STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135051	A. BUILDING _____ B. WING _____	08/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CANYON WEST OF CASCADIA	2814 SOUTH INDIANA AVENUE 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** - 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, policy review, nationally recognized standards of practice, and staff interview, it was determined the facility failed to ensure infection control prevention practices were implemented and maintained to provide a safe and sanitary environment. This failure created the potential for negative outcomes by exposing residents to the risk of infection and cross-contamination including COVID-19. Findings include: 1. The facility's COVID-19 policy, revised 7/21/20, directed staff to move COVID-19 positive residents to a COVID-19 unit. The policy stated the roommates of residents who tested positive may be exposed and it was not recommended to place them with another roommate until 14 days after their exposure, and they did not exhibit symptoms or test positive. The CDC website, accessed on 8/6/20, Responding to Coronavirus in Nursing Homes, stated residents with a confirmed case of COVID-19 should be transferred to a designated COVID-19 care unit. The guidance also stated, Roommates of residents with COVID-19 should be considered exposed and potentially infected and, if at all possible, should not share rooms with other residents unless they remain asymptomatic and/or have tested negative for [DIAGNOSES REDACTED]-CoV-2 14 days after their last exposure (e.g., date their roommate was moved to the COVID-19 care unit). Exposed residents may be permitted to room share with other exposed residents if space is not available for them to remain in a single room. This policy and guideline was not followed. The facility's COVID-19 surveillance and tracking, as of 8/5/20, documented all residents were tested on [DATE]. The surveillance also documented residents who had negative results from the test on 7/16/20 were tested again on 7/22/20. The Resident Listing Report, dated 8/5/20 at 8:44 AM, provided by the facility listed the name of each resident and their location in the facility. Residents who tested negative for COVID-19 were sharing rooms with those residents who tested positive. Resident #35 and Resident #36 shared a room in the 300 hall. The door to their room had an Orange sign posted and a Red sign posted outside. Resident #35 tested positive for COVID-19 on 7/20/20. Resident #36 tested negative for COVID-19 on 7/20/20 and 7/31/20. Resident #35 and Resident #36 remained in the same room and were not moved or isolated for more than 14 days once their test results were received. On 8/5/20 at 10:10 AM, LPN #2 said resident rooms with a Red and an Orange sign posted at their doors were residents with both positive and negative COVID-19 test results. LPN #2 said residents were kept together because the resident with a negative COVID-19 test was previously exposed by their roommate who tested positive for COVID-19. On 8/5/20 at 12:00 PM, LPN #1 said rooms with a Red and an Orange sign on the doors indicated those rooms were occupied by a resident who tested positive for COVID-19 and the roommate had tested negative. LPN #1 said all the residents in the facility were considered to be exposed to COVID-19. On 8/5/20 at 2:15 PM, the Administrator, with the DON and ICP present, said due to the spread of COVID-19 throughout the facility there were only the Red and Orange zones in the facility. The DON and the ICP said a resident was admitted to the facility on [DATE] and was placed on quarantine. The DON said the resident developed signs and symptoms of COVID-19 on day 15 of his/her admission. The resident was admitted to the hospital on [DATE] and tested positive for Covid-19. The DON said they tested all their residents and employees for COVID-19 on 7/16/20 and three residents had tested positive. The residents were placed on isolation with enhanced droplet precautions at the far end of the 100 hall. The DON said residents who tested negative on 7/16/20 were retested on [DATE] which resulted in 18 more positive COVID-19 cases. The DON said on 7/24/20, they considered the facility as a COVID building due to increasing number of cases among their residents and employees. Another round of testing was completed on 7/28/20 which resulted in 11 more positive cases. The DON said most of the positive results were from the residents who resided in the 200 and 300 halls and since many of their staff were also infected with COVID-19 and symptomatic, room changes were planned to cohort residents. The DON said on 8/3/20, the 100 hall was closed and residents were transferred to either the 200 or 300 halls. The DON said residents whose COVID-19 test results were negative but whose roommates were positive were placed together since they were exposed to their roommates. The DON and Administrator said they had also made the decision based on residents' behavioral concerns, gender, and COVID-19 test results and symptoms. On 8/6/20 at 4:00 PM and 4:25 PM, the DON with the Clinical Resource nurse, with the Administrator present, said the facility only had enough nurses to staff two hallways and had used the MDS nurse, Clinical Resource nurses, travel nurses, agency nurses, facility nurse managers, and she had also worked the floor to keep up with the demand. The Clinical Resource nurse said roommates were cohorted even if one tested negative and one tested positive because it was not logistically possible to move everyone based on their test results. The Clinical Resource nurse said the facility also had to take into consideration the residents' behaviors and past resident to resident altercations. 2. The facility's Covid-19 policy, revised 7/21/20, directed staff to assist residents to perform hand hygiene prior to eating. This policy was not followed. On 8/5/20 from 12:07 PM to 12:47 PM, lunch trays in the 200 and 300 halls were served to residents. a. The following was observed in the 200 hall: -At 12:25 PM, CNA #1 delivered and set up Resident #1's meal on his tray table in his room. CNA #1 did not offer hand hygiene to Resident #1 prior to eating his lunch. -At 12:32 PM, NA #1 delivered and set up Resident #2's meal on her tray table in her room. NA #1 did not offer hand hygiene to Resident #2 prior to eating her lunch. -At 12:34 PM, NA #1 delivered and set up Resident #3's meal on her tray table in her room. NA #1 did not offer hand hygiene to Resident #3 prior to eating her lunch. -At 12:38 PM, NA #1 delivered and set up Resident #4's meal on his tray table in his room. NA #1 did not offer hand hygiene to Resident #4 prior to eating his lunch. -At 12:40 PM, CNA #2 delivered and set up Resident #5's meal on his tray table in his room. CNA #2 did not offer hand hygiene to Resident #5 prior to eating his lunch. -At 12:40 PM, CNA #2 delivered and set up Resident #6's meal on his tray table in his room. CNA #2 did not offer hand hygiene to Resident #6 prior to eating his lunch. -At 12:46 PM, CNA #2 delivered and set up Resident #7's meal on his tray table in his room. CNA #2 did not offer hand hygiene to Resident #7 prior to eating his lunch. -At 12:47 PM, CNA #1 delivered and set up Resident #8 meal on her tray table in her room. CNA #1 did not offer hand hygiene to Resident #8 prior to eating her lunch. On 8/5/20 at 12:50 PM, NA #1 said he said he had not offered residents hand hygiene when he delivered their meal trays and said he probably should have. On 8/5/20 at 12:53 PM, CNA #1 said she had not offered residents hand hygiene when she delivered their meal trays. CNA #1 said she did not know she was to offer residents hand hygiene before meals. On 8/5/20 at 1:36 PM, CNA #2 said she said she had not offered residents hand hygiene when she delivered their meal trays. On 8/5/20 at 2:15 PM, the ICP said she expected staff to offer residents hand hygiene before their meals. b. The following was observed in the 300 hall: The HA, delivered and set-up Resident #18's meal for her on her over bed table. The HA did not offer Resident #18 hand hygiene before eating her meal. The Rehabilitation Technician delivered and set-up Resident #15's meal for her on her over bed table and left the room. The Rehabilitation Technician did not offer Resident #15 hand hygiene before eating her meal. The HA delivered and set-up Resident #19's meal for her on her over bed table and then left the room. The HA did not offer Resident #19 hand hygiene before eating her meal. CNA #4 delivered and set-up Resident #14's meal on her over bed table and then left the room. CNA #4 did not offer Resident #14 hand hygiene before eating her meal. CNA #4 delivered and set-up Resident #20 meal on his over bed table and then left the room. CNA #4 did not offer Resident #20 hand hygiene before eating his meal. CNA #4 delivered and set-up Resident #21's meal on his over bed table and then left the room. CNA #5 did not offer Resident #21 hand hygiene before eating his meal. The HA delivered 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 -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) set-up Resident #22's meal on his over bed table and then left the room. The HA did not offer Resident #22 hand hygiene before eating her meal. CNA #5 delivered and set-up Resident #23's meal on her over bed table and then left the room. CNA #5 did not offer Resident #23 hand hygiene before eating her meal. On 8/5/20 at 12:50, CNA #3, CNA #4, CNA #5, and the HA said they did not offer hand hygiene to the residents when they delivered and set-up their meals. CNA #5 said she forgot to offer hand hygiene to the residents. CNA #3 and CNA #4 said they did not know they were to offer residents hand hygiene before meals. The Rehabilitation Technician said she did not know she was to offer residents hand hygiene before their meals. On 8/5/20 at 2:15 PM, the ICP said she expected staff to offer residents hand hygiene before their meals. 3. The facility's Handwashing policy, dated 10/1/17, stated hand hygiene was to be performed using an alcohol-based hand rub or with soap and water after gloves are removed, between resident contacts, and after touching contaminated items whether or not gloves were worn. This policy was not followed. On 8/5/20 beginning at 9:10 AM, the HA wore an N95 mask (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) and a face shield and entered Residents #9's and Resident #10's room and put on a pair of gloves. She then removed Resident #9's trash bag and placed a new trash bag into the trash can. The HA then went to take the trash bag from Resident #10's trash can and placed a new trash bag into the trash can. The HA put the trash bags into a red trash bag, removed her gloves and exited the room and went to the Utility Room without performing hand hygiene. After dropping the red trash bag in the Utility Room, the HA then entered Resident #13's room. The HA put on gloves without performing hand hygiene, and took Resident #13's trash bag and replaced it with a new trash bag. The HA then put the trash bag inside a red plastic bag, removed her gloves, did not perform hand hygiene, and went to Resident #16 and Resident #17's room. The HA removed the trash bag from Resident #16's trash and then she walked toward Resident #17's bed and took the trash bag from his trash. The HA placed a new trash bag and put both the trash bags inside a red plastic bag. The HA then removed her gloves and exited Resident #16 and #17's room without performing hand hygiene. At 9:30 AM, the HA entered Resident #14 and Resident #15's room. The HA put on a pair of gloves and was heard talking to Resident #14. She then took the trash bag from Resident #14's trash can and placed a new trash bag into the trash can. The HA then walked toward Resident #15's bed and removed the trash bag from her trash can and placed a new trash bag into the trash can. She then put the two trash bags into a red plastic bag and removed her gloves. The HA did not perform hand hygiene after removing her gloves. Resident #14 spoke to the HA, the HA put on a new pair of gloves, entered the rest room and came out with another plastic bag of trash and a white towel on her hand. She removed her gloves, performed hand hygiene, carried the red plastic bag and two clear plastic bags of trash and exited Resident #14 and Resident #15's room. On 8/5/20 at 9:45 AM, the HA said she did not perform hand hygiene before and after removing her gloves when she entered residents room when she collected their trash, but when she realized she was being observed by the surveyor she remembered to perform hand hygiene after she exited Residents #14 and #15's room.