STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135146	A. BUILDING _____ B. WING _____	**07/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASCADIA OF BOISE	**6000 W DENTON ST BOISE, ID 83704**

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, policy review, and staff interview, it was determined the facility failed to ensure infection control prevention practices were consistently implemented to provide a safe and sanitary environment. This failure created the potential for negative outcomes by exposing residents to the risk of infection and cross-contamination including COVID-19. Findings include: 1. The facility's policy for PPE Donning (putting on) and Doffing (taking off), dated 4/6/20, provided the following directions regarding use of PPE: * When putting on a gown, position the top of the gown around the neck, then fasten and secure the ties around the neck and around the waist with the ties at the back of the gown. * When putting on a face mask, secure the ties or elastic bands at the middle of the head and at the neck. Ensure the fit to the bridge of the nose and fit the face mask snugly to the face and below the chin. The front of the face mask is contaminated, and staff should not touch it. The facility's policy for Hand Hygiene, dated 3/3/20, directed staff to perform hand hygiene after touching contaminated items. These policies were not followed. a. On 7/22/20 at 9:00 AM, Resident #2's room had a red sign posted on the door. The sign indicated Resident #2 was on enhanced droplet precautions, and a gown, respirator face mask, eye protection, and gloves were required. On 7/22/20 at 9:06 AM, the Respiratory Therapist put on PPE, including a blue isolation gown, and then he carried respiratory supplies into Resident #2's room. The Respiratory Therapist did not tie the lower ties on the gown, leaving his back exposed as he entered the room. The Respiratory Therapist replaced the respiratory equipment on the far side of Resident #2's bed, and Resident #2 was sitting on the opposite edge of the bed facing the door. After several minutes, the Respiratory Therapist obtained a trash can and disposed of the used respiratory equipment in the room. The Respiratory Therapist's gown remained untied below the neck, and as he leaned forward over the trash can the gown became more open, exposing his sides as well as his back. The Respiratory Therapist then removed the trash bag from the trash can, put a new trash bag in the trash can, removed his gloves and gown, and sanitized his hands. The Respiratory Therapist said Resident #2 was on precautions and was quarantined due to either being a new admission or being out of the facility. The Respiratory Therapist said prior to entering the room, staff should put on a gown, gloves, respirator face mask, and eye protection. The Respiratory Therapist said the gown should have been tied, and he did not tie it because he was changing out equipment that was not near Resident #2. b. On 7/22/20 at 10:54 AM, CNA #1 was in the hall at a computer kiosk near Resident #2's room. CNA #1 was wearing a respirator face mask and goggles. The bottom strap of the respirator face mask was hanging over the front of CNA #1's face below the face mask. The top strap of the face mask was in place on the top of CNA #1's head. CNA #1 said that was not the correct way to wear the face mask, and she was wearing it that way because it hurt her face. CNA #1 said staff were to wear a face mask and eye protection at all times. c. On 7/22/20 at 12:45 PM, RN #2 was sitting at the nurse's station, and he was wearing a respirator face mask below his nose. He adjusted the face mask by touching it on the outside, and he began typing on the computer keyboard. RN #2 touched the outside of the face mask 4 times as he continued typing on the computer keyboard and talking to the surveyor. RN #2 did not perform hand hygiene at any time after he touched the outside of his face mask. RN #2 said his face mask kept dropping below his nose, and it should cover his face and nose. RN #2 said he should have obtained a new face mask or washed his hands. d. On 7/22/20 at 1:47 PM, Resident #2's room had a red sign posted on the door. The sign indicated Resident #2 was on enhanced droplet precautions, and a gown, respirator face mask, eye protection, and gloves were required. RN #2 performed hand hygiene and entered the room. RN #2 was wearing a face shield and respirator face mask, and he did not put on a gown or gloves. RN #2 spoke to Resident #2 for approximately 2 minutes, exited the room, and performed hand hygiene. RN #2 said he should have put on a gown and gloves before he entered Resident #2's room. On 7/22/20 at 3:35 PM, the Interim DON said when staff put on an isolation gown it should be tied, and when putting on a face mask it should be secured over the mouth and nose with the straps in place. The Interim DON said it was not appropriate for a face mask to be worn with the lower strap over the front the face, staff should avoid touching the front of the face mask, and if they touched the front of the face mask they should clean their hands. The Interim DON said staff should put on a gown and gloves in addition to their face mask and face shield prior to entering an isolation room. 2. a. On 7/22/20 at 10:09 AM, a red sign was posted on the room doors of Resident #1, Resident #2, and Resident #3. The sign indicated each resident was on enhanced droplet precautions, and it directed staff to keep the door closed. At that time, the doors were fully open or mostly open for each of the mentioned residents. The doors were observed in the same position on 7/22/20 at 10:54 AM, 11:15 AM, and 12:59 PM. b. On 7/22/20 at 12:54 PM, Resident #4's door was wide open while working with the Physical Therapist in the room. On 7/22/20 at 1:06 PM, the door to Room A15 was open 12 inches. The Physical Therapist said the residents' doors were supposed to be closed. She said she was in Room A15 with Resident #4 and she did not close the door.

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.