STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385044	A. BUILDING _____ B. WING _____	10/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRESTIGE CARE AND REHABILITATION - MENLO PARK	745 NE 122ND AVENUE PORTLAND, OR 97230

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** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined the facility failed to implement appropriate infection control practices including social distancing, entrance screening, disinfection of personal protective equipment (PPE), shared equipment and environmental surfaces for 3 of 3 units observed and direction for face mask use and hand hygiene for 7 of 10 residents observed (#1 and 6 random residents) for infection control. This placed resident(s) at increased risk for COVID-19 infection. Findings include: 1. On 9/29/20 at 2:02 PM, staff were observed during shift change from day to evening. Staff entered and exited the facility from two primary locations, the front door and a side entrance at the end of the front hall near the time clock. Although environmental cues including six-foot markings on the floor and signs cueing staff and residents to socially distance were posted; staff stood side-by-side and in small groups waiting to clock in and out. Staff were observed to socialize while they waited their turn at the time clock in a small hallway within close proximity (one-to-two feet) of each other. Staff then walked to the front desk where COVID-19 screening occurred. Staff 18 (Receptionist/Screener) stood behind a desk verbally cueing six staff to socially distance. Staff ignored both the verbal and environmental cues, standing shoulder-to-shoulder and reaching over each other to collect items needed to begin their shift. One staff was observed to enter the facility using the front door without a face mask in place and talk with Staff 18 at the front desk prior to donning a face mask. Surveyor attempts to interview the staff being screened were ignored/avoided. When interviewed on 9/29/20 at 2:10 PM, Staff 18 stated this was not the normal process, but was caused by the shift change activity. Staff 18 identified another staff usually helped, but it was difficult to complete the screening task when alone at the desk. The shift change observations were shared with Staff 17 (RCM) on 9/29/20 at 3:20 PM. Staff 17 stated staff were provided information about the importance of socially distancing, but more education needed to be completed. On 9/30/20 at 1:52 PM, Staff 19 (Kitchen Staff) stood in close proximity (one-to-two feet) with two staff at the time clock while conversing. Staff 19 stated she knew the rule was six feet distance between staff, but sometimes forgot. Although Staff 19 was wearing a face mask and face shield, the face mask was observed positioned below her nose. 2. On 10/1/20 at 2:10 PM Staff 18 (Receptionist/Screener) greeted surveyors at the front nurses' station. Staff 18 checked the surveyors' temperatures and asked if they had any signs or symptoms of COVID-19. No further screening questions were asked before surveyors were permitted to leave the screening area. On 10/2/20 at 5:45 AM Staff 21 (LPN) checked the surveyors' temperatures, but no screening questions were asked. On 10/5/20 at 12:32 PM Staff 2 (DNS/Infection Control Specialist) confirmed staff and visitors should be screened before entering the facility with temperatures checked, all questions asked and documentation completed. 3. Resident 1 was admitted to the facility in 2020 with [DIAGNOSES REDACTED]. On 10/1/20 at 2:57 PM four unidentified residents walked by the front nurses' station desk towards the back hall wearing their face masks below their noses or on top of their heads. Staff at the front desk did not direct residents to properly wear their face masks. On 10/1/20 at 3:14 PM Resident 1 entered the facility with no face mask in place. Resident 1 wheeled herself/himself through the hall to her/his room when Staff 13 (LPN) spoke to Resident 1 but did not educate or direct Resident 1 to wear a face mask. On 10/1/20 at 3:57 PM and 4:08 PM two unidentified residents were observed in the facility without face masks. Staff did not direct the residents to wear a face mask in the facility. On 10/2/20 at 8:30 AM Staff 17 (RCM) indicated residents were directed to wear face masks in the facility and perform hand hygiene when residents returned to the facility. On 10/5/20 at 10:45 AM an unidentified resident entered the facility, did not perform hand hygiene at the entrance and wheeled himself/herself by the front desk to the back hall while staff was present. In an interview on 10/5/20 at 12:32 PM Staff 1 (Administrator) and Staff 2 (DNS/Infection Control Specialist) confirmed staff needed additional education to more frequently direct residents to wear their face masks and perform hand hygiene. 4. On 10/1/20 at 3:50 PM Staff 6 (CNA) wiped down a vital machine with Sani-Wipes but did not complete the two minute wet contact time according to manufacturer's instructions before giving the machine to another staff member. On 10/1/20 at 5:00 PM Staff 6 exited room [ROOM NUMBER] which required full PPE (personal protective equipment) due to droplet precautions and wore a face shield and mask. Staff 6 did not disinfection her face shield before entering room [ROOM NUMBER] which did not require any PPE. On 10/1/20 at 5:13 PM Staff 6 stated she only cleaned her face shield if it was visibly soiled between resident rooms. On 10/2/20 at 6:36 AM Staff 8 (CNA) exited room [ROOM NUMBER] which required full PPE due to droplet precautions and wiped her face shield with Sani-Wipes. At 6:37 AM the face shield of Staff 8 was observed dry due to product evaporation and placed back on her face. Staff 8 also wiped the vital machine with Sani-Wipes but did not complete the two minute wet contact time according to manufacturer's instructions before using the blood pressure cuff on another resident. When asked about the required contact time for Sani-Wipes, Staff 8 indicated one to two minutes needed to pass but the surface did not need to remain wet in order to disinfect the vital machine. On 10/2/20 at 7:59 AM Staff 10 (CNA) delivered a meal tray to room [ROOM NUMBER] which required full PPE due to droplet precautions and did not disinfect her face shield before she assisted with a meal tray delivered to another room that did not require PPE. On 10/2/20 at 12:54 PM Staff 2 (DNS/Infection Control Specialist) confirmed staff should disinfect their face shields after exiting a room that required full PPE and follow the contact time to disinfect face shields and equipment. 5. Centers for Disease Control Interim Infection Prevention and Control Recommendations for Healthcare Personnel During Coronavirus Disease 2019 (COVID-19) Pandemic revised 7/15/20 instructed facilities to ensure environmental cleaning and disinfection procedures were followed consistently and correctly. The disinfecting solution (hdqC2) used within the facility had online manufacturer's instructions which stated apply solution . so as to wet all surfaces thoroughly. Allow to remain wet for ten minutes, then remove excess liquid. On 10/1/20 at 3:45 PM, Staff 5 (Housekeeper) sprayed a cloth with hdqC2 and immediately wiped down handrails in the halls of the facility. The handrails did not remain wet for the required ten minutes according to manufacturer's instructions. On 10/2/20 at 10:15 AM, Staff 4 (Housekeeper) sprayed hdqC2 onto hallway handrails and doorknobs and immediately wiped the solution off the surfaces. The spray bottle did not provide the contact time required to be effective. Upon request, Staff 4 was unable to locate information regarding the contact time needed in order to disinfect a surface using hdpC2. Staff 4 also stated no training on the use of hdqC2 was provided. On 10/2/20 at 10:27 AM, Staff 3 (Housekeeping Manager) was interviewed about disinfection of high touch surfaces. Staff 3 responded that housekeepers should spray the chemicals onto the surfaces and leave it on for five to ten minutes and then wipe it down. On 10/5/20 at 10:47 AM, Staff 5 was interviewed on their second day on the job. Staff 5 stated she had received no training on how to properly use hdqC2 to sanitize surfaces. On 10/5/20 10:48 AM, Staff 5 was observed spraying hdqC2 onto handrails and doorknobs in hallways and inside residents' rooms and immediately wiped surfaces dry. On 10/5/20 at 11:09 AM, Staff 3 stated Staff 5 had received basic training which included the order and process for cleaning areas of the facility, but had not received training on the use of hdqC2 to disinfect surfaces. On 10/5/20 at 12:35, Staff 1 (Administrator) and Staff 2 (DNS/Infection Control Preventionist) stated an understanding of the need for a ten minute

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 -** Many	(continued... from page 1) contact time with hdqC2 in order to disinfect surfaces. Staff 1 confirmed all housekeeping staff should know how to properly use disinfecting products when sanitizing high touch surfaces in the facility.