STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385277	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CREEKSIDE REHABILITATION AND NURSING	812 SE 48TH AVENUE PORTLAND, OR 97215

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to notify the physician related to a resident's change in condition for 1 of 4 sampled residents (# 1) review for infection control. This placed residents at risk for a decline in health and possible hospitalization . Findings include: Resident 1 admitted to the facility in 2014 with [DIAGNOSES REDACTED]. A 7/31/20 physician order [REDACTED]. Staff were to indicate if symptoms of cough or shortness of breath were a change of condition from baseline. Staff were to notify the doctor immediately if Resident 1 had a temperature of 100.4F or higher. On 8/4/20 at 1:02 PM Staff 6 (CNA) was observed to inform Staff 7 (LPN) of Resident 1's temperature of 100.9F. Staff 6 further stated the resident looked as though she/he had blush on, had a little cough, and the resident reported not feeling well. On 8/4/20 at 1:14 PM Staff 5 (LPN) was observed to inform Staff 7 she would give Resident 1 Tylenol (pain medication) for the fever and re-check the resident's temperature later. The surveyor attempted to question Staff 5 about Resident 1, but Staff 5 stated she was too busy to be interviewed but stated three other residents had been sent out to the hospital for fevers. On 8/4/20 at 1:39 PM Staff 6 (CNA) stated she re-checked Resident 1's temperature and it was 99.8F. Staff 6 further stated she told Staff 5 prior to talking with Staff 7 about Resident 1's 100.9F temperature and symptoms and Staff 5 stated I do not have time to deal with this right now. Staff 6 stated the facility had sent multiple residents out to the hospital for fevers and was unsure why Resident 1 was not sent out. A review of Resident 1's medical record did not indicate the resident's physician was notified of the resident's significant change in condition related to COVID-19 symptoms. On 8/5/20 at 2:36 PM Staff 5 refused to be interviewed. On 8/6/20 at 12:48 PM Staff 3 (Regional RN) acknowledged the above findings and stated the expectation was for the physician to be notified for signs and symptoms of COVID-19. Refer to F658 and F684.
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to ensure Staff 5 (LPN) adhered to professional standards related to residents' changes in condition for 2 of 4 sampled residents (#s 1 and 7) reviewed for change in conditions. This placed residents at risk for delay in treatment. Findings include: OAR [PHONE NUMBER] Scope and Practice Standards for Licensed Practical Nurses indicated the following: The Board recognizes that the LPN has a supervised practice that occurs at the clinical direction and under the clinical supervision of the RN or LIP who have authority to make changes in the plan of care, and encompasses a variety of roles, including, but not limited to: (2) Standards related to the LPN's responsibility for ethical practice, accountability for services provided, and competency. The LPN shall: (a) Provision of client care; (d) Demonstrate honesty, integrity and professionalism in the practice of licensed practical nursing; (3) Standards related to the LPN's responsibility for nursing practice. Applying practical nursing knowledge, at the clinical direction and under the clinical supervision of the RN or LIP, the LPN shall: (a) Conduct focused assessments by: (A) Collecting data through observations, examinations, interviews, and records in an accurate and timely manner as appropriate to the client's health care needs and context of care. (E) Recognizing signs and symptoms of deviation from current health status; and Evaluate client responses to nursing interventions, progress toward measurable outcomes, and communicate such to appropriate members of the health care team. (5)Standards related to the LPN's responsibility for client advocacy. The LPN shall: (b) Intervene on behalf of the client to identify changes in health status, to protect, promote and optimize health, and to alleviate suffering; OAR [PHONE NUMBER] Conduct Derogatory to the Standards of Nursing indicated the following: Conduct that adversely affects the health, safety, and welfare of the public, fails to conform to legal nursing standards, or fails to conform to accepted standards of the nursing profession, is conduct derogatory to the standards of nursing. Such conduct includes, but is not limited to: (3) Conduct related to the client's safety and integrity: (b) Failing to take action to preserve or promote the client's safety based on nursing assessment and judgment; (4) Conduct related to communication: (C) Failing to document information pertinent to a client's care; (f) Failing to communicate information regarding the client's status to members of the health care team in an ongoing and timely manner as appropriate to the context of care; or (g) Failing to communicate information regarding the client's status to other individuals who are authorized to receive information and have a need to know. 1. Resident 1 admitted to the facility in 2014 with [DIAGNOSES REDACTED]. A 7/31/20 physician order [REDACTED]. Staff were to indicate if symptoms of cough or shortness of breath were a change of condition from baseline. Staff were to notify the doctor immediately if Resident 1 had a temperature of 100.4F or higher. On 8/4/20 at 1:02 PM Staff 6 (CNA) was observed to inform Staff 7 (LPN) of Resident 1's temperature of 100.9F. Staff 6 further stated the resident looked as though she/he had blush on, had a little cough, and the resident reported not feeling well. On 8/4/20 at 1:14 PM Staff 5 (LPN) was observed to inform Staff 7 she administered Tylenol (pain medication) to Resident 1 for fever and would re-check the resident's temperature later. The State Surveyor attempted to question Staff 5 about Resident 1, but Staff 5 stated she was too busy to be interviewed but stated three other residents had been sent out to the hospital for fevers. (Record review revealed no PRN Tylenol order and no documentation indicating Tylenol was administered). On 8/4/20 at 1:39 PM Staff 6 stated she re-checked Resident 1's temperature and it was 99.8F. Staff 6 further stated she told Staff 5 prior to informing Staff 7 about Resident 1's symptoms and Staff 5 stated I do not have time to deal with this right now. Staff 6 stated the facility had sent multiple residents out to the hospital for fevers and was unsure why Resident 1 was not sent out. Staff 6 further stated the nurses decided if a resident was to be assessed and/or isolated for symptoms indicative of COVID-19. A review of Resident 1's medical record did not indicate the Resident's 100.9F temperature was recorded, was assessed for the indicated symptoms, or the physician was notified. On 8/4/20 at 8:40 PM Staff 9 (LPN) stated she was informed no assessment or documentation was completed for Resident 1's symptoms during the previous shifts. Staff 9 stated she assessed Resident 1 and was now notifying the physician of Resident 1's change of condition. On 8/5/20 at 1:25 PM Staff 11 (CNA) stated on 8/4/20 Staff 5 did not address multiple residents' symptoms, including Resident 1. On 8/5/20 at 2:36 PM Staff 5 refused to be interviewed. On 8/6/20 at 12:48 PM Staff 3 (Regional RN) acknowledged the above findings and stated the expectation was for nurses to assess residents immediately for any change of condition, notify the physician for significant changes and to accurately document findings in the medical record. 2. Resident 7 admitted to the facility 7/13/20 with [DIAGNOSES REDACTED]. A 7/31/20 physician order [REDACTED]. Staff were to indicate if symptoms of cough or shortness of breath were a change of

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385277	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CREEKSIDE REHABILITATION AND NURSING	812 SE 48TH AVENUE PORTLAND, OR 97215

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 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) condition from baseline. Staff were to notify the doctor immediately if Resident 7 had a temperature of 100.4F or higher. On 8/5/20 at 1:25 PM Staff 11 (CNA) stated she reported to Staff 5 (LPN) on 8/4/20 that Resident 7 had a nasty sounding cough and the cough was worse from the resident's baseline. Staff 11 further stated Staff 5 did nothing when Staff 11 reported Resident 7's change of condition and did not assess the resident. The 8/4/20 TAR for day and evening shift was signed by Staff 5 and did not indicate the resident had a cough. The 8/4/20 night shift TAR signed by Staff 9 (LPN) indicated Resident 7 had a cough but there was no change of condition. An 8/5/20 Progress Note documented at 1:15 PM indicated Resident 7 was transferred to the hospital for a change of condition with the development of shortness of breath, [MEDICAL CONDITION], chest pain, a sore throat and a cough. The 8/5/20 evening TAR signed by Staff 5 indicated the resident had a change of condition, a cough, and shortness of breath. A review Resident 7's medical record did not indicate an assessment was completed for the resident's change of condition for 8/4/20. On 8/5/20 at 2:36 PM Staff 5 refused to be interviewed. On 8/6/20 at 12:48 PM Staff 3 (Regional RN) acknowledged the above findings and stated the expectation was for nurses to assess residents immediately for any change of condition indicative of COVID-19 and to document findings in the medical record. Refer to F580 and F684.
F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to respond appropriately to residents' change of condition related to COVID-19 for 2 of 4 sampled residents (#s 1 and 2) reviewed for infection control. This failure, determined to be an immediate jeopardy situation, and lack of response to perform comprehensive assessments for residents presenting with COVID-19 symptoms delayed placing residents under transmission based precautions and was likely to delay treatment and cause serious harm and/or death. Findings include: The 6/25/20 CDC (Centers for Disease Control and Prevention) Preparing For COVID-19 In Nursing Homes guidance included the following instructions for nursing facilities: *All fevers and symptoms consistent with COVID-19 among admitted patients should be properly managed and evaluated (e.g., place any patient with unexplained fever or symptoms of COVID-19 on appropriate Transmission-Based Precautions and evaluate). Additionally, more than two temperatures over 99.0F might be a sign of fever in this population. *Residents in the facility who develop symptoms consistent with COVID-19 could be moved to a single room pending results of COVID-19 testing. *While awaiting results of testing, staff should wear N95 respirator, eye protection, gloves and gown when caring for residents. *Have a plan for how roommates, other residents and staff who were potentially exposed to an individual with COVID-19 will be handled (e.g., monitor closely, avoid placing unexposed residents into a shared space with them). *Any reusable PPE (Personal Protective Equipment) must be properly cleaned, decontaminated and maintained after and between uses. At the time of survey on 8/4/20 the facility had a resident census of 27. There was one resident on contact and droplet precautions for signs of COVID-19. The remaining residents were tested for COVID-19 on 7/28/20 and pending results. No other facility residents were on any type of infection control precautions. 1. Resident 1 admitted to the facility in 2014 with [DIAGNOSES REDACTED]. On 8/4/20 at 1:02 PM Staff 6 (CNA) was observed to report to Staff 7 (LPN) that Resident 1 had a fever the previous night, a current temperature of 100.9F, appeared to have blush on, a cough and the resident reported she/he did not feel good. On 8/4/20 at 1:39 PM Staff 6 stated she re-checked Resident 1's temperature with a temp dot instead of the same thermometer with a result of 99.8F. Staff 6 stated she reported Resident 1's temperature, cough and the resident's report of not feeling good to Staff 5 (LPN) prior to reporting to Staff 7 and Staff 5 replied, I don't have time to deal with this right now . Review of Resident 1's MAR indicated [REDACTED]. No assessment of Resident 1's change of condition or physician notification was completed. Review of Resident 1's medical record revealed no assessment of Resident 1's symptoms which were consistent with COVID-19. On 8/4/20 at 1:14 PM Staff 5 stated she was too busy to be interviewed. 2. Resident 2 was admitted to the facility in 2019 with [DIAGNOSES REDACTED]. Resident 4's (Resident 2's roommate) 8/3/20 progress note revealed Resident 4 was in the hospital and tested positive for COVID-19. A review of Resident 2's medical record revealed on 8/3/20 at 12:49 PM Resident 2 had a fever of 100.4F and refused medications, fluids and food. On 8/4/20 Resident 2 continued to refuse medications. No assessment of Resident 2's change of condition on 8/3/20 was completed, including the general COVID-19 screening. On 8/4/20 at 6:30 PM the facility administrative staff, including Staff 1 (Administrator) and Staff 4 (Administrator In Training) were informed of the immediate jeopardy (IJ) situation and an immediate plan of correction (POC) was requested. On 8/4/20 at 9:07 PM the facility submitted a plan of correction which was accepted by the survey team. The IJ Removal Plan included: -Resident #s 1 and 2 would be assessed by the licensed nurse on 8/4/20 by 9:30 PM. After the assessment was completed the nurse would contact the physician and follow orders as directed. -CNAs on shift would check temperatures of all facility residents and notify the nurse of any residents with COVID-19 symptoms. For any resident with COVID-19 like symptoms the charge nurse would then perform an assessment. -DNS or designee would audit the TAR three times a day (AM, PM, HS) for 1 week, then daily for one month to ensure any resident showing COVID-19 symptoms would be identified and assessed timely. -DNS or designee would in-service all licensed nurses on how to appropriately fill out the COVID-19 TAR, signs and symptoms of COVID-19, timely assessments of changes of condition and notification would be completed by 8/5/20 at 4:00 PM. -The results of the COVID-19 symptoms TAR audits would be reviewed daily by the NHA (Nursing Home Administrator) and monthly by the QAA committee to ensure that changes of condition were identified and addressed timely. This would continue monthly until a lesser time frame was determined appropriate. Any identified problems would result in a change to the plan of care. On 8/4/20 at 8:40 PM Staff 9 (LPN) verified she had assessed Residents 1 and 2 for COVID-19 symptoms and a change of condition and notified the residents physicians. On 8/5/20 multiple observations were made of Staff 3 (Regional RN) completing the staff in-service per the IJ Plan of correction. On 8/5/20 Staff 5 (LPN) and Staff 7 (LPN) verified they received the staff in-service per POC. On 8/5/20 at 4:00 PM Staff 3 provided verification that all licensed nurses received the required POC in-servicing, Staff 3 further stated the TAR audits were started and all elements of the POC were completed.
F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to ensure sufficient staff were available to meet resident needs for 2 of 2 halls (Long and Short) reviewed for staffing. This placed residents at risk for delayed assistance and unmet care needs. Findings include: 1. Resident 12 admitted to the facility in 2019 with [DIAGNOSES REDACTED]. The 7/2020 Shower Sheet indicated Resident 12 received showers on Sundays and Wednesdays. The sheet did not indicate resident 12 was offered or received a shower on 7/26/20. Resident 12's current careplan indicated the Resident required 1:1 supervision due to physically assaulting another resident. On 8/5/20 at 1:25 PM Staff 11 (CNA) stated there were two CNAs working day shift for 37 residents on 7/26/20 for both Long and Short halls in the facility. Staff 11 further stated since staff and residents tested positive for COVID-19 the facility was short-staffed on multiple occasions and staff were unable to complete any resident showers on those days including on 7/26/20. On 8/6/20 at 12:32 PM Staff 2 (DNS) stated she assisted CNAs on the floor on 7/26/20 and there were only two CNAs to care for 37 residents. Staff 2 stated residents were unable to receive showers due to limited staff and Resident 12 was care planned for 1:1 supervision and this was unable to be accommodated due to the lack of staff. 2. The following staffing concerns were reported to the survey team: On 8/4/20 at 2:59 PM Staff 7 (LPN) stated she was the only nurse for evening shift and felt short-staffed. Staff 7 further stated she was three hours behind administering medication to residents. On 8/5/20 at 11:55 AM Staff 10 (CNA) stated the facility was short-staffed on weekends and would sometimes only have two CNAs. Staff 10 stated on days the facility was short-staffed residents were unable to receive showers. Staff 10 further stated she recently changed from evening to day shift due to lack of staffing during the evening shift. On 8/5/20 at 1:25 PM Staff 11 (CNA) stated there were two CNAs working day shift for 37 residents on 7/26/20 and Staff 2 (DNS) came out to the floor to assist. Staff 11 further stated since staff and residents tested positive for COVID-19 the facility was short-staffed on multiple occasions and staff were unable to complete resident showers on those days. On 8/6/20 at 12:32 PM Staff 2 (DNS) stated she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385277	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CREEKSIDE REHABILITATION AND NURSING	812 SE 48TH AVENUE PORTLAND, OR 97215

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 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) assisted the CNAs on 7/26/20 and there were only two other CNAs to care for 37 residents. Staff 2 stated residents were unable to receive showers due to limited staff and Resident 12 was care planned for 1:1 supervision and this was unable to be accommodated due to the lack of staff. Staff 2 further stated since the facility staff and residents started to test positive for COVID-19 staffing was an issue. 3. On 8/4/20 at 1:14 PM Staff 5 (LPN) was observed to inform Staff 7 she was so busy, running late and was behind administering medication for residents. Staff 5 appeared overwhelmed and rushed. On 8/4/20 at 2:59 PM Staff 7 (LPN) was observed to be the only nurse in the facility for 27 residents since 2:00 PM. Staff 7 appeared rushed and kept stating how behind she was. Staff 7 was observed telling multiple staff she was three hours late administering medications. 4. The 7/25/20 Staffing Schedule indicated there were two CNAs for 37 residents. Refer to F684 and F727.
F 0727 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.** Based on observation, interview and record review it was determined the facility failed to ensure an RN was on duty for at least eight hours a day, seven days a week. This placed residents at risk for unassessed and unmet nursing needs. Findings include: The 8/4/20 through 8/6/20 Staff Schedule indicated there was no RN on duty. On 8/4/20 at 1:14 PM Staff 5 (LPN) and Staff 7 (LPN) were the only nurses observed in the facility for 27 residents. On 8/4/20 at 2:59 PM Staff 7 (LPN) was observed to be the only nurse in the facility. On 8/5/20 through 8/6/20 there were no RNs observed on duty in the facility for 26 and 24 residents respectively. The DNS was out of the facility for both dats indicated. On 8/6/20 at 12:53 PM Staff 3 (Regional RN) confirmed no RN was on duty and the DNS was out of the facility from 8/4/20 through 8/6/20. Refer to F684 and F727.
F 0838 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.** Based on interview and record review it was determined the facility failed to complete a comprehensive facility wide assessment to ensure sufficient staffing was in place for resident acuity. This placed residents at risk for unmet needs. Findings include: The 11/11/19 Facility Assessment indicated the facility staffed to state minimums and CNAs were evenly assigned residents at the beginning of each shift. There was no indication resident acuity was taken into consideration for staffing. On 8/4/20 Staff 6 (CNA) and Staff 7 (LPN) stated the facility was staffed according to its census and not based on the acuity of residents. On 8/6/20 at 1:56 PM Staff 3 (Regional RN) confirmed the facility assessment indicated the facility only staffed according to the state minimum staffing ratios and not to resident acuity. Staff 3 further stated there was no further indication the facility staffed based on resident needs in the assessment.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to ensure medical records were complete and accurate for 5 of 12 residents (#s 1, 2, 3, 5 and 7) reviewed for infection control. This placed residents at risk for inaccurate medical records. Findings include: 1. Resident 2 admitted to the facility in 2019 with [DIAGNOSES REDACTED]. A 7/30/20 physician order [REDACTED]. Staff were to indicate if symptoms of cough or shortness of breath were a change of condition from baseline. Staff were to notify the doctor immediately if Resident 2 had a temperature of 100.4F or higher. a. The 8/2020 TAR indicated the 8/3/20 COVID-19 symptom monitoring documentation was left blank for day and evening shifts. On 8/6/20 at 1:18 PM Staff 3 (Regional RN) acknowledged the COVID-19 documentation on the TAR was left blank for 8/3/20 day and evening shifts. b. The 7/2020 and 8/2020 TAR was reviewed and indicated 13 out of 18 shifts documented Resident 2's temperature at 97.7F and two of those shifts for temperature were left blank. On 8/6/20 at 1:18 PM Staff 3 (Regional RN) acknowledged the COVID-19 monitoring documentation temperatures on the TAR were inaccurate unless the Resident's temperatures were an anomaly. 2. Resident 1 admitted to the facility in 2014 with [DIAGNOSES REDACTED]. A 7/31/20 physician order [REDACTED]. Staff were to indicate if symptoms of cough or shortness of breath were a change of condition from baseline. Staff were to notify the doctor immediately if Resident 1 had a temperature of 100.4F or higher. a. On 8/4/20 at 1:02 PM Staff 6 (CNA) was observed to inform Staff 7 (LPN) of Resident 1's temperature of 100.9F. Staff 6 further stated the resident looked as though she/he had blush on, had a little cough, and the resident reported not feeling well. On 8/4/20 at 1:39 PM Staff 6 stated she re-checked Resident 1's temperature and it was 99.8F. The 8/2020 TAR indicated on 8/4/20 the day and evening shifts signed by Staff 5 (LPN) that Resident 1 had no cough and no change in condition. The temperatures were documented as 97.8F for AM and 99.8F for PM. On 8/6/20 at 12:49 PM Staff 3 (Regional RN) acknowledged the COVID-19 documentation on the TAR was inaccurate for 8/4/20. b. The 8/2020 TAR indicated the 8/3/20 COVID-19 symptom documentation was left blank for evening shift. On 8/6/20 at 12:49 PM Staff 3 (Regional RN) acknowledged the COVID-19 documentation on the TAR was left blank for 8/3/20 evening shift. 3. Resident 7 admitted to the facility 7/13/20 with [DIAGNOSES REDACTED]. On 8/5/20 at 1:25 PM Staff 11 (CNA) stated she reported to Staff 5 on 8/4/20 that Resident 7 had a nasty sounding cough and the cough was worse from the resident's baseline. The 8/4/20 TAR for day and evening shift was signed by Staff 5 (LPN) and did not indicate the resident had a cough. The 8/4/20 night shift TAR signed by Staff 9 (LPN) indicated Resident 7 had a cough but there was no change of condition. An 8/5/20 Progress Note indicated Resident 7 was transferred to the hospital for a change of condition with the development of shortness of breath, [MEDICAL CONDITION], chest pain, a sore throat and a cough. On 8/5/20 at 2:36 PM Staff 5 refused to be interviewed. On 8/6/20 at 12:53 PM Staff 3 (Regional RN) acknowledged the inaccuracies on the TAR for 8/4/20. 4. Resident 5 admitted to the facility 5/2020 with [DIAGNOSES REDACTED]. An 8/3/20 Progress Note indicated the resident was not coughing since this morning. The note further indicated the resident refused fluids and had a temperature of 99.8F. The 8/2020 TAR was reviewed and revealed 8/3/20 COVID-19 monitoring was left blank for day and evening shifts. On 8/6/20 at 12:53 PM Staff 3 (Regional RN) acknowledged the COVID-19 monitoring documentation on the TAR was left blank for 8/3/20 day and evening shifts. 5. Resident 3 was admitted to the facility 3/2020 with [DIAGNOSES REDACTED]. a. The Vital Summary oxygen saturation report revealed oxygen saturations of 62% on 7/28/20 and 80% on 7/30/20 (normal range is 96-100%). Review of Resident 3's medical record revealed no follow-up of the low oxygen saturation levels, no respiratory status assessment and no documented concerns regarding Resident 3's respiratory status. On 8/5/20 at 1:43 PM Staff 3 (Regional RN) acknowledged the 7/28/20 and 7/30/20 oxygen saturation entries were documentation errors. b. The 8/4/20 12:29 PM Progress note indicated Resident 3 remained on contact and droplet precautions. On 8/4/20 at 1:02 PM Resident 3 was observed in her/his room with no infection control precautions in place. On 8/4/20 at 11:55 AM Staff 1 (Administrator) stated Resident 3 was not on isolation or infection control precautions.
F 0880 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 1. Based on observation, interview and record review it was determined the facility failed to implement COVID-19 infection control practices for residents previously exposed to positive or symptomatic COVID-19 residents related to proper resident isolation and PPE (Personal Protective Equipment) usage for 3 of 4 sampled residents (#s 1, 2 and 3) reviewed for Infection Control. This failure, determined to be an immediate jeopardy situation, of not isolating residents who were previously exposed to positive or symptomatic COVID-19 residents, determined to be an immediate jeopardy situation, resulted in the potential for cross-contamination between the suspected COVID-19 residents and transmission to non-COVID-19 residents. Findings include: The 6/25/20 CDC (Centers for Disease Control and Prevention) Preparing For COVID-19 In Nursing Homes guidance included the following instructions for nursing facilities: *All fevers and symptoms consistent with COVID-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385277	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CREEKSIDE REHABILITATION AND NURSING	812 SE 48TH AVENUE PORTLAND, OR 97215

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 -** Many	(continued... from page 3) among admitted patients should be properly managed and evaluated (e.g., place any patient with unexplained fever or symptoms of COVID-19 on appropriate Transmission-Based Precautions and evaluate). Additionally, more than two temperatures over 99.0F might be a sign of fever in this population. *Residents in the facility who develop symptoms consistent with COVID-19 could be moved to a single room pending results of COVID-19 testing. *While awaiting results of testing, staff should wear N95 respirator, eye protection, gloves and gown when caring for residents. *Have a plan for how roommates, other residents and staff who were potentially exposed to an individual with COVID-19 will be handled (e.g., monitor closely, avoid placing unexposed residents into a shared space with them). *Any reusable PPE (Personal Protective Equipment) must be properly cleaned, decontaminated and maintained after and between uses. The 7/15/20 CDC Interim Infection Prevention and Control Recommendations for Health Care Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic *Dedicated medical equipment should be used when caring for patients with suspected or confirmed COVID-19 infection. *All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected (after resident use). At the time of survey on 8/4/20 the facility had a resident census of 27. There was one resident on contact and droplet precautions for signs of COVID-19. No other facility residents were on any type of infection control precautions. The following infection control observations, interviews and record review were made: 1. Resident 3 admitted to the facility 3/2020 with [DIAGNOSES REDACTED]. A 8/3/20 Progress Note revealed Resident 3 transferred rooms because her/his roommate had symptoms of COVID-19. On 8/4/20 at 1:02 PM Resident 3 was observed in her/his room without any infection control precautions. (Per CDC Guidelines, Resident 3 was expected to be put on contact and droplet infection control precautions related to her/his potential exposure to COVID-19). Staff 10 (CNA) was observed to walk into Resident 3's room wearing a face mask, face shield and gloves. Staff 10 exited the room without doffing her PPE and proceeded to enter and exit multiple other resident rooms wearing the same face mask and face shield. On 8/4/20 between 12:01 PM and 6:30 PM multiple facility nursing staff were observed to enter and exit resident rooms (which were expected to be on transmission-based precautions per CDC guidelines) wearing the same face masks and face shields and did not disinfect or discard PPE appropriately. 2. Resident 1 admitted to the facility in 2014 with [DIAGNOSES REDACTED]. The following observations were made on 8/4/20: * 1:02 PM Staff 6 (CNA) reported to Staff 5 (LPN) Resident 1 had a fever, cough and malaise. * 1:39 PM Staff were observed to enter Resident 1's room wearing a face shield and face mask only. Resident 1 was not on any infection control precautions. * 3:01 PM Staff 8 (CNA) was observed to enter and exit Resident 1's room wearing a face shield and face mask only. Staff 8 did not doff the face mask or disinfect the face shield after exiting the resident room. * 4:35 PM staff were observed to enter and exit multiple resident rooms when wearing the same face mask and face shield. 3. Resident 2 admitted to the facility in 2019 with [DIAGNOSES REDACTED]. Resident 4's (Resident 2's roommate) 8/3/20 progress note revealed Resident 4 was in the hospital and tested positive for COVID-19. An 8/3/20 progress note revealed Resident 2 had a fever of 100.4F, refused medications, fluids and food. The following observations were made on 8/4/20: * 1:39 PM Resident 2 was observed to not be on contact or droplet infection control precautions. * Resident 2 was observed to independently roam the hallway most of the day with the resident's face mask positioned under her/his chin. * 3:14 PM and 4:51 PM staff were observed to enter Resident 2's room without proper PPE. There were two other residents in the room. * 8:01 PM Resident 2 was pushed down the hallway in a wheelchair to the outside patio by a staff member. Resident 2 was observed to have a moist cough. 4. The following observations and interviews were conducted on 8/4/20 of the single resident room (Resident 6) on contact and droplet precautions: * 1:12 PM Staff 19 (CNA) exited room [ROOM NUMBER] (a transmissions-based precaution room), doffed the PPE gown but left on the gloves, face mask and face shield. Staff, while wearing the contaminated face mask, face shield and gloves proceeded to walk down the hall to the soiled utility room, punch in the access code and enter the soiled utility room. * 3:41 PM Staff 7 (LPN) was observed to exit room [ROOM NUMBER] and place a contaminated thermometer and oximeter on top of the clean PPE cart. Staff 7 was observed to doff the PPE gown outside of room [ROOM NUMBER] and perform hand hygiene. Staff 7 then doffed the contaminated N95 mask and face shield and placed the contaminated face shield on the nursing station counter prior to disinfecting the shield. The nursing station counter was disinfected at the request of the intervening surveyor. Staff 7 then instructed Staff 13 (CNA) to disinfect the thermometer and oximeter. The top of the PPE cart was not disinfected. * 4:38 PM two medics entered Resident 6's room (room [ROOM NUMBER]) wearing only N95 masks. At 4:47 PM both medics stated they were not told the resident exhibited signs of COVID-19 and their policy was to be in full PPE gear if entering a potential COVID-19 positive resident room. On 8/4/20 at 1:39 PM Staff 6 (CNA) stated she was informed of resident updates through the night nurse or secondhand. Staff 6 acknowledged she was unaware which residents were previously exposed to positive or symptomatic COVID-19 residents or had current COVID-19-like symptoms. On 8/4/20 at 3:02 PM Staff 8 (CNA) stated the facility did not communicate with the CNAs which residents were on isolation precautions or residents who were exhibiting signs of COVID-19. Staff 8 stated he received all resident information through rumors. Staff 8 stated he was given one N95 mask to wear throughout the shift and wore the same mask into every room. On 8/4/20 at 2:15 PM Witness 2 (Epidemiologist) stated she visited the facility on 8/3/20 and made several infection control recommendations to the facility Administration which included transferring Resident 3 out of Resident 6's room, placing Resident 3 on COVID-19 infection control precautions and developing cohorting and isolation units. The facility failed to implement COVID-19 infection control practices for residents previously exposed to positive or symptomatic COVID-19 residents which resulted in residents not placed on COVID-19 isolation precautions, improper PPE usage and facility-wide staff and resident exposure to possible COVID-19 infection. On 8/4/20 at 6:30 PM the facility administrative staff including Staff 1 (Administrator) and Staff 4 (Administrator In Training) were informed of the immediate jeopardy (IJ) situation and an immediate plan of correction (POC) was requested. On 8/4/20 at 9:07 PM the facility submitted a plan of correction which was accepted by the survey team. The IJ Removal Plan included: -Resident #s 1, 2 and 3 were appropriately placed on isolation with contact and droplet precautions. Residents 1, 2 and 3 would be placed in a private room to the maximum extent possible until cohorting became necessary due to room availability and capacity. - Staff 1 or designee would complete room changes to separate negative and presumptive positive residents and assign designated staff. - Staff 1 or designee would complete staff screening during business hours and the charge nurse was responsible for screening outside of business hours. -All other residents with roommates who had tested positive or presumptive positive would be placed on isolation with contact and droplet precautions by 8/5/20 at 4:00 PM. -Staff in-servicing would be completed on how to use and complete the COVID-19 TAR, signs and symptoms of COVID-19, timely assessments of changes of condition and notification and would be completed by 8/5/20 at 4:00 PM. -DNS or designee would audit the TAR three times a day (AM, PM, HS) for one week, then daily for one month to ensure any resident who exhibited COVID-19 symptoms would be identified and placed on isolation with contact and droplet precautions. -DNS or designee would audit COVID-19 lab results daily to ensure all roommates of individuals who tested positive were placed on isolation with contact and droplet precautions. DNS or designee would in-service all staff on isolation, upgraded precautions, proper PPE usage and the new screening process. -The results of the audit would be reported by the DNS to the QAA committee monthly or until a lesser frequency was determined appropriate. Appropriate isolation room changes would be completed by 8/5/20 at 4:00 PM. On 8/4/20 at 8:40 PM Staff 9 (LPN) verified she had assessed Residents 1, 2 and 3 for COVID-19 symptoms and a change of condition and notified all the residents' physicians. Staff 9 verified Resident's 1, 2 and 3 were placed on contact and droplet precautions. On 8/5/20 multiple observations were made of Staff 3 (Regional RN) completing the staff in-service per the IJ Plan of correction. On 8/5/20 Staff 5, 6, 7, 8, 10, 11, 13 and 17 all verified they received the staff in-service per POC. On 8/5/20 between 3:30 PM and 3:50 PM multiple observations were made of staff entering and exiting resident rooms, performing appropriate hand hygiene and donning PPE correctly. No infection control concerns were identified. On 8/5/20 at 4:00 PM Staff 3 provided verification that all staff had received the required POC in-servicing, all residents who were positive or presumptive positive for COVID-19 were placed on isolation in private rooms. All residents with roommates who were positive or presumptive positive were placed on isolation. Staff 3 further stated the TAR audits were initiated, the process for screening staff was updated per the POC and the facility had designated staff working with the isolation residents. Staff 3 verified all elements of the POC had been completed. 2. Based on observation, interview and record review it was determined the facility did not implement proper infection control practices for 1 of 1 kitchens reviewed for infection control, 1 of 1 resident (#12) reviewed for COVID-19 CDC screening. This placed residents at risk for possible cross-contamination and COVID-19 infection. Findings include: a. On 8/4/20 at 1:07 PM Staff 16 (Dietary Aide) was observed to turn bowls over with his bare hands and placed his thumbs inside each bowl as he turned the bowl. Staff 15 (Dietary) was observed in the kitchen not wearing a hair restraint. At 1:09 PM Staff 16 stated he was expected to wear gloves and not place his thumbs inside the bowls. Staff 16 then started to dish up fruit slices into one of the bowls. The surveyor stopped Staff 16 and requested the bowls be sanitized. At 1:10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385277	A. BUILDING _____ B. WING _____	**08/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CREEKSIDE REHABILITATION AND NURSING	**812 SE 48TH AVENUE PORTLAND, OR 97215**

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 -** Many	(continued... from page 4) PM Staff 15 verified she did not have on a hair restraint and further stated she forgot. b. On 8/4/20 at 2:15 PM Witness 2 (Epidemiologist) stated she visited the facility on 8/3/20 and made several infection control recommendations to the facility Administration which included disinfecting the food tray cart when it returned to the kitchen. On 8/4/20 at 1:06 PM the food tray cart was observed to be brought into the kitchen without being disinfected. On 8/5/20 at 1:07 PM the food tray cart was left outside the kitchen door. The top of the food tray cart was covered with multiple plastic food lids. Staff 15 (Dietary) disinfected the sides of the food cart but not the top. The surveyor intervened prior to the food cart being brought into the kitchen and requested Staff 3 (Regional RN) to observe the situation. On 8/5/20 at 1:10 PM Staff 3 acknowledged the top of the food cart needed to be cleared and properly disinfected prior to bringing the contaminated cart into the kitchen. c. On 8/5/20 at 11:34 AM an unattended, dirty linen bag was observed on the floor outside of room [ROOM NUMBER]. Staff 10 (CNA) verified the dirty linen bag should not be on the floor, picked the bag up and disposed of the bag appropriately in the Soiled Utility Room. d. On 8/5/20 at 2:39 PM an unattended trash bag was observed on the floor next to the medication cart in the long hall. Staff 13 (CNA) stated an agency nurse did that. Staff 13 proceeded to pick up the trash bag and disposed of the bag appropriately in the Soiled Utility Room. e. The 6/25/20 CDC (Centers for Disease Control and Prevention) Preparing For COVID-19 In Nursing Homes guidance instructed the facility to screen residents entering the facilty for symptoms consistent with COVID-19 or exposure to others with COVID-19 infection and ensure they are [MEDICATION NAME] source control. The guidance further instructed to check the residents temperature. On 8/4/20 at 1:02 PM Staff 6 (CNA) reported Resident 12 and Resident 13 frequently left the facility were not screened upon return. Record review of the COVID-19 Resident Screening forms revealed from 6/26/20 through 8/4/20 the five residents who left the facility routinely were screened six times. Five of the six times the screening process was completed properly. Resident 13 was screened appropriately one of two times when screened. Resident 12 had no completed screening forms. On 8/4/20 at 3:34 PM Resident 12 stated when she/he returned to the facility from being out in the community she/he was not screened and did not get her/his temperature checked. On 8/4/20 at 1:41 PM Staff 1 (Administrator) stated the facility staff did not consistently screen the two residents who routinely left the facility for recreational purposes and enhanced monitoring of the two residents was not in place. On 8/4/20 at 2:59 PM Staff 4 (AIT - Administrator in Training) instructed Staff 14 (Physical Therapy Assistant) facility staff needed to start screening residents when they returned to the facility.