years old, and had symptoms consistent with COVID-19 on [DATE] and tested positive for COVID-19 on [DATE]. Record review of R17's progress notes, care plans, lab reports, death report, and respiratory surveillance line list showed resident was admitted on [DATE], readmitted on [DATE], resided on Hall 200, was over [AGE] years old, and had symptoms consistent with COVID-19 on [DATE] and tested positive for COVID-19 on [DATE] and died at the facility on [DATE] with COVID-19 listed as the principle cause of death. Record review of R2's progress notes, care plans, lab reports, and respiratory surveillance line list showed resident was admitted on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. On [DATE] at about 8:00 PM, resident was very fatigued, minimally responsive, and unable to swallow medications or drink fluids and had sporadic jerking movements. Resident was transferred to the emergency room . On [DATE] at the emergency room , resident tested positive for COVID-19. *R17 tested positive for COVID-19 on [DATE]. Review of Testing events (as of 2020?08?12) document showed first testing event after R17's positive result was [DATE], seven days later. Residents who resided on Hall 200 and previously tested negative for COVID-19 should have been tested at [DATE] testing event after R17's was positive for COVID-19 but these residents were not tested : R14, R9, R2, R13, R11, R12, R18, R19, R5, R10 and R6. R2 later tested positive for COVID-19 on [DATE] after becoming symptomatic requiring transfer to the hospital. There was no documented evidence that these residents refused testing. There was no documented evidence of serial weekly testing of all resident and all staff who resided or worked on Hall 200. *R2 tested positive for COVID-19 on [DATE]. Review of Nursing schedule, dated [DATE] to [DATE] and Point of Care bladder tasks for R2 showed the following staff worked on Hall 200: CNA4 on ,[DATE], ,[DATE] and ,[DATE], CNA5 on ,[DATE], ,[DATE], CNA6 on ,[DATE], ,[DATE], and ,[DATE], LN3 on ,[DATE], and LN4 on ,[DATE]. Review of Testing events (as of 2020?08?12) document showed first testing event after R2's positive result was [DATE]. The above staff, CNA4, CNA5, CNA6, LN3 and LN4, previously tested negative for COVID-19 and should have been tested at [DATE] testing event after R2 tested positive for COVID-19 but wasn't. Review of Testing events (as of 2020?08?12) document showed first testing event after R2's positive result was [DATE]. Residents who resided on Hall 200 and previously tested negative for COVID-19 should have been tested at [DATE] testing event after R2's was positive for COVID-19 but these residents were not tested : R14, R9, R13, R11, R12, R18, R19, R10 and R6. There was no documented evidence that these residents refused testing. During an interview on [DATE] at 8:00 AM Administrator and Director of Nursing (DON) stated that the facility conducted weekly testing for [DIAGNOSES REDACTED]-CoV-2 (severe acute respiratory syndrome coronavirus 2), [MEDICAL CONDITION] that causes COVID-19 for staff who worked in the COVID unit, staff who were symptomatic or staff who wanted testing. The facility also tested staff who were symptomatic. Several staff had previously tested positive for COVID-19, with two nurses who had recovered from COVID-19 and were returning to work this week. During an interview on [DATE] at 11:30 AM IP stated that after R2 tested positive on [DATE], we tested non-verbal residents which would be R5 and R7. R6, R10 and R9 are all verbal so they can report if they are fatigue and how much they are eating so they were not tested . During an interview on [DATE] at 12:10 PM IP stated that the facility has testing every Thursdays and Fridays and we test if residents or staff are symptomatic or had exposure. In addition, COVID unit staff are tested . We use Crush the Curve and get the [MEDICATION NAME] test results within 36 hours. We just got the rapid machine for testing. During an interview on [DATE] at 3:20 PM IP stated that we call staff when they have positive COVID test results and tell them what symptoms they could be experiencing, encourage them to contact others who might have been exposed, offer PPE and sanitizer. Staff do their own notification for contact tracing. When R2 had positive COVID results, we were already watching Hall 200 closely because other residents had already tested positive in that hall. Staff were already aware of COVID positive residents and staff self-refer for testing if they feel they had exposure, staff know which staff they had lunch with or interact with or when they worked. There was no systematic process to ensure all staff and all residents who previously tested negative for COVID-19 and who worked or resided in Hall 200 were tested . Email communications, dated [DATE] at 10:53 AM, from Administrator in response to surveyor request for confirmation or additional information received from interview with IP, showed: *In response to statement Testing is available for staff every Thurs and Friday and staff avail themselves to testing, Administrator wrote Yes this is correct *In response to statement Not all staff and residents are tested whenever any resident or staff tests positive, Administrator wrote We did test the entire facility at first. We assess and look at all residents for signs and symptoms daily. Staff screened daily *In response to statement Testing events (as of 2020?08?12) document provided shows all residents and staff who have been tested (shows testing events on ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE] and results received on ,[DATE]), Administrator wrote Correct, we also tested ,[DATE] and ,[DATE]. Email communications, dated [DATE] at 11:08 AM, showed in response to request for date when entire facility was first tested , showed Administrator wrote Our entire facility was tested on ,[DATE]. Email communications, dated [DATE] at 1:20 PM, to Administrator from surveyor showed question How does the facility address the following as outlined by the CDC? Testing in Nursing Homes: How long should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135019	A. BUILDING _____ B. WING _____	**08/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ORCHARDS OF CASCADIA, THE	**404 NORTH HORTON STREET NAMPA, ID 83651**

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 -** Immediate jeopardy **Residents Affected -** Few F 0885 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 3) facilities continue serial testing of HCP? If there is a COVID?19 out **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform residents, their representatives and families of cumulative updates of COVID-19 in the facility. This failure deprived residents, their representatives or families from having the opportunity to choose whether they wanted to move forward with the COVID-19 management plan being proposed by the facility given the number of cumulative cases. This failure affected all 60 residents in the facility. Findings include: During an interview on 8/12/20 at 8:00 AM Administrator and Director of Nursing (DON) stated that the facility census was 60. Review of facility's LTC (Long Term Care) Respiratory Surveillance Line List, dated 8/5/20, showed during time period of 6/26/20 to 8/5/20, 16 residents and 21 staff tested positive for COVID-19. Out of this total number of residents and staff who tested positive for COVID-19, 7 residents (R) (R4, R15, R8, R16, R3, R17 and R2) resided on Hall 200 and 3 staff member (Licensed Nurse (LN)1, LN2, Certified Nursing Assistant (CNA)3) was primarily assigned to work on Hall 200. Residents and staff had symptoms consistent with COVID-19 and tested positive for COVID-19 almost weekly. For example: Record review of R15's progress notes, lab reports, and respiratory surveillance line list showed resident was admitted on ,[DATE], resided on Hall 200, was over [AGE] years old, and had symptoms consistent with COVID-19 on 7/13/20 and tested positive for COVID-19 on 7/13/20. Record review of R8's progress notes, care plans, lab reports, and respiratory surveillance line list showed resident was admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of R16's progress notes, lab reports, and respiratory surveillance line list showed resident was admitted on [DATE], readmitted on [DATE], resided on Hall 200, was over [AGE] years old, and had symptoms consistent with COVID-19 on 7/18/20 and tested positive for COVID-19 on 7/22/20. Record review of R3's progress notes, lab reports, and respiratory surveillance line list showed resident was admitted on [DATE], resided on Hall 200, was over [AGE] years old, and had symptoms consistent with COVID-19 on 7/18/20 and tested positive for COVID-19 on 7/22/20. Record review of R17's progress notes, care plans, lab reports, death report, and respiratory surveillance line list showed resident was admitted on [DATE], readmitted on [DATE], resided on Hall 200, was over [AGE] years old, and had symptoms consistent with COVID-19 on 7/23/20 and tested positive for COVID-19 on 7/24/20. During an interview on 8/12/20 at 3:30 PM Infection Preventionist (IP) stated that residents, representatives and families are notified of facility's COVID-19 status and actions to prevent or contain COVID-19 by Administrator and (Activity Director) every Monday by either calling family or Power of Attorney. During an interview on 8/12/20 at about 3:45 PM Administrator stated that he notifies residents, representatives and families of facility's COVID-19 status and actions to prevent or contain COVID-19 through either calling or emailing and provided a recent letter sent to communicate this information. Review of the above reference letter, dated 7/24/20, sent to residents, representatives, families to communicate COVID-19 information showed At (name of facility), we tested and confirmed that we currently have staff and residents infected with the COVID-19 virus The communications did not inform residents, representatives and families of the cumulative update status as there was no documented evidence of the number of staff or the number of residents who were infected with COVID-19. Email communications was sent to Administrator on 8/19/20 at 2:20 PM communicating above finding and requesting for any additional information. No additional information was received as of 8/21/20 at 8:30 AM, 2 days later. Review of facility's policy, Screening and Management of Coronavirus COVID-19, revision date 7/21/20, showed Notification of Resident/Resident Advocates with an Outbreak Residents and resident advocates will be notified by 5pm on the next calendar day if the following occurs: a. A single confirmed COVID-19 case of staff or resident .Communication will include mitigating action plans implemented The policy did not include reference to providing cumulative updates as outlined in the regulation. Please also refer to F880.