STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505389	A. BUILDING _____ B. WING _____	**06/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVAMERE REHABILITATION OF CASCADE PARK	**801 SOUTHEAST PARK CREST AVENUE VANCOUVER, WA 98683**

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 -** Few	**Provide and implement an infection prevention and control program.** Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment to prevent the development and transmission of communicable diseases and infections when the facility failed to disinfect resuable pulse oximeter (medical device used to measure pulse rate and oxygen saturation level) and blood pressure (BP) cuff after use on 3 of 3 unsampled residents (R) (R6, R7, R8) for 1 of 1 vital sign monitoring observation. This failure increased the risk for the spread of infection and its associated complications. Findings include: During Entrance interview on 6/2/20 at 9:30 AM Administrator, Director of Nursing (DON) and Infection Preventionist (IP) stated that facility census was 78 and the facility had no current COVID-19 positive residents or staff. Hall 300 was their designated COVID-19 if there were residents who were new admissions and needed to be quarantined for 14 days with transmission based precautions or if any resident was known or suspected of COVID-19. Observation on 6/2/20 at 2:15 PM showed Certified Nursing Assistant (CNA)1 in R6's room with vital sign equipment on cart next to resident's bed. BP cuff was on resident's arm and pulse oximeter was placed and enveloped resident's finger. CNA1 obtained measurements, wrote down information, and removed BP cuff and pulse oximeter and washed hands in resident's room. Without cleaning or disinfecting BP cuff and pulse oximeter, CNA1 walked across the hall and entered R7's and R8's room with same vital sign cart. There was only one BP cuff on vital sign cart. Also on the vital sign cart was a container labeled Microkill Bleach germicidal bleach wipes. CNA1 placed the BP cuff on R7's arm and pulse oximeter on R7's finger, obtained measurements and then walked over to R8's side of the room. Without cleaning or disinfecting BP cuff and pulse oximeter, CNA1 placed BP cuff on R8's arm and pulse oximeter on R8's finger. CNA1 took measurements and then left the room and walked down the hall. During a concurrent observation and interview on 6/2/20 at 2:30 PM CNA1 returned outside of R8's room and was observed wiping down BP cuff with wipes. CNA1 stated that he just used the bleach wipes (pointed to container on the vital signs cart) to wipe down cart stand, BP cuff and pulse oximeter. When asked when BP cuff and pulse oximeter are wiped down with disinfecting wipes, CNA1 stated that he wipes it down after he completes taking a bunch of resident's vital signs. CNA1 further stated that he had about 4 to 5 residents vital signs to take, so he felt it was a good time to wipe down the BP cuff and pulse oximeter, that he had wiped down the equipment before use of R6 and now that he used equipment on all his residents, he was wiping equipment again. When asked about wiping down equipment between resident use, such as after R6 and before R7 and after R7 and before R8, CNA1 stated that he should have done that, but didn't. During an interview on 6/2/20 at 2:45 PM DON stated that staff are supposed to clean BP cuff and pulse oximeter after use on one resident and before use on another resident. During Exit Conference on 6/2/20 at 3:00 PM DON, IP, Administrator, and Corporate Nurse confirmed BP cuff and pulse oximeter are reusable medical equipment that should be cleaned between resident use. Record review of Medication Administration Record [REDACTED]. R6, R7, and R8 resided on Hall 300, which was the facility's designated COVID-19 unit, for known or suspected COVID-19 residents or new admissions who required transmission based precautions during the first 14 days of admission or before confirmed COVID-19 negative test results were available. Facility policy, Cleaning and Disinfection of Resident-Care Items and Equipment, dated October 2009, showed non-critical items are those that come in contact with intact skin but not mucous membranes. Non-critical resident-care items include blood pressure cuffs. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes). Centers for Disease Control and Prevention Guideline for Disinfection and Sterilization in Healthcare Facilities, https://www.cdc.gov/infectioncontrol/guidelines/disinfection/index.html, accessed 6/2/20 showed perform low-level disinfection for noncritical patient-care surfaces (e.g., bedrails, over-the-bed table) and equipment (e.g., blood pressure cuff) that touch intact skin. Disinfect noncritical medical devices (e.g., blood pressure cuff) with an EPA-registered hospital disinfectant using the label's safety precautions and use directions. Ensure that, at a minimum, noncritical patient-care devices are disinfected when visibly soiled and on a regular basis (such as after use on each patient or once daily or once weekly).

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