STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385145	A. BUILDING _____ B. WING _____	10/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROBISON JEWISH HEALTH CENTER	6125 SW BOUNDARY STREET PORTLAND, OR 97221

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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, record review, it was determined the facility failed to perform proper HH (hand hygiene) appropriately for 7 of 17 staff (#s 4, 5, 6, 8, 13, 15, and 17) reviewed, failed to socially distance for 2 of 17 staff (#s 16 and 17) reviewed, failed to ensure best practices for appropriate storage of PPE (Personal Protective Equipment) including KN/N95 respirators 2 of 7 units (Stern and 800 Hall) and 1 of 1 PPE storage room (# 119) reviewed, face shields 1 of 1 PPE storage room (# 119) reviewed. The facility failed to ensure appropriate use of gowns for 2 of 2 quarantine units (Stern and 800 Hall) reviewed. This placed residents at risk for cross contamination and possible exposure to infectious agents. Findings include: 1. The 7/15/20 CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic guidance revealed healthcare professionals (HCP) should perform hand hygiene (HH) before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process. The facility's 7/8/20 Acknowledgement: Required Protective Measures To Avoid The Spread of COVID-19 revealed staff agreed to wash their hands and/or use hand sanitizer regularly: - before and after starting work. - after touching common surfaces (such as door knobs, keypads, etc.). - in-between resident care, after going to the bathroom, after taking a break, before/after eating. - after coughing, sneezing, or touching their nose or mouth. On 10/15/20 at 10:00 AM, Staff 13 (LPN) touched her respirator and face shield, no HH was immediately performed. On 10/15/20 at 10:01 AM, Staff 4 (RN) touched her respirator without completing HH immediately. On 10/15/20 at 10:31 AM, Staff 15 (Med Aide) touched her respirator and face shield, no HH was immediately performed. On 10/15/20 at 10:46 AM and 10:53 AM, Staff 5 (RN) touched her respirator and adjusted her hair without completing HH. On 10/15/20 at 10:50 AM, Staff 17 (CNA) touched her respirator and face shield, no HH was immediately performed. On 10/15/20 at 11:15 AM, Staff 6 (RN) touched her respirator and face shield, no HH was immediately performed. On 10/15/20 at 12:07 PM, Staff 8 (CNA) entered and exited two resident rooms while passing meal trays without completing HH. On 10/15/20 at 1:15 PM, Staff 4 touched her respirator several times without completing HH immediately. In an interview on 10/15/20 at 10:00 AM, Staff 13 stated she was aware she should have performed HH after touching her respirator and face shield. In an interview on 10/15/20 at 10:31 AM, Staff 15 stated she agreed she should have performed HH after touching her respirator and face shield. In an interview on 10/15/20 at 10:50 AM, Staff 17 stated she was unaware she needed to perform HH after touching her respirator and face shield. In an interview on 10/15/20 at 10:53 AM, Staff 5 stated she was aware she had not completed HH but should have. In an interview on 10/15/20 at 11:15 AM, Staff 6 stated she was unaware she needed to perform HH after touching her respirator and face shield. In an interview on 10/15/20 at 12:13 PM, Staff 8 stated she should have completed HH after dropping off resident meal trays. In an interview on 10/15/20 at 1:15 PM, Staff 4 stated she should complete HH after touching her respirator. In an interview on 10/16/20 at 2:27 PM, Staff 1 (Administrator), Staff 2 (DNS) and Staff 3 (RN COVID-19 Consultant) stated they expected staff to complete HH after touching respirators, face shields. hair and between resident meal trays. 2. The 7/15/20 CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic guidance revealed for healthcare professionals (HCP) the potential for exposure to COVID-19 is not limited to direct patient care interactions. Transmission can also occur through unprotected exposures to asymptomatic or pre-symptomatic co-workers in breakrooms or co-workers or visitors in other common areas. Examples of how physical distancing can be implemented for HCP include: emphasizing the importance of source control and physical distancing in non-patient care areas, providing family meeting areas where all individuals (e.g., visitors, HCP) can remain at least 6 feet apart from each other, designating areas for HCP to take breaks, eat, and drink that allow them to remain at least six feet apart from each other, especially when they must be unmasked. The facility's 7/8/20 Acknowledgement: Required Protective Measures To Avoid The Spread of COVID-19 revealed staff agreed to maintain safe-distancing from colleagues while at work and from residents and clients except when providing care. Staff to understand that safe-distancing means maintaining at least a 6 foot distance from others around me. On 10/15/20 at 10:48 AM, Staff 16 (CNA) and Staff 17 (CNA) stood close in kitchen talking, not socially distanced. On 10/15/20 at 10:57, Staff 16 and Staff 17 stood close at computer station talking, not socially distanced. In an interview on 10/16/20 at 2:35 PM, Staff 1 (Administrator), Staff 2 (DNS), and Staff 3 (RN COVID-19 Consultant) stated they expected staff to socially distance at least 6 feet in common areas. 3. The 6/28/20 CDC Strategies for Optimizing the Supply of N95 Respirators, Limited re-use of N95 Respirators guidance revealed One effective strategy to mitigate the contact transfer of pathogens from the respirator to the wearer could be to issue each HCP who may be exposed to COVID-19 patients a minimum of five respirators. Each respirator will be used on a particular day and stored in a breathable paper bag until the next week. This will result in each worker requiring a minimum of five N95 respirators if they put on, take off, care for them, and store them properly each day. This amount of time in between uses should exceed the 72 hour expected survival time for [DIAGNOSES REDACTED]-CoV2 ([MEDICAL CONDITION] that caused COVID-19).3 HCP should still treat the respirator as though it is still contaminated and follow the precautions outlined in CDC's re-use recommendations. The facility's 7/8/20 Acknowledgement: Required Protective Measures To Avoid The Spread of COVID-19, Clean Masks revealed if staff mask becomes soiled, wet or is dropped, staff agree to replace it immediately. Paper masks are single day use only. KN95 and N95 masks can be stored according to procedures in the individual Tupperware container provided, and used no longer than seven (7) days. On 10/15/20 at 11:00 AM, room [ROOM NUMBER] a respirator was stored in labeled plastic container with lid. On 10/15/20 at 11:55 AM, a KN95 respirator was stored in an open container on the table in the lounge area. On 10/15/20 at 1:15 PM, in the nurse's room on the Stern unit two respirators were stored in a sealed, non-breathable plastic container. On 10/16/20 at 9:26 AM, in room [ROOM NUMBER] a N95 respirator was stored inside a sealed, non-breathable plastic container and sat on the interior of a face shield. There were no visible indicators on the respirator or container to determine how many times the respirator was used. On 10/16/20 at 10:10 AM, in room [ROOM NUMBER] on the 800 hall there were multiple N95 respirators stored in sealed, non-breathable plastic container. There were no visible indicators on the respirators or containers to determine how many times the respirators were used. In an interview on 10/15/20 at 10:31 AM, Staff 15 (Med Aide) stated she stored the N95 respirator in a rubber maid container with a lid in her car. In an interview on 10/15/20 at 10:38 AM, Staff 16 (CNA) stated she stored her N95 respirator in plastic container labeled with her name. In an interview on 10/15/20 at 10:50 AM, Staff 17 (CNA) stated she stored her N95 respirator in a container and could wear the respirator for seven days. In an interview on 10/15/20 at 11:15 AM, Staff 6 (RN) stated she stored her N95 respirator in a container or took it to her car and threw it away at home. She also stated we could wear these N95's for days. In an interview on 10/15/20 at 12:13 PM, Staff 8 (CNA) stated she reused N95 respirator seven days consecutively and stored it in the plastic bin after her shift. In an interview on 10/15/20 at 12:20 PM, Staff 9 (RN) stated she received one N95 for seven consecutive days, stored the respirator in a plastic bin for the seven days then discarded it. Staff 9 stated she put tally marks on the respirator to track the shifts. In an interview on 10/15/20 at 1:15

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) PM, Staff 4 (RN) showed this surveyor the nurse area where they stored respirators. Staff 4 stated staff reused their respirators for three to four shifts and discarded them. Staff 4 stated staff stored them in the plastic containers. In an interview on 10/16/20 at 10:10 AM, Staff 11 (LPN) stated she stored her N95 respirator in the sealed, plastic container. Staff 11 stated they could reuse the respirators for seven consecutive shifts. Staff 11 stated she tracked the seven days by placing a mark on the respirator each shift but was unaware of how other staff tracked their respirator use. In an interview on 10/16/20 at 10:25 AM, Staff 18 (Housekeeper) stated staff reused their N95 respirators two to three days consecutively. In an interview on 10/16/20 at 1:28 PM, Staff 2 (DNS) and Staff 3 (RN COVID-19 Consultant) stated the staff reuse their respirators for seven days and store them in a sealed plastic container. Staff 2 and Staff 3 stated they were responsible for implementing the most current CDC guidelines and were not aware of the updated CDC guidance related to N95 reuse. In an interview on 10/16/20 at 2:27 PM, Staff 1 (Administrator), Staff 2 and Staff 3 stated they should be following the most current CDC guidelines for respirator use and reuse. 4. The 9/15/20 CDC Emergency Considerations for Personal Protective Equipment and CDC 7/15/20 Strategies for Optimizing the Supply of Eye Protection guidance revealed, if a disposable face shield is reprocessed, it should be dedicated to one healthcare professional (HCP). After reprocessing, a face shield should be stored in a transparent plastic container and labeled with the HCP's name to prevent accidental sharing. On 10/15/20 at 11:00 AM, room [ROOM NUMBER] multiple unlabeled face shields were stored in large clear trash bags. On 10/16/20 at 9:26 AM, room [ROOM NUMBER] seven of approximately 16 face shields had no HCP names labeled on the shields. In an interview on 10/16/20 at 2:27 PM, Staff 1 (Administrator), Staff 2 (DNS) and Staff 3 (RN COVID-19 Consultant) stated they should be following the most current CDC guidelines and all face shields should be labeled and stored appropriately. 5. The facility's 7/8/20 Acknowledgement: Required Protective Measures To Avoid The Spread of COVID-19 Personal Protective Equipment (PPE) revealed staff agreed to wear PPE according to best practices, and not be wasteful. The 10/9/20 CDC Strategies for Optimizing the Supply of Isolation Gowns revealed gown reuse was not recommended for conventional (measures consisting of engineering, administrative, and personal protective equipment (PPE) controls that should already be implemented in general infection prevention and control plans) or contingency (measures that may be used temporarily during periods of expected isolation gown shortages. Contingency capacity strategies should only be implemented after considering and implementing conventional capacity strategies. While current supply may meet the facility's current or anticipated utilization rate, there may be uncertainty if future supply will be adequate and, therefore, contingency capacity strategies may be needed) strategies for PPE use. The reuse of gowns was only recommended during crisis strategy (strategies that are not commensurate with standard U.S. standards of care but may need to be considered during periods of known gown shortages. Crisis capacity strategies should only be implemented after considering and implementing conventional and contingency capacity strategies. Facilities can consider crisis capacity strategies when the supply is not able to meet the facility's current or anticipated utilization rate). The 10/9/20 CDC Strategies for Optimizing the Supply of Isolation Gowns, Crisis Capacity Strategies, Extended use of isolation gowns revealed Consideration can be made to extend the use of isolation gowns (disposable or reusable) such that the same gown is worn by the same HCP when interacting with more than one patient housed in the same location and known to be infected with the same infectious disease (i.e., COVID-19 patients residing in an isolation cohort). However, this can be considered only if there are no additional co-infectious [DIAGNOSES REDACTED]. If the gown becomes visibly soiled, it must be removed and discarded or changed as per usual practices. a. On 10/15/20 at 9:56 AM, the Stern unit had a sign posted at the entry door to wear full PPE (N95 respirator, eye protection, gown and gloves) while in resident rooms. On 10/15/20 at 9:56 AM and 10:06 AM, the Stern unit had two unlabeled hooks in rooms 201, 204, 205, 208 and 218 with one gown hanging on each hook. On 10/15/20 at 10:01 AM, Staff 4 (RN) wore a gown in the kitchen area of the Stern unit. Staff 4's gown was not tied around the waist and came into contact with multiple surfaces and was not changed. On 10/15/20 at 10:07 AM, Staff 5 (CNA) wore a gown in the hallway, donned a second gown over the top of the gown and went into a resident room to gather a used cup. Staff 5 doffed one gown, placed it back onto the hook in the resident's room and went to the kitchen area without doffing the other gown. On 10/15/20 at 1:08 PM, the staff on Stern unit were no longer wearing gowns in the common areas. On 10/16/20 at 10:29 AM, the Stern unit had two unlabeled hooks in rooms 201, 204, 205, 208 and 218 with one gown hanging on each hook. In an interview on 10/15/20 at 10:11 AM, Staff 5 stated the entire Stern unit was on a 14-day quarantine due to possible exposure to COVID-19. Staff 5 stated staff wore one gown all shift in the common areas, donned a second gown when entering resident rooms, doffed the second gown and placed it on the hook within the resident's room. Staff 5 stated they reused the gowns in the resident rooms all shift. Staff 5 stated the hooks and/or gowns were not labeled. Staff 5 stated they knew which gown was theirs because they discussed it. In an interview on 10/15/20 at 10:15 AM and 1:15 PM, Staff 4 stated all the residents on the Stern unit were exposed to COVID-19. Staff 4 stated staff used a gown in the common areas and donned a second gown when in resident rooms. Staff 4 stated they reused the gowns in resident rooms and at the end of each shift the gowns were placed in the dirty laundry. Staff 4 stated a medical professional told staff to stop wearing gowns in the common areas, only during resident care. In an interview on 10/16/20 at 12:42 PM, Staff 12 (CNA) stated approximately 12 days ago the facility quarantined the Stern unit for possible exposure to COVID-19. Staff 12 stated during the first days of the quarantine staff wore a gown all day long and donned a second gown when entering resident rooms, but administration told them to stop. Staff 12 stated there were a lot of discrepancies with gown use because at one point there were gown shortages, but it was no longer a problem. Staff 12 stated staff should doff their gown after each resident encounter. Staff 12 stated the hooks are not labeled but staff discussed which hooks to use and he used the one closest to the door. In an interview on 10/16/20 at 1:28 PM, Staff 2 (DNS) and Staff 3 (RN COVID-19 Consultant) stated the facility had enough supplies of gowns, was using the contingency strategy for gown use and was not in crisis capacity. In an interview on 10/16/20 at 2:27 PM, Staff 1 (Administrator), Staff 2 and Staff 3 stated they expected the facility and staff to follow the current CDC guidance for gown use and staff should not double gown. b. The 800 hall had a sign posted on the entry door to wear full PPE (N95 respirator, eye protection, gown and gloves) while in resident rooms. The facility's 10/15/20 Daily Census sheet revealed nine residents were on the 800 hall. On 10/15/20 at 11:43 AM, there were no PPE stations outside resident rooms in the 800 hall. Staff 7 (CNA), Staff 8 (CNA) and Staff 9 (RN) were not donning or doffing gowns between resident rooms. On 10/16/20 at 9:46 AM, in the common area on the 800 hall a launderable gown was draped over a chair near the computer. On 10/16/20 at 9:55 AM and 9:59 AM, there were no PPE stations outside resident rooms in the 800 hall. Staff 11 (LPN) entered and exited resident rooms without donning or doffing gowns between each room. In an interview on 10/15/20 at 11:46 AM, Staff 7 stated all the residents on the 800 hall are on a 14-day COVID-19 monitoring quarantine due to admission or readmission status. Staff 7 stated staff reused one gown for the entire shift for all the residents. Staff 7 stated they changed gowns if the gown became soiled. In an interview on 10/15/20 at 12:13 PM, Staff 8 stated all residents on 800 unit were on quarantine for monitoring of COVID-19 symptoms. Staff 8 stated she used the same gown between rooms and only donned new gowns if she left the unit. In an interview on 10/15/20 at 12:20 PM, Staff 9 stated the 800 unit had nine or ten residents on a 14 quarantine for monitoring of COVID-19 symptoms and were not all COVID-19 positive. Staff 9 stated staff wore one gown per shift for all residents unless they left the unit for a break. In an interview on 10/16/20 at 9:57 AM, Staff 10 (Speech Pathologist) stated she did not know whose gown was on the chair, but the gown should not be laying around. In an interview on 10/16/20 at 10:10 PM, Staff 11 (LPN) stated there were no concerns with having enough gowns or PPE at the facility that she was aware of. Staff 11 stated the 800 hall reused the same gown between residents for their entire shift unless they left the unit. In an interview on 10/16/20 at 1:28 PM, Staff 2 (DNS) and Staff 3 (RN COVID-19 Consultant) stated the facility had enough gowns, was using the contingency strategy for gown use and was not in crisis capacity. In an interview on 10/16/20 at 2:27 PM, Staff 1 (Administrator), Staff 2 and Staff 3 stated they expected the facility and staff to follow the current CDC guidance for gown use.