



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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August 22, 2018

Royal Jensen, Administrator
Cascadia of Boise
6000 W. Denton St.
Boise, ID 83704

RE: August 9, 2018, Initial Certification Survey Report for Cascadia of Boise

Dear Mr. Jensen:

This is to advise you of the findings of the **Medicare/Medicaid** initial survey of Cascadia of Boise, which was done on **August 9, 2018** by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility is in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance.

Royal Jensen, Administrator
August 22, 2018
Page 2 of 2

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 4, 2018**.

The components of a Plan of Correction as required by CMS must:

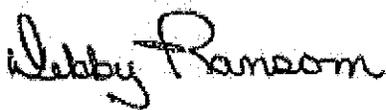
- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

The administrator must sign and date the first page of the federal survey report, Form CMS-2567.

We can not recommend certification to CMS Regional Office and/or State Medicaid Agency until the facility is found to be in substantial compliance with the requirements at 42 CFR 483.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,

A handwritten signature in black ink that reads "Debby Ransom". The signature is written in a cursive, flowing style.

Debby Ransom, RN, RHIT, Chief
Bureau of Facility Standards

DR/lj
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/22/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001090	(K2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/09/2018
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NAME OF PROVIDER OR SUPPLIER CASCADIA OF BOISE	STREET ADDRESS, CITY, STATE, ZIP CODE 6000 W DENTON ST BOISE, ID 83704
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(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the initial federal certification survey conducted at the facility from 8/7/18 to 8/9/18. The surveyors conducting the survey were: Debby Ransom, RN, RHIT Belinda Day, RN Laura Thompson, RN, BSN Acronyms used in the report: CNA - Certified Nursing Assistant DON - Director of Nursing LPN - Licensed Practical Nurse SDC - Staff Development Coordinator Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)	F 000		
F 550 SS=D	§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550	RECEIVED AUG 27 2018 FACILITY STANDARDS This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Cascadia of Boise does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. F550 Resident Specific The ID team reviewed resident #151 and resident #101 for resident rights practices in relation to meals/meal service. Other Residents No other residents reside at the facility to have been affected.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Executive Director DATE: 8-27-18

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 550	<p>Continued From page 1</p> <p>must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents' dignity during meals when:</p> <ul style="list-style-type: none"> * Residents were not provided timely ongoing assistance to eat their meals. * Residents were not allowed to eat their meals without unnecessary interruptions. * Residents were not provided a choice of whether to use a clothing protector. * Residents were not allowed to complete their meals before the food was removed. * Staff assisting residents with dining wore disposable gloves when doing so. <p>This was true for 2 of 2 residents whose meals</p>	F 550	<p>Facility Systems Staff have been provided education regarding dignity during meals. Re-education is provided by the SDC and/or designee to include prevention of interruptions for medication assistance at meal times, consistent and timely assistance throughout the meal, providing options for napkin/clothing protectors, prevention of meals being cleared prior to residents being done with intake, and use of gloves in the dining room only as appropriate. -The system is amended to include on-going meal observations and re-training as necessary to validate dignity occurs.</p> <p>Monitor The DNS and/or designee will audit 10 meal services weekly for 4 weeks, then 5 weekly for 8 weeks. Starting the week of 8/24/18 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> <p>Date of Compliance: 9/1/18</p>		

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F 550	<p>Continued From page 2</p> <p>were observed. This deficient practice placed residents at risk of hunger, weight loss, and a diminished sense of self-worth. Findings include:</p> <p>1. Resident #151 was admitted to the facility on 6/8/18 with diagnoses that included history of unspecified dementia without behavior disturbance, major depressive disorder, anxiety disorder, insomnia, dysarthria (unclear speech) following cerebral infarction (stroke) affecting right non-dominant side, asthma, muscle weakness, age-related osteoporosis, and dysphagia (difficulty swallowing).</p> <p>Resident #151's current Nutrition Care Plan, initiated 6/11/13, documented the following interventions:</p> <p>*Provide a calm, quiet setting at meal times with adequate eating time. *Resident #151 does best with handled cups or light weight cups. She needs cueing and assistance with beverages.</p> <p>Resident #151's current Activity of Daily Living (ADL) Care Plan, initiated 6/8/18, documented she required cueing and the assistance of 1 person for all meals/snacks. The care plan stated Resident #151 needed cues and reminders to take bites and to swallow.</p> <p>Resident #151's dignity was not promoted while dining, as follows:</p> <p>a. On 8/7/18 at 5:29 PM, LPN #1 and CNA A were both wearing blue disposable gloves while assisting Resident #151 with her evening meal.</p> <p>b. On 8/9/18 at 9:03 AM, breakfast was delivered</p>	F 550		
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F 550	<p>Continued From page 3</p> <p>to Resident #151's table. Resident #151 was eating breakfast with CNA B assisting by putting food on the utensil and handing the utensil to Resident #151.</p> <p>On 8/9/18 at 9:12 AM, CNA B, while sitting at another table, called across both dining tables and cued Resident #151 to eat. Resident #151 fed herself two bites with a spoon.</p> <p>On 8/9/18 at 9:15 AM, CNA B called across both dining tables and cued Resident #151 to take another bite. Resident #151 did not respond.</p> <p>On 8/9/18 at 9:16 AM, LPN #2 removed Resident #151 from the table. Resident #151's meal intake before leaving the table was 4-5 bites of scrambled eggs and no intake of waffles with strawberries and whipped cream. LPN #2 used a gait belt and walker and cued Resident #151 to pick up her feet and took her to her room. LPN #2 asked CNA B to bring water to Resident #151's room.</p> <p>On 8/9/18 at 9:20 AM, CNA B arrived at Resident #151's room with water.</p> <p>On 8/9/18 at 9:29 AM, Resident #151 came out of her room with the assistance of LPN #2.</p> <p>On 8/9/18 at 9:30 AM, Resident #151 was seated in a dining chair.</p> <p>On 8/9/18 at 9:31 AM, LPN #2 cued Resident #151 to eat and walked away.</p> <p>On 8/9/18 at 9:32 AM, Resident #151 was sipping coffee alone at the dining table.</p>	F 550			

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F 550	<p>Continued From page 4</p> <p>On 8/9/18 at 9:34 AM, Resident #151 was wiping her face and looking around.</p> <p>On 8/9/18 at 9:35 AM, CNA B returned to Resident #151 and cut up her waffles.</p> <p>On 8/9/18 at 9:37 AM, Resident #151 took one bite of waffle and at 9:38 AM, Resident #151 took another bite of waffle.</p> <p>On 8/9/18 at 9:40 AM, CNA B was talking to Resident #151 in Spanish and Resident #151 was sipping her coffee.</p> <p>On 8/9/18 at 9:41 AM, LPN #2 arrived at the dining table with crushed medications. Resident #151 was taken away from the meal by LPN #2.</p> <p>On 8/9/18 at 9:44 AM, Resident #151 was in her room with LPN #2 and CNA B.</p> <p>On 8/9/18 at 9:46 AM, Resident #151's remaining food was removed from the table before she returned from her room.</p> <p>On 8/9/18 at 9:53 AM, Resident #151 returned to the dining table.</p> <p>Resident #151 did not receive consistent cueing or assistance to eat her breakfast. Her meal was also repeatedly interrupted for medication administration and the majority of her meal was removed before she was provided the assistance and opportunity to eat it.</p> <p>In an interview on 8/9/18 at 1:18 PM, LPN #2 was asked about the administration of Resident #151's medications during breakfast. LPN #2 said she attempted to give Resident #151's</p>	F 550		

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F 550	<p>Continued From page 5</p> <p>mediations but she refused to take the medications. LPN #2 said she then crushed the medications and put them in applesauce.</p> <p>In an interview with CNA A on 8/8/18 at 8:14 PM, regarding Resident #151's dining assistance needs, CNA A stated Resident #151's family preferred staff to feed her since that was what they did at home. CNA A also said because the facility was fully staffed they could accommodate the family's request. When asked if Resident #151 could feed herself and how she let staff know if she wanted to feed herself, CNA A stated Resident #151 would reach for food with her utensil and staff assisted her if needed.</p> <p>In an interview with CNA B on 8/8/18 at 8:59 AM, when asked if she assisted Resident #151 with meals, CNA B said it depended on how Resident #151 was doing at the time of the meals, sometimes she fed Resident #151 and other times Resident #151 fed herself. When asked if she wore gloves to feed Resident #151, CNA B replied no.</p> <p>c. On 8/9/18 at 12:00 PM, CNA B went to a cabinet and got a blue clothing protector and put it on Resident #151 without asking her permission.</p> <p>2. Resident #101 was admitted to the facility on 6/4/18 with cerebral infarction (stroke), dysarthria (unclear speech), hemiplegia and hemiparesis (paralysis on one side of the body), vascular dementia with behavioral disturbance, major depressive disorder, pressure ulcer (sore) of left hip, and edema (swelling).</p> <p>Resident #101's dignity was not promoted while</p>	F 550			

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F 550	<p>Continued From page 6 dining, as follows:</p> <p>a. On 8/7/18 at 5:29 PM, LPN 1 and CNA A were observed wearing blue disposable gloves while assisting Resident #101 with his evening meal.</p> <p>b. On 8/9/18 at 9:03 AM, breakfast was delivered to Resident #101's table.</p> <p>On 8/9/18 at 9:15 AM, CNA B left Resident #101 at the dining table to take water to another resident's room.</p> <p>On 8/9/18 at 9:21 AM, 18 minutes after his meal was served, CNA B returned to the dining room and began assisting Resident #101 to eat.</p> <p>On 8/9/18 at 9:24 AM, LPN #2 called for CNA B to help her. CNA B stopped feeding Resident #101 to assist LPN #2.</p> <p>On 8/9/18 at 9:28 AM, CNA B returned to Resident #101 at the dining table, stirred his coffee and assisted him to eat.</p> <p>On 8/9/18 at 9:35 AM, LPN #2 took Resident #101 to his room to be orally suctioned.</p> <p>On 8/9/18 at 9:46 AM, Resident #101 returned to the dining table.</p> <p>Resident #101 was not assisted with his meal in a timely manner and his meal was interrupted when CNA B attended to other tasks.</p> <p>c. On 8/9/18 at 12:00 PM, CNA B went to a cabinet and got a blue clothing protector and put it on Resident #101 without asking his permission.</p>	F 550			

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F 860 SS=D	<p>Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to:</p>	F 880	<p>F880 Resident Specific The clinical management team reviewed resident #101 for adverse reaction to failed infection control practices. Resident show no evidence of infection.</p> <p>Other Residents The clinical management team reviewed other residents for potential risk of poor infection control practices. Adjustments have been made as indicated.</p> <p>Facility Systems Staff have been educated to proper hand hygiene practices. Re-education was provided by the SDC and/or designee for proper use of sanitizer and hand washing, use of gloves/changing of gloves, management of secretions, and process for managing trash in and out of the resident room. In addition, licensed nurses were skills checked by the SDC and/or designee regarding clean dressing change The system is amended to include observation/surveillance rounds for meeting infection control guidelines and following facility policy.</p>		

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F 880	<p>Continued From page 8</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, record review, and staff interview, it was determined the facility failed to ensure staff followed facility policy and nationally recognized guidelines for infection prevention for 1 of 2 residents (Resident #101) who were observed during the survey. This placed residents and staff at risk for the transmission and possible spread of infectious agents. Findings include: A facility policy infection Prevention and Control</p>	F 880	<p>Monitor</p> <p>The DNS and/or designee will audit 2 dressing changes/10 occurrences for gloves/hand hygiene practices weekly for 4 weeks, then 1 dressing change/5 occurrences for gloves/hand hygiene weekly for 8 weeks. Starting the week of 8/24/18 review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> <p>Date of Compliance: 9/1/18</p>	

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F 880	<p>Continued From page 9</p> <p>Program, dated 10/31/17, stated the infection prevention and control program included processes to minimize healthcare associated infections through an organization-wide program. The policy stated the program included the use of standard precautions by staff and monitoring compliance with standard practices which included, but was not limited to, hand hygiene and the use of personal protective equipment.</p> <p>This policy was not followed. Examples include:</p> <ol style="list-style-type: none"> 1. A facility policy Clean Dressing Change, dated 11/28/17, documented the steps for performing a dressing change on a wound. The steps included performing hand hygiene prior to the dressing change, with glove changes, and at the completion of the dressing change. The policy also stated glove changes were to be completed after removing the dirty dressing, after cleansing the wound, and after application of the clean dressing. <p>Resident #101 was admitted to the facility on 6/4/18, with diagnoses which included dementia, CVA, and hip and knee contractures. Resident #101 was admitted to the facility with a Stage IV pressure ulcer to his left hip and was on hospice.</p> <p>An observation of wound care was conducted on 8/8/18 beginning at 11:00 AM, by LPN #1 for Resident #101. LPN #1 washed her hands prior to going over to the bedside, and the wound and dressing supplies were on a bedside table covered with a chux (a pad that protects the surface from fluid and are disposable). Resident #101 was laying on his right side in his bed and LPN #1 uncovered him and lowered his pants to expose the dressing. She then put on gloves and</p>	F 880			

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NAME OF PROVIDER OR SUPPLIER CASCADIA OF BOISE			STREET ADDRESS, CITY, STATE, ZIP CODE 8000 W DENTON ST BOISE, ID 83704		
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F 880	<p>Continued From page 10 removed a square band-aid covering the wound.</p> <p>Resident #101's wound had a small opening in the center, LPN #1 threw the band-aid in a trash can next to the head of the bed and removed her gloves. She then put on new pair of gloves, without performing hand hygiene, and sprayed wound cleanser onto gauze and cleaned the wound. While cleansing the wound Resident #101 grunted and grimaced and she asked a couple of times if he wanted pain medication, he stated no. LPN #1 then went to the bathroom and washed her hands, returned to the bedside and donned gloves.</p> <p>LPN #1 then proceeded with dressing the wound per the physician order. After the wound was dressed LPN #1 removed a black sharpie pen from her pocket, prior to removing her gloves, and wrote her initials and the date on the dressing. LPN #1 removed her gloves and threw them in the trash can. She did not perform hand hygiene after removing her gloves. She moved the wound supplies (bottle of packing gauze, medi-honey tube, and spray bottle of wound cleanser) from the bedside table onto a paper towel on top of the night stand. LPN #1 gathered up the chux, which had the dirty supplies, and threw it into the trash can without wearing gloves.</p> <p>LPN #1 gathered the trash bag from the trash can and pulled it out and knotted it, and placed a new trash bag in the trash can without wearing gloves. She did not perform hand hygiene before pulling up Resident #101's sweat pants, handing him back his call light, and placing his blanket back over him. LPN #1 next moved to the other side of the bed and used the remote control to lower his bed. She went back to the other side of the bed</p>	F 880			

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F 880	<p>Continued From page 11</p> <p>and without wearing gloves picked up the paper towel from the night stand, with the wound supplies inside, in one hand, and grabbed the trash bag in the other hand and walked towards the bathroom.</p> <p>LPN #1 set the paper towel with the wound supplies on the bathroom counter, set the trash bag on the floor, and proceeded to wash her hands. When she finished she did not don gloves when she picked up the wound supplies in the paper towel in her left hand and the trash bag in her right hand and walked out of the room to the dirty utility room. LPN #1 used her bare right hand, with the trash bag in that hand, and used a key pad to open the door. She lifted the trash bin lid with her bare right hand and placed the trash bag inside. LPN #1 used the same hand to get a paper towel and with the paper towel grabbed the wound supplies from her left hand. The new paper towel did not completely cover the wound supplies and her bare hand touched the bottles and tube. She did not perform hand hygiene after touching the door or touching the trash can. LPN #1 did not perform hand hygiene before picking up the wound supplies with her right hand and leaving the dirty utility room.</p> <p>LPN #1 walked over to the wound cart, opened the drawer, and placed the wound supplies into a plastic bag in the second drawer. She did not perform hand hygiene prior to touching the cart.</p> <p>At that point, the observations were discussed with LPN #1 and she confirmed she did miss opportunities for hand hygiene.</p> <p>During an interview on 8/8/18 at 12:05 PM, the DON was asked about expectations for hand</p>	F 880			

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F 880	<p>Continued From page 12</p> <p>hygiene and hygiene with wound care. She stated the expectation was hand hygiene will be done whenever gloves are removed and hands were washed prior to wound care. The DON confirmed, after discussion regarding the observation of wound care, there were missed opportunities for hand hygiene and poor awareness of when to use gloves and when going from dirty to clean or vice versa.</p> <p>2. A facility policy Hand Hygiene/Handwashing, dated 11/28/17, stated gloves are worn when contact with blood or other potentially infectious materials, mucous membranes, and non-intact skin could occur. The policy included references from the CDC (Centers for Disease Control and Prevention) and WHO (World Health Organization).</p> <p>The CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007), accessed from the web on 8/15/18, stated Standard Precautions are based on the principle that all blood, body fluids, secretions, and mucous membranes may contain transmissible infectious agents. Standard Precautions include prevention practices which apply to all patients. These include hand hygiene and the use of personal protective equipment, which include the use of gloves or a gown, in anticipation of possible exposure.</p> <p>The facility policy and standards for prevention were not followed.</p> <p>a. Resident #101 was observed in the dining area on 8/7/18 beginning at 5:40 PM. He was sitting in his specialized wheelchair at a dining room table with LPN #1 and the Activity Director.</p>	F 880		

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F 880	<p>Continued From page 13</p> <p>Resident #101 was coughing and had a gurgling sound in his throat. The Activity Director picked up a food protector from the dining room table, to attempt to have Resident #101 spit out the phlegm. She placed the food protector back onto the dining table and did not perform hand hygiene. Resident #101 coughed again several times with audible gurgling of phlegm. LPN #1 then offered the same food protector to attempt to have him spit out phlegm into it, using her bare hands. After removing the food protector from Resident #101's mouth LPN #1 did not perform hand hygiene. The food protector was then placed back onto the dining room table.</p> <p>b. Resident #101 was observed having breakfast on 8/8/18 beginning at 9:10 AM. He was assisted by LPN #1 and CNA A. Resident #101 was coughing and had a gurgling sound coming from his throat while trying to eat his breakfast. Both CNA A and LPN #1 offered the food protector for Resident #101 to spit any phlegm into when he was coughing. Neither were wearing gloves when holding the food protector by his mouth and directing him to cough and spit out the phlegm. After removing the food protector from Resident #101's mouth it was placed on the dining room table. No hand hygiene was performed by LPN #1 or CNA A after removing the food protector from Resident #101's mouth.</p> <p>An interview was conducted on 8/9/18 beginning at 1:50 PM, with the Administrator, DON, and SDC. The DON stated staff were trained with a web based video and testing, then observed for competencies. The DON and SDC confirmed no formal observations were documented regarding infection control. They stated they have both worked on the floor with the staff and observed</p>	F 880			

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F 880	Continued From page 14 practices which did not follow education or recommendations and had re-educated and redirected staff.	F 880		