STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135095	A. BUILDING _____ B. WING _____	**09/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHERRY RIDGE OF CASCADIA	**501 WEST IDAHO BOULEVARD EMMETT, ID 83617**

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 residents received hand hygiene prior to eating their meals. This was true for 4 of 4 residents (#1, #2, #3, and #4) reviewed for hand hygiene. This failure created the potential for negative outcomes by exposing residents to the risk of infection and cross-contamination including COVID-19. Findings include: The facility's Hand Hygiene policy for residents, revised 7/21/20, directed staff to assist residents to wash their hands prior to entering the dining room. The policy stated Alcohol Based Hand Rub may be used as directed. This policy was not followed. On 9/23/20, from 12:00 PM to 12:25 PM, lunch trays were served to residents. The following was observed: - At 12:00 PM, the ICP delivered and set-up Resident #1's meal on her tray table in her room. The ICP did not offer hand hygiene to Resident #1 prior to eating her lunch. - At 12:10 PM, the ICP delivered and set-up Resident #3's meal on her tray table in her room. The ICP did not offer hand hygiene to Resident #3 prior to eating her lunch. - At 12:25 PM, the ICP delivered and set-up Resident #4's meal on her tray table in her room. The ICP did not offer hand hygiene to Resident #4 prior to eating her lunch. On 9/23/20 at 12:37 PM, CNA #1 said she usually offered residents hand hygiene before and after their meals, but she forgot to offer hand hygiene to Resident #2 when she delivered his meal tray. On 9/23/20 at 12:35 PM, the ICP said she usually offered residents hand hygiene before their meals, but said she forgot to offer hand hygiene to the residents when she delivered their meal trays. The ICP said she expected staff to offer residents hand hygiene before their meals.
F 0882 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	Based on record review and staff interview, it was determined the facility failed to ensure an ICP with specialized training in infection control and prevention was appointed to the facility. This failure had the potential to negatively impact all 6 residents who resided in the facility and all of the staff. This deficient practice created the potential for staff to not receive appropriate infection control prevention training and provide resident care inconsistent with current standards of practice for infection prevention and control. Findings include: The facility's Infection Prevention and Control Program policy, revised 11/28/19, documented the facility was to employ a clinical professional with specialized training in infection control and prevention. This policy was not followed. On 9/23/20 at 10:30 AM, the facility provided documentation the ICP completed 3 of 23 course modules for the Nursing Home Infection Preventionist training offered by the CDC. The facility also provided the following documents that were not from a nationally recognized source: * A transcript from Genesis Healthcare Inc. for Specialized Training in Infection Prevention and Control. * A certificate of completion for a 4-hour workshop on infection control taken in 2011 from Stanbridge College in Irvine, California. On 9/23/20 at 10:55 AM, the ICP said she had not completed the CDC infection control training. She said she completed an infection control course in 2011 and March of 2020 provided by a previous employer and said she thought those were acceptable. On 9/23/20 at 1:05 PM, the Clinical Resource Nurse said she thought the courses the ICP had taken previously satisfied the requirements in the regulation.

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.