STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135144	A. BUILDING _____ B. WING _____	10/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASCADIA OF NAMPA	900 N HAPPY VALLEY RD NAMPA, ID 83687

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 0684 **Level of harm** - Minimal harm or potential for actual harm **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, record review and staff interview, it was determined the facility failed to ensure professional standard of nursing practice was followed for medication administration. This was true for 1 of 1 (#7) resident observed for medication administration. This failed practice created the potential for harm should resident experience complication from medications such as dry mouth or throat irritation. Findings include: Resident #7 was admitted to the facility on [DATE], with multiple [DIAGNOSES REDACTED]. Resident #7's October 2020 physician's orders [REDACTED]. The order included instruction for Resident #7 to rinse her mouth with water after administration of the medication. On 10/27/20 at 12:40 PM, RN #1 was observed when she administered Resident #7's inhaled medication Atrovent. Resident #7 was observed to take one puff of the Atrovent Aerosol Solution orally, and then gave the inhaler back to RN #1. Resident #7 did not rinse her mouth after inhaling the Atrovent Aerosol Solution. On 10/27/20 at 12:42 PM, surveyor asked RN #1 what kind of inhaler Resident #7 did received. RN #1 reviewed Resident #7 physician's orders [REDACTED]. RN #1 said Resident #7 should have taken two puffs of the medication. RN #1 then went back to Resident #7's room and asked her to take another puff of the Atrovent Aerosol Solution. Resident #7 did not rinse her mouth after inhaling the Atrovent Aerosol Solution. On 10/27/20 at 2:30 PM, RN #1 reviewed Resident #7's physician's orders [REDACTED].#7 to rinse her mouth after administering the Atrovent Aerosol Solution. RN #1 said she should have told Resident #7 to rinse her mouth with water.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, and staff interview, it was determined the facility failed to ensure infection control prevention practices were implemented and maintained 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 Blood Glucose Monitoring policy and procedure, dated 12/20/17, directed staff to do the following: * Place cleaned glucometer on a barrier. *Assemble blood glucose test strip, alcohol wipe, lancet, gauze pad, and clean barrier. Approach resident and place items on over bed table with clean barrier protection. This policy was not followed: On 10/27/20 at 11:45 AM, RN #2 placed the glucometer with test strip inserted on it on top of Resident #1's overbed table. There was no barrier between the glucometer and the overbed table. RN #2 with her gloved hand pricked Resident #1's right little finger after cleaning it with an alcohol swab and took the glucometer. RN #2 said the glucometer was not reading Resident #1's blood glucose. RN #2 then removed the test strip and put it back two times In the process of removing and inserting the test strip back into the glucometer, RN #2 touched the tip of the test strip. RN #2 then pressed Resident #1's little finger to get a drop of his blood into the test strip. RN #2 said the glucometer was not turning on and said she would get another glucometer. RN #2 came back with another glucometer, placed the glucometer on top of the overbed with no barrier between the glucometer and the overbed table. When RN #2 finished checking Resident #1's blood glucose, she removed her gloves, performed hand hygiene and exited Resident #1's room. On 10/27/20 at 1:35 PM, RN #2 said she placed the glucometer on top of Resident #1's overbed table with no barrier. RN #2 also said she removed and inserted the test strip twice and in the process touched the tip of the test strip. RN #2 said she should have put a barrier between the glucometer and Resident #1's overbed table and should not have touched the tip of the test strip. On 10/27/20 at 12:30 PM, RN #1 took a test strip and inserted it into the glucometer and placed the glucometer on top of the medication cart. There was no barrier between the glucometer and the medication cart. RN #1 then prepared a 2 x 2 gauze, lancet device, alcohol swab, picked up the glucometer on top of the medication cart and entered Resident #7's room. RN #1 also had an inhaler on her hand when she entered Resident #7's room. Inside Resident #7's room, RN #1 placed the glucometer on top of Resident #7's overbed table. RN #1 did not put a barrier between the glucometer and the overbed table. RN #1 then gave the inhaler to Resident #7 and asked her to take one puff orally. RN #1 then checked Resident #7's blood glucose, removed her gloves, performed hand hygiene and exited the room. On 10/27/20 at 2:30 PM, RN #1 said she carried the glucometer with the test strip, lancet device, alcohol swab, gauze and an inhaler in her hand when she entered Resident #7's room. RN #1 said she placed glucometer with the test strip, lancet device, alcohol swab and gauze on top of Resident #7's table because she wanted to administer the inhaler first to her before she checks her blood glucose. RN #1 said she did not put a barrier between the supply and the glucometer. RN #1 said she carried the supply on her hand because she did not have anything to put the supply on when she went to Resident #7's room. RN #1 said she did not know what kind of a barrier she could use to put the glucometer, lancet device, alcohol swab and gauze on. On 10/27/20 at 3:03 PM, the DNS said there should be a barrier when staff put the glucometer on any surfaces. The DNS said the barrier could be a paper towel or an empty cup. 2. The CDC website accessed on 10/29/20, Prevention to Prevent Transmission of Infectious Agents stated Airborne Precautions prevent transmission of infectious agents that remain infectious over long distances when suspended in the air (e.g., [MEDICAL CONDITION] ([DIAGNOSES REDACTED]), [MEDICATION NAME] virus (chickenpox), M. [MEDICAL CONDITION], and possibly [DIAGNOSES REDACTED]-CoV). In settings where Airborne Precautions cannot be implemented due to limited engineering resources (e.g., physician offices), masking the patient, placing the patient in a private room (e.g., office examination room) with the door closed, and providing N95 or higher level respirators or masks if respirators are not available for healthcare personnel will reduce the likelihood of airborne transmission until the patient is either transferred to a facility with an AIIR or returned to the home environment, as deemed medically appropriate. This guidance was not followed. Resident #2 was admitted to the facility on [DATE], with multiple [DIAGNOSES REDACTED]. Resident #2's care plan, initiated on 6/18/20, documented his dining needs met through in room by staff as he requires assistance and/or was a swallowing/choking risk. On 10/27/20 at 11:59, CNA #3 was at the door of Resident #2's room wearing a gown, gloves, N95 and a face shield. CNA #3 said she was waiting for Resident #2's lunch tray to be delivered to his room. Resident #2's room had a sign posted on the door. The sign indicated Resident #2 was on Enhanced Droplet Precaution. CNA #3 said Resident #2 was under observation because his roommate tested positive for COVID-19 and was transferred to the facility's Covid unit. A staff then handed a food tray to CNA #3 and CNA #3 went inside Resident #2's room. After a few minutes, CNA #3 removed his gown and gloves, performed hand hygiene and exited Resident #2's room. CNA #3 left Resident #2's room opened. On 10/27/20 at 12:12 PM, the Activity Director (AD) walked by Resident #2's room with his door opened. On 10/27/20 at 12:45 PM, Resident #2's room was observed to be opened. On 10/27/20 at 1:10 PM, Dietary Aide #1 walked by Resident #2's room with his door opened. On 10/27/20 at 1:14 PM, CNA #3 exited Resident #2's room and left his door opened. CNA #3 said she collected Resident #2's food tray. On 10/27/20 at 2:00 PM, the Infection Preventionist (IP) said residents' door on Enhanced Droplet of Precaution should be kept close for protection of the staff and other residents. The IP and the surveyor went to Resident #2's room and saw his door opened. The IP said Resident #2's door should be kept opened because he was on a

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) thickened liquid diet and needed to be monitored while eating. On 10/27/20 at 2:20 PM, CNA #3 said Resident #2 used to eat in the dining room, but when he was placed on precaution he started eating in his room. CNA #3 said Resident #2's door should be kept close because he was on precaution, but she left it opened because Resident #2 was on a thickened liquid diet and needed to be monitored while eating. CNA #3 said she assisted another resident in the dining room and was not able to check on Resident #2 while he was eating. CNA #3 said she did not inform the nurse or other CNAs that she delivered Resident #2's food tray. On 10/27/20 at 3:03 PM, the DNS together with the IP said Resident #2 able to feed himself and only needed supervision while eating. The DNS said Resident #2's door was open, so staff could visualize him from his door while he was eating. The DNS was informed that staff passing by Resident #2's room could not see him in his room which the IP agreed. When asked if Resident #2's door should be kept opened, the DNS said she would look for their policy. On 10/28/20 at 9:30 AM, the Administrator said the Speech Therapist clarified that Resident #2 could eat his meal in his room without supervision. 3. The facility's Screening and Management of Coronavirus COVID-19, revised 7/21/20, directed staff to assist residents to wash their hands when potentially soiled, before eating, after toileting, after coughing/sneezing, when leaving their rooms, and as indicated. This policy was not followed. a. On 10/27/20 from 12:05 PM to 5:35 PM, food trays were being served to residents. The following was observed in the Cascade unit: -At 12:05 PM, CNA #3 and CNA #5, delivered and set up Resident #3 and Resident #4's food trays on their overbed table in their room. CNA #3 and CNA #5 did not offer hand hygiene to Resident #3 and Resident #4 before eating their meal. -At 12:08 PM, the AD delivered and set up Resident #5's food tray on his overbed in his room. The AD did not offer hand hygiene to Resident #5 before eating his meal. -At 12:21 PM, the AD delivered and set up Resident #6 food tray on her overbed table in her room. The AD did not offer hand hygiene to Resident #6 before eating her meal. On 10/27/20 at 1:08 PM, the AD said she did not offer hand hygiene to the residents when she delivered their meal trays. The AD said she should have offered hand hygiene to the residents before eating their meals. On 10/27/20 at 1:14 PM, CNA #3 said did not offer hand hygiene to Resident #4 when she delivered her food tray. On 10/27/20 at 1:25 PM, CNA #5 said she did not offer hand hygiene to residents when she delivered their food trays. b. The following was observed in the Alpine unit (Covid unit): -At 5:20 PM, CNA #4 delivered and set up Resident #8's food tray on his overbed table in his room. CNA #4 did not offer hand hygiene to Resident #8 before eating his meal. -At 5:24 PM, CNA #7 delivered and set up Resident #9's food tray on her overbed table in her room. CNA #7 said he did not offer hand hygiene to Resident #9 before eating her meal. -At 5:25 PM, CNA #4 delivered and set up Resident #10's food tray on her table in her room. CNA #4 did not offer hand hygiene to Resident #10 before eating her meal. -At 5:26 PM, CNA #4 delivered and set up Resident #11's food tray on her overbed table in her room. CNA #4 did not offer hand hygiene to Resident #11 before eating her meal. On 10/27/20 at 5:28 PM, CNA #4 said she did not offer hand hygiene to the residents when she delivered their food trays. On 10/27/20 at 3:03 PM, the IP said he expected the staff to offer residents hand hygiene before every meal. -At 5:16 PM, CNA #2 was observed delivering a meal tray to Resident #13 in room A12 and placing it on a bedside table, assisting Resident #13 with a transfer from bed to wheelchair, then placing the table in front of Resident #13. An offer or reminder to the resident to use hand hygiene before eating was not heard. The CNA said she had not offered the resident hand hygiene and said, I was preoccupied. On 10/27/20 at 3:10, the IP said a resident was to be offered hand hygiene before meals. The IP said if a resident was independent the staff should remind them to use hand hygiene or ask the resident if they wanted to wash their hands prior to eating a meal. 4. The facility's policy for Transmission - Based Precautions, Conventional Plan, dated 9/10/20, documented under Standard Precautions, informed staff a gown and gloves were required upon entry into a resident room to complete care. And, documented under Enhanced Droplet Precautions, staff were to include the use of an N95 respirator or follow indications of specific zones and other droplet precaution directives. The Facility's COVID-19 Exposure - Asymptomatic, Enhanced Droplet Precautions sign on or near a door of a resident under observation, informed staff full Personal Protective Equipment (PPE) was required for entry into the room as the potential for aerosolization of respiratory infection was present. The sign informed staff the required PPE were a gown, N95 respirator, eye protection (goggles or face shield), and gloves. The sign noted that these expanded precautions were to be used along with standard precautions. On 10/27/20 at 11:15 AM, the DNS said Area A was the COVID-19 unit, and Area B was the non-COVID-19 unit with some residents under observation with enhanced droplet precautions. On 10/27/20 at 12:28 PM, CNA #1 was observed entering Resident #1's room B19, in Area B, with a lunch tray without wearing gloves or a gown. Resident #1 was under observation for COVID-19. The door to room B19 had a COVID-19 Exposure - Asymptomatic, Enhanced Droplet Precautions sign beside the door. CNA #1 said the COVID-19 positive resident had been moved from room B19 to a room in area A and the Enhanced Precautions sign was no longer needed. CNA #1 said he entered the room with a face shield and N95 respirator and had not donned a gown and gloves as the sign directed. On 10/27/20 at 3:00 PM, the IP said the expectation was for staff to follow the guidance on the enhanced precaution signage for those residents on isolation, and to wear a KN95 or N95 respirator, face shield, gown, and gloves. The IP said they were to don the gown and gloves before entering the room and to remove them before exiting the room. 5. The facility's policy on Transmission-Based Precautions, Conventional Plan, dated 9/10/20, documented hand hygiene was indicated utilizing Alcohol Based Hand Rub (ABHR) and/or hand washing with soap and water before and after wearing gloves. The facility's policy on Hand Hygiene, dated 9/10/20, documented the opportunities for hand hygiene included after removing gloves. On 10/27/20 at 12:55 PM, RN #1 was observed removing gloves after disinfecting a glucometer, then donning a new pair of gloves. RN#1 said he/she did not use hand hygiene between doffing and donning the pairs of gloves. On 10/27/20 at 3:05 PM, the IP said staff were to use hand hygiene before donning and after doffing gloves, and between wearing pairs of gloves. 6. The CDC guidance for Preparing for COVID-19 in Nursing Homes, updated June 25, 2020 and accessed 10/29/20, stated facilities were to provide supplies necessary to adhere to recommended infection prevention and control practices. And, for environmental cleaning and disinfecting, the facility was to ensure EPA-registered, hospital grade disinfectants were available to allow for frequent cleaning of high-touch surfaces and to use an Environmental Protection Agency (EPA)-registered disinfectant from List N on the EPA website to disinfect surfaces that might be contaminated with [DIAGNOSES REDACTED]-CoV-2. The United States EPA, List N Tool: COVID-19 Disinfectants website, accessed 10/28/20, stated all products on the list met the EPA's criteria for use against [DIAGNOSES REDACTED]-CoV-2, [MEDICAL CONDITION] that caused COVID-19. Betco, pH7 Ultra Neutral Cleaner was not found on this list. On 10/27/20 at 1:41 PM, the Housekeeper #1 was observed cleaning room B17, in Area B, with residents under observation inside. She said they cleaned the resident room floors with pH7 Ultra Neutral Cleaner, produced by Betco, daily. She said she asked her supervisor and reports the supervisor said the product does not kill Coronavirus. On 10/27/20 at 3:10 PM, the IP said the expectation was the cleaning products used would kill [DIAGNOSES REDACTED]-CoV-2 and/or was EPA approved. On 10/28/20 at 12:08 PM, the Administrator said, via a phone interview, the facility housekeeper cleaned the non-COVID-19 unit room floors with a bleach solution during a deep clean at the time of a room change, when one resident moved out and another moved in. On 10/28/20 at 1:20 PM, via phone interview, the Housekeeping Manager and Administrator said the Betco, pH7 Ultra Neutral Cleaner was used to clean the floors in the non-COVID unit daily. On 10/28/20 at 1:48 PM, the Administrator said they did not have a manufacturer's product information sheet did not state the Betco, pH7 Ultra Neutral Cleaner killed the [DIAGNOSES REDACTED]-CoV-2 virus. 7. The facility's policy for Laundry, dated 9/10/20, instructed staff to deliver the laundry to the appropriate area in a covered or closed container. Clean laundry and linens were to be kept covered in a bin or rack until ready to use. On 10/27/20 at 4:40 PM, clothes were observed hanging on a mobile rack near room A26 in Area A, the COVID-19 unit, by the double doors closest to the laundry room. The clothes were partially covered by a white linen sheet laid over the top of the clothes leaving to of the length of the clothes exposed below the sheet edge. On 10/27/20 at 4:49 PM, CNA #4 said clean laundry was brought in on a cart and distributed by the CNAs on the unit. On 10/27/20 at 5:00 PM, the IP said the clothes should have been fully covered when delivered to Area A. The IP observed the laundry cart and said the laundry was not covered, and he did not know why it was not covered. The IP said the CNAs were expected to deliver the clothes to the resident's rooms. On 10/27/20 at 5:07 PM, CNA #4 said she started work at 4:00 PM and saw the clothes rack there and thought the housekeeper delivered the clothes.