STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385180	A. BUILDING _____ B. WING _____	**04/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MARQUIS NEWBERG	**441 WERTH BLVD NEWBERG, OR 97132**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide a sanitary environment to prevent infections when staff did not implement measures to help prevent the development of urinary tract infections for 1 of 1 resident (R) (R1) observed for indwelling catheter and did not clean and disinfect, per manufacturer's instructions, to ensure the decontamination of durable medical equipment used in the care of 2 of 2 residents (R3 and R4) observed for use of the equipment. These failures increased the risk for infection and its associated discomfort and complications. Findings include: *Indwelling catheter care Record review of the facility's policy titled, Catheter Care, Urinary-Level III, dated 3/2018, showed the purpose of the procedure is to prevent infection of the resident's urinary tract and included be sure the catheter tubing is kept off the floor. Review of R1's record showed the facility admitted the resident on 4/22/20 with [DIAGNOSES REDACTED]. Review of R1's care plan showed problem for risk for history of UTI related to history of UTI, [MEDICATION NAME] (artificial opening in the abdominal area to drain urine), date initiated was 4/27/19, with interventions of foley (flexible tube in the bladder that drains urine) catheter care per MD order. Observation on 4/29/20 at 10:00 AM showed R1 sat in his wheelchair in the 400 hall bistro. A urinary catheter bag and tubing hung from the Resident's wheelchair underneath the seat. About 3 inches of the tubing rested on the carpeted floor. Licensed Nurse (LN) 1 wheeled resident to his room about 50 feet down the hall and administered medications. When done, LN1 wheeled resident back to 400 hall bistro with catheter tubing dragging on the carpet. During interview on 4/29/20 at about 10:10 AM LN1 stated that R1's catheter tubing was touching the carpet and it shouldn't be because it was an infection control issue. LN1 stated that was a good catch. LN1 adjusted the tubing so it wasn't touching the carpet. When R1 asked what LN1 was doing, LN1 stated that she was lifting up tubing because it was dragging on the floor. *Durable medical equipment Record review of the facility's policy titled, Cleaning and Disinfection of Resident-Care Items and Equipment, dated 8/2018, showed reusable items are cleaned and disinfected between residents (e.g., durable medical equipment). Durable medical equipment (DME) must be cleaned and disinfected before reuse by another resident. Reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturer's instructions. Sani-Cloth Bleach Germicidal Disposable Wipe container label showed To clean, disinfect and deodorize: use a wipe to remove heavy soil. Unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full four (4) minutes. Use additional wipe(s) if needed to assure continuous 4 minute wet contact time. During concurrent observation and interview on 4/29/20 at 9:50 AM showed Physical Therapist (PT)1 wiping down Sara Stedy sit to stand manual lift durable medical equipment device (device that allows residents to pull themselves up into a standing position) outside of room [ROOM NUMBER]A (R4). PT1 used several cloth wipes on multiple surfaces of stedy device. When asked what was used to wipe down stedy, PT1 showed surveyor Sani-cloth germicidal disposable wipe container (orange top). During interview on 4/29/20 at 9:52 AM Certified Nursing Assistant (CNA)1 was asked to touched stedy that was just wiped down by PT1. CNA1 stated that the stedy was not too wet now and when asked how long the stedy should stay wet, CNA1 stated, 2 minutes. Observation on 4/29/20 at 10:20 AM showed CNA2 moved stedy from nursing station across bistro to room [ROOM NUMBER](R3). After about 10 minutes, CNA2 removed stedy from room [ROOM NUMBER] and wiped it down with Sani-cloth Bleach wipes. During interview on 4/29/20 at 1035 AM CNA1 and CNA2, when asked what the contact time was for Sani-cloth bleach wipes, CNA2 stated that the stedy is not used on residents right after each other, it sits in the hallway between uses. When asked how long the stedy needed to stay wet from the sani-cloth bleach wipes, CNA2 stated 2 minutes. CNA1 and CNA2 looked at the Sani-cloth bleach wipe container and stated that the label says 4 minutes contact time and they didn't know this. During interview on 4/29/20 at 11:20 AM when asked what the Sani-cloth bleach wipe contact time was, PT1 stated that when she cleaned/disinfected stedy she tried to make sure she wiped down all the areas that the resident touched and had contact with. When asked how long the stedy needed to stay wet from the sani-cloth bleach wipes to ensure the stedy was cleaned and disinfected, PT1 stated, I don't know how long it needs to stay wet, but I can check the container and find out. When asked when she wiped down stedy after use with resident in room [ROOM NUMBER]A how long was stedy kept wet with sani cloths, PT1 stated 15 to 30 seconds. PT1 looked at the sani-cloth bleach wipe container and stated that the label says 4 minutes contact time and said, That's a long time. During interview on 4/29/20 at 5:15 PM with Administrator, Director of Nursing/Infection Preventionist (DON/IP) and Corporate Nurse, the above findings were shared. DON/IP stated that R1's urinary catheter tubing should not be touching the carpet and nodded head that R1 has a history of UTIs. No further information was provided for lack of staff knowledge with disinfecting wipes contact time.

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