STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135014	A. BUILDING _____ B. WING _____	07/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CALDWELL CARE OF CASCADIA	210 CLEVELAND BOULEVARD CALDWELL, ID 83605

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 -** Immediate jeopardy **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, staff interview, review of nationally recognized standards of practice, policy review, review of facility documents, review of employee screening logs, review of employee work schedules and timesheets, it was determined the facility failed to ensure infection control prevention practices were implemented and maintained to prevent and contain COVID-19. These failures placed all residents and staff at risk for exposure to COVID-19 with the likelihood of serious harm, impairment, or death. Findings include: On [DATE] at 12:00 PM, the DON confirmed the facility had experienced a total of 103 COVID-19 positive cases, including staff and residents, beginning on [DATE]. The DON confirmed 11 residents died , and she said another resident died the previous night related to COVID-19. 1. The facility's policy for Screening and Management of COVID-19, revised [DATE], documented the following: * Staff, vendors, and providers were screened for risk of COVID-19 exposure before entering resident care areas. The screening included checking the temperature and self-report of respiratory symptoms. If a risk factor was identified, a medical review was completed with that person, and a determination was made whether they could enter resident care areas. If the person had a fever, they were sent home immediately. Staff were instructed to leave the work area and notify their supervisor if they developed symptoms during their shift. * Staff who had or were suspected of having COVID-19, with mild to moderate illness and not severely immunocompromised, were allowed to return to work if they met the following conditions: 1. At least 24 hours passed since the last fever, without the use of fever-reducing medication; and 2. There was improvement in symptoms; and 3. at least 10 days passed since symptoms first started. * Asymptomatic staff who had unprotected exposure to COVID-19 may be excluded from work for 14 days after the last exposure. The CDC Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19, dated [DATE], stated, HCP should self-monitor when they are not at work and be actively screened upon entering the facility. The facility policy and CDC guidelines were not followed. The facility's employee screenings logs and timesheets, dated [DATE] through [DATE] and from [DATE] through [DATE], were reviewed for all employees of the facility. There were inconsistencies between the timesheets and the staff screening logs. a. The following staff were not screened prior to working their shift: * The screening logs and timesheets, dated [DATE], did not include screening for 6 CNAs, 1 LPN, 1 Dietary Staff, and the Maintenance Director. * The screening logs and timesheets, dated [DATE], did not include screening for 2 CNAs, 1 LPN, 1 RN and the Maintenance Director. * The screening logs and timesheets, dated [DATE], did not include screening for 8 CNAs, 2 LPNs, 1 RN, 1 Housekeeper, and 1 Social Worker. b. The employee screening log included a section to document a temperature, six yes/no questions related to symptoms associated with COVID-19, a section for the initials of the reviewer, and a section for action taken. The employee screening logs did not include documentation of an action taken when staff answered yes to potential symptoms of COVID-19. * The screening logs and timesheets, dated [DATE], documented 1 CNA and 1 Social Worker worked when they answered yes to the questions of symptoms associated with COVID-19. * The screening logs and timesheets, dated [DATE], documented 1 Social Worker worked when they answered yes to the questions of symptoms associated with COVID-19. * The screening logs and timesheets, dated [DATE], documented 1 CNA, 1 LPN, and 1 PTA worked when they answered yes to the questions of symptoms associated with COVID-19. * The screening logs and timesheets, dated [DATE], documented 3 CNAs, and 1 NA worked when they answered yes to the questions of symptoms associated with COVID-19. * The screening logs and timesheets, dated [DATE], documented 1 PTA and 1 Dietary Staff worked when they answered yes to the questions of symptoms associated with COVID-19. * The screening logs and timesheets, dated [DATE], documented 1 CNA and 1 PTA worked when they answered yes to the questions of symptoms associated with COVID-19. On [DATE] at 12:46 PM, Housekeeper #1 said when he entered the building, he came in the West Wing door, took his own temperature, wrote his own answers to questions on the screening log, and went to the laundry room to get his assignment. Housekeeper #1 said no one asked him the questions in the screening log. On [DATE] at 1:30 PM, CNA #14 said when she came to work she checked her temperature and answered the screening questions. CNA #14 said she filled out the information herself and left it for the nurse to look at it. On [DATE] at 1:45 PM, RN #4 said when she came to work she checked her temperature and answered the questions on the screening log, and she entered the information herself. RN #4 said if there was a question about whether a staff member had symptoms, that person should go to the charge nurse. RN #4 said she did not know who reviewed the staff screening logs or when they were reviewed. On [DATE] at 1:48 PM, CNA #4 said when he entered the building, he came in the West Wing door, performed hand hygiene, took his own temperature, wrote it in the screening log, put on a gown, a face mask, goggles or face shield, and proceeded to report to work. CNA #4 said he answered the questions on the screening log himself and no one observed him. On [DATE] at 3:15 PM, the DON said staff were expected to screen with a partner or ask someone to witness their temperatures. The DON said if the staff had symptoms they were expected to ask to see the RN, or they did not come in to work. On [DATE] at 3:16 PM, the IP said she reviewed the screening logs at certain times and she initialed the log. The DON said she and the IP reviewed the screening logs at least daily. When asked who was responsible for overseeing the employee screening process, the DON said, we tag team it. 2. The facility's policy for Screening and Management of COVID-19, revised [DATE], documented staff were to use the following guidelines for PPE: * Use of PPE in the COVID-19 unit (Red Zone): Continuously wear a gown, respirator face mask, eye protection, and gloves. The facility had red signs posted outside the doors of residents who were positive for COVID-19. The red sign was to inform staff Enhanced Droplet Precautions were in place, and full PPE was required. The sign documented a gown, a respirator face mask, eye protection (goggles or face shield), and gloves were required upon entry. Staff were observed not following the Enhanced Droplet Precautions and wearing all PPE indicated on the sign when entering resident rooms. Examples include: a. On [DATE] at 10:20 AM, CNA #1 entered room [ROOM NUMBER]. A red sign was posted on the door, which indicated a COVID-19 positive resident inside, CNA #1 was wearing a gown, a respirator face mask, and eye protection, but he was not wearing gloves. CNA #1 performed hand hygiene on exit from the room. On [DATE] at 1:30 PM, CNA #1 said he did not wear gloves in the room because he did not provide cares to the resident and was just checking on her. b. On [DATE] at 10:56 AM, Resident #12 had a red sign posted on their door. RN #4 entered Resident #12's room with medication in a clear plastic medication cup. RN #4 was wearing a gown, goggles, and a blue surgical mask over a white mask, and she was not wearing gloves. RN #4 then exited the room with the medication cup in her hand, and she obtained a washcloth from the linen closet outside Resident #12's room. RN #4 did not put on gloves, and she re-entered the room. RN #4 went to the sink and moistened the washcloth and went to Resident #4's bedside, which was behind a closed curtain. RN #4 emerged from behind the curtain and then washed her hands and exited the room. RN #4 said the red sign on the door meant staff were to wear a gown, goggles, and face mask because of COVID-19. RN #4 said If I was going to do something I would wear gloves-I tried to wake her (Resident #12) up, but she was not going to wake up. I saw chocolate pudding on her face, so I got a washcloth from the linen closet and wiped her face. RN #4 said she did not wear gloves when she went into Resident #12's room. c. On [DATE] at 10:39 AM, CNA #4 entered room [ROOM NUMBER] which had a red sign posted on the door. CNA #4 was wearing a gown, a face mask, and eye protection, but he was not wearing gloves. CNA #4 walked around the room as he looked around and touched various items in the room with his bare hands. CNA #4 touched a resident's bedside table, then he went to another resident's dresser and

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 -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) opened the drawer. CNA #4 looked in the drawer, picked up some clothing items with his bare hands, and placed the items back in the drawer. After he closed the dresser drawer, CNA #4 exited the room. When asked about the red sign on the door that directed staff to wear gloves in the room, CNA #4 said he wore them if he did anything with the resident. d. On [DATE] at 12:25 PM, CNA #2 was providing drinks to Resident #16 from a cart on the West Wing. CNA #2 was wearing a gown, a respirator face mask and goggles, and was not wearing gloves. A red sign was posted on the door. CNA #2 said she did not put on gloves to go into the room, she only put on gloves if she was going to touch the resident or their things, not when she was handing them something. e. On [DATE] at 1:56 PM, CNA #4 went into room [ROOM NUMBER] with a red sign posted on the door while distributing paper products. He had on a gown, face mask and goggles, and did not put on gloves. CNA #4 said he performed hand hygiene when he came out of the room. CNA #4 stated he was unsure whether he should have worn gloves. f. On [DATE] at 12:59 PM, the Social Worker entered Resident #15's room. A red sign was posted on the door, which indicated Enhanced Droplet Precautions were in place and full PPE was required. The sign documented a gown, a respirator face mask, eye protection (goggles or face shield), and gloves were required. The Social Worker was wearing a white lab coat, which was buttoned up the front, goggles, a face mask, and gloves. The Social Worker did not put on a gown prior to entering the room, and she talked to Resident #15 behind a closed curtain for several minutes. The Social Worker then exited the room, removed her gloves, and disposed of them. The Social Worker was still wearing the same lab coat, goggles, and face mask. She said the resident was on precautions because she was COVID-19 positive. The Social Worker said she did not perform cares for Resident #15. The Social Worker said she talked with Resident #15 about her menu. The Social Worker said the red sign on the door indicated staff were to wear PPE, including a gown, gloves, a face mask, and eye wear. The Social Worker said she considered the lab coat as her gown, and she put it in the laundry at the end of the day or she would change it if it became soiled. On [DATE] at 2:53 PM, the DON said when staff go into a room with a red precaution sign staff were to follow what was on the red precaution sign and perform hand hygiene when they go in and out of the room and use gloves. On [DATE] at 3:08 PM, the IP said a gown should have been worn over the Social Worker's white lab coat when entering Resident #15's room. The IP said staff should wear gloves when going into a room that was on precautions. 3. The facility's policy for PPE Donning and Doffing, revised [DATE], directed staff to Put on Mask or Respirator. If the respirator has a nosepiece, it should be fitted to the nose with both hands, not bent or tented. Do not pinch the nosepiece with one hand. Respirator/face mask should be extended under the chin. Both your mouth and nose should be protected. Do not wear respirator/face mask under your chin . The facility's policy also stated Protective glasses must wrap around the eyes. Vented glasses are not acceptable. This policy was not followed. a. On [DATE] at 10:26 AM, RN #1 was wearing regular eyeglasses with small clear pieces attached on each side behind the lenses. The attachments were approximately 2 inches in length and 1 inch or less in width, and there were several small openings in the plastic attachments. The top of RN #1's eyeglass lenses were just at or slightly below her eyebrows, and her glasses did not wrap around her eyes. RN #1 said she purchased the eyeglass attachments from Amazon, and the advertisement said they were acceptable. On [DATE] at 11:00 AM, the DON said she could not find information regarding the appropriate use of the eyeglass attachments as eye protection. b. On [DATE] from 11:20 AM to 11:40 AM, RN #1 was talking on a cell phone at the nurse's station. A white mask was hanging underneath her chin and neck, and it was not secured to her face. RN #1 said her mask should be over her mouth and nose with the straps in place, and it was not in place while she was talking on the phone because she pulled it down so the other person on the phone could hear her. On [DATE] at 3:08 PM, the IP said a face mask should be worn to cover the mouth and nose, and it was not acceptable for staff to wear it below their chin. 4. The facility's policy for Hand Hygiene, dated [DATE], stated hand hygiene was to be performed: * After touching blood, body fluids, secretions, excretions and contaminated items, whether gloves are worn. * After handling soiled equipment or utensils. * After removal of medical/surgical or utility gloves. * After gloves are removed between resident contacts, and when otherwise indicated to avoid transfer of microorganisms to other residents or environments. This policy was not followed. a. On [DATE] beginning at 10:27 AM, Housekeeper #2 was in room [ROOM NUMBER] mopping the floor with gloved hands. She then took off her gloves and put new gloves on without performing hand hygiene and continued mopping. Housekeeper #2 then grabbed a plastic yellow triangular wet floor sign and placed it outside of room [ROOM NUMBER] and closed the door to the room. She took off her gloves and put them in the trash and put new gloves on without performing hand hygiene. Housekeeper #2 then entered room [ROOM NUMBER]. She took a cloth from a bucket on her cart and wiped down the plastic glove box holder in the room, wiped the television screen, and the light fixtures at the end of the bed. She then wiped the top of the bedside table and the table legs. Housekeeper #2 touched her hair with her right hand with her contaminated glove, removed her gloves and put on new gloves without performing hand hygiene, and then wiped her forehead with the back of her right hand. She then grabbed a new cloth from her cart, went back into room [ROOM NUMBER] and opened the bathroom door and proceeded to clean surfaces in the bathroom. Housekeeper #2 exited the bathroom in room [ROOM NUMBER], removed her gloves, put them in the trash and put new gloves on without performing hand hygiene. She went to her cart outside of the room and took a toilet brush into the bathroom in room [ROOM NUMBER] and proceeded to clean. When she finished cleaning she placed the toilet brush back on her cart and grabbed a broom from the cart and swept the bathroom and then the floor by the bed. She moved the bedside table with her gloved hand and then swept under the bed. Housekeeper #2 finished sweeping the room, returned the broom to her cart, then reached into a bucket with mop pads in liquid solution. She wrung out one of the pads in the bucket and went back into the room and mopped the bathroom. Housekeeper #2 exited the bathroom and took the mop over by the bed and reached down to pick up the call light that was on the floor and placed it on the bedside table without cleaning it. Housekeeper #2 continued to mop the floor until she reached the doorway to room [ROOM NUMBER]. She took off the dirty mop pad and disposed of it and put the mop on the cart. She removed her gloves and took the broom from the cart and swept the rest of the debris in the doorway of room [ROOM NUMBER]. Housekeeper #2 did not perform hand hygiene after removing her gloves. Housekeeper #2 then replaced the broom on the cart and pushed her housekeeping cart down the hallway toward the next room. On [DATE] at 10:58 AM, Housekeeper #2 said she should have performed hand hygiene before and after putting on gloves and when exiting a resident's room. b. The facility's policy for PPE Donning and Doffing, dated [DATE], stated hands were to be washed prior to putting on a new gown. This policy was not followed. On [DATE] at 11:10 AM, CNA #6 entered the building through the west wing door where the screening log and staff PPE were located just inside the door. CNA #6 took her stored respirator face mask from a paper bag and secured it over her nose and mouth. CNA #6 then took a cloth gown from a rack across from the west wing door way and put it on over her scrubs and fastened the back of the gown. CNA #6 then put her name badge on and performed hand hygiene. CNA #6 did not perform hand hygiene before putting on her PPE. On [DATE] at 11:13 AM, CNA #6 said she should have performed hand hygiene before putting on her PPE. On [DATE] at 2:48 PM, the IP said staff should perform hand hygiene in and out of rooms, before putting on PPE, when putting on new gloves, and after taking off gloves. 5. The facility's policy for Handling, Transport, and Storage of Laundry, updated [DATE], stated the following: * After washing, cleaned and dried textiles, fabrics, and clothing are hung, folded, and prepared for transport, distribution and storage by methods that ensure their cleanliness until use (e.g., covered cart, closing closet doors, etc.). * Staff will handle and transport the laundry with appropriate measures to prevent cross-contamination. * Clean linens must be transported by methods that ensure cleanliness and protection from dust and soil during intra or inter-facility loading, transport, and unloading. * Clean linen must always be kept separate from contaminated linen through the use of separate rooms, closets, or other designated spaces with a closing door as the most secure methods for reducing the risk of accidental contamination. This policy was not followed. On [DATE] at 11:10 AM, next to the West entrance door was a metal clothing rack with gowns on hangers. CNA #6 was putting on PPE and took a gown from the metal clothing rack. The gowns hung loosely on hangers on the metal rack and did not have a protective covering. On [DATE] at 12:42 PM, 16 cloth gowns were observed on hangers on a metal clothing rack against the wall between the kitchen door and room [ROOM NUMBER]. The gowns hung loosely on hangers on the metal rack and did not have a protective covering. The Case Manager was walking by the gowns, toward the 100 hall, and brushed his left shoulder against some of the gowns. On [DATE] at 12:55 PM, Housekeeper #4 was pulling an empty clothing rack down the 200 hall toward the door that led to the laundry outside of the building. As she walked by the clothing rack on the wall between the kitchen door and room [ROOM NUMBER], her left shoulder lightly brushed against some of the gowns. On ,[DATE] at 12:58 PM, Housekeeper #4 said the gowns hanging on the rack were clean gowns she provided from the laundry for staff to use when entering residents' rooms. Housekeeper #4 said she did not realize she brushed against the gowns and agreed if she did they would be contaminated. She said the gowns were considered clean linen and should be covered when transported or stored in the hall. On [DATE] at 3:16 PM, the IP said the gowns should be covered when stored in the hall. 6. The facility's Transmission-Based Precautions Conventional Plan, updated [DATE], stated resident care equipment was to be cleaned and disinfected before use on another resident using an Environmental Protection Agency (EPA)

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) registered disinfectant. This policy was not followed. On [DATE] at 10:52 AM, CNA #3 was in room [ROOM NUMBER] with a clip board, thermometer, and pulse oximeter. The clip board was on top of Resident #17's bedside table with the thermometer and pulse oximeter on top of it. CNA #3 picked up the clip board and equipment on top of it, crossed the hall to room [ROOM NUMBER] and placed the clip board onto Resident #18's dresser. CNA #3 did not sanitize the clipboard prior to leaving room [ROOM NUMBER] and before placing it on Resident #18's dresser. CNA #3 performed hand hygiene, put on new gloves and cleaned the thermometer and pulse oximeter, then took Resident #18's vital signs. After she took Resident #18's vital signs, CNA #3 sanitized the thermometer and set the thermometer on top of Resident #18's dresser, removed her gloves, and wrote on the clip board. CNA #3 then performed hand hygiene, put on new gloves, and took the thermometer from Resident #18's dresser and took Resident #19's temperature who was in the same room as Resident #18. CNA #3 did not sanitize the thermometer that was on Resident #18's dresser before taking Resident #19's temperature. On [DATE] at 10:55 AM, CNA #3 said she had placed the clip board on Resident #17's bedside table and then placed it on Resident #18's dresser. She said she put the thermometer down on Resident #18's dresser, then picked it up and took Resident #19's temperature. On [DATE] at 3:00 PM, the DON said the equipment used to take vital signs should have been sanitized between each resident use, and the equipment should have been placed on microorganism barriers, and not directly on resident furniture. 7. The facility's PPE Conservation Plan, dated [DATE], stated: * Extended use (of PPE) refers to the practice of wearing the same PPE for repeated encounters with several residents, without removing between the encounters. Extended use may be implemented when multiple residents are infected, and residents are placed together in dedicated area, room or unit(s). * Reuse refers to the practice of using the same piece of PPE for multiple encounters with residents under precautions but removing it ('doffing') between encounters of other residents. The PPE is stored between encounters and reused. This policy was not followed. The facility's policy for Screening and Management of COVID-19, revised [DATE], documented staff were to use the following guidelines for PPE: * In the Orange Zone (negative for COVID-19 but previously exposed of positive): Use the two-gown system, respirator face mask, eye protection, gloves, and one time use gown for care. On [DATE] at 11:49 AM, CNA #2 took a yellow gown hanging on a rack outside of room [ROOM NUMBER] and put it on over the gown she was wearing in COVID-19 positive rooms, she then put a surgical face mask over the top of her respirator face mask that she wore into COVID-19 positive rooms. CNA then took a cup of soy milk and a cup of cranberry juice into room [ROOM NUMBER] that had an orange sign on it indicating it was a negative COVID-19 room. The sign directed staff to use a two-gown system, respirator face mask, eye protection (goggles or face shield) and gloves. The sign did not instruct staff to put on a clean gown over a dirty gown and it did not instruct staff to put on a surgical face mask over their respirator face mask. On [DATE] at 12:21 PM, LPN #1 said the COVID-19 positive residents had a red precaution sign posted on their door, and it instructed staff to put on a gown, a respirator face mask, a face shield, and gloves. LPN #1 said the COVID-19 negative residents had an orange precaution sign posted on their door, and it instructed staff to put on an additional disposable/washable one-time use gown for care. On [DATE] at 1:30 PM, CNA #1 said the orange precaution signs meant the resident was COVID-19 negative and the staff was to put on an extra gown and face mask over the already donned gown and N95/respirator because the gown and N95/respirator were already contaminated. On [DATE] at 11:44 AM, the Administrator said he was unsure what guidance was used for the two-gown system. On [DATE] at 5:29 PM, the Administrator sent the guidelines regarding the use of a two-gown system, was from a slide presentation by RB Health Partners, Inc., titled Combating A Super-Spreader COVID-19 Guidance for Long-Term Care, [DATE]. Under the section on Zone System, the document stated for COVID-19 positive residents, staff should use: * Full PPE - filtering facepiece respirator and face shield preferred * Two-gown system - Base gown to protect clothing - Disposable gown for high contact care activities The guidelines did not recommend a two-gown system for residents who were negative for COVID-19. 8. The facility's Dining Standards policy, dated [DATE], stated when providing in-room dining, food being transported to resident rooms was covered. This policy was not followed. Examples include: On [DATE] at 12:30 PM, CNA #3 was distributing lunches to rooms 111 through 116 on the COVID-19 positive West Wing unit from an uncovered rack on casters. Paper plates set on trays in the rack were covered with tin foil, and the Styrofoam cups with salad and dessert were not covered. The rack was rolled down the hall as the lunches were distributed. On [DATE] at 3:04 PM, the DON said the lunch trays should be transported in covered carts. On [DATE] at 4:15 PM, the Administrator and DON were informed of an Immediate Jeopardy determination for 42 CFR 483.80 (F880) via phone, and the Immediate Jeopardy template was subsequently sent via fax.