

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

PRINTED: 08/25/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/14/2020
NAME OF PROVIDER OR SUPPLIER ASPEN PARK OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 420 ROWE STREET MOSCOW, ID 83843		
(X4) ID 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	
E 000	<p>Initial Comments</p> <p>A COVID-19 Focused Emergency Preparedness Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on June 10, 2020 onsite at Aspen Park of Cascadia..</p> <p>The facility was found to be in substantial compliance with 42 CFR §483.73 related to E-0024 (b)(6).</p> <p>Facility resident census 45 Resident sample 6</p> <p>The CMS Team: Barbara Dagg RN, Health and LSC surveyor</p> <p>Federal surveyors can be reached at: US Department of Health and Human Services Centers for Medicare and Medicaid Services 701 Fifth Avenue Suite 1600 Mailstop 400 Seattle, WA 98104 206.615.2313 206.615.2088 (Fax)</p>	E 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/22/2020

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 000	<p>INITIAL COMMENTS</p> <p>A COVID-19 Focused Infection Control Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on June 10, 2020 onsite at Aspen Park of Cascadia. Off site reord review was concluded on June 14, 2020.</p> <p>The facility was not in substantial compliance with 42 CFR §483.80 infection control regulations.</p> <p>Facility Resident Census 45. Resident sample 6.</p> <p>The CMS Team: Barbara Daggy RN, Health and LSC surveyor</p> <p>Federal surveyors can be reached at: US Department of Health and Human Services Centers for Medicare and Medicaid Services 701 Fifth Avenue Suite 1600 Mailstop 400 Seattle, WA 98104 206.615.2313 206.615.2088 (Fax)</p>	F 000			
F 880 SS=E	<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>	F 880		7/30/20	

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F 880	<p>Continued From page 1</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:</p> <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct 	F 880			

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F 880	<p>Continued From page 2</p> <p>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 and interviews the facility failed to ensure all staff implemented measures to prevent contamination of surfaces in common areas with potential for cross contamination and spread of infectious organisms from one person to another or from a contaminated surface to a resident. These failures potentially affected nine randomly observed residents who ate in the dining room and all residents who consumed water or ice from the nourishment center ice/water dispenser and placed them at risk for infection.</p> <p>Findings include:</p> <p>During the entrance interview on 6/10/20 at 9:30 AM, the administrator said the facility was COVID-free with no residents or staff testing positive for COVID-19 and no residents on transmission-based precautions for COVID-19.</p>	F 880	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Aspen Park of Cascadia does not admit that the deficiencies listed on the CMS form 2567 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.</p> <p>#1. Resident Specific: Resident # 6 was affected by this practice of HK1 not disinfecting or sanitizing the outside of the water pitcher before returning it to the resident room.</p>		

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F 880	<p>Continued From page 3</p> <p>The administrator reported a low incidence of COVID-19 in the community and county but acknowledged risk due to close proximity to a Washington State college town with co-mingling of persons from the two communities.</p> <p>1. During observation of the 300 resident hall on 6/10/20 at 10:54 AM housekeeping staff HK1 exited resident room 301. HK1 placed cleaning cloths on the housekeeping cart in the corridor then removed gloves and washed hands with soap and water. Resident R6 called from resident room 301 asking for ice water. HK1 re-entered room 301 and went to the window bed. HK1 took R6's water pitcher from the room to the nourishment center down the hall. HK1 placed the water pitcher directly on the tray of the ice/water dispenser and activated controls to add ice/water to the pitcher. HK1 took the filled pitcher back into room 301. HK1 used hand sanitizer gel then resumed housekeeping duties. HK 1 did not disinfect or sanitize the outside of the water pitcher before taking it from or returning it to the resident room and did not disinfect or sanitize the surface of the ice/water dispenser.</p> <p>2. During the lunch meal observation on 6/10/20 from 12:15 PM to 12:40 PM, nine residents each sat at a separate table. Six staff fed residents, one staff to one resident, and/or assisted with the meal service. Five staff wore cloth face covers (cloth face masks) and one staff wore a surgical mask. Six resident's cloth face covers were placed directly on the dining tables with no protective barriers between the surface of the tables (table top) and the face covers. Two cloth face covers hung freely on wheelchair handles and one randomly observed resident R7 wore a cloth face cover on her forearm.</p>	F 880	<p>Other Residents: Facility residents have the potential of being affected by this practice. Adjustments have been made as indicated.</p> <p>Facility Systems: Staff development Coordinator educated staff on not reusing water pitcher's and/or other kitchenware. If a resident requests a refill, staff has been directed to provide clean kitchenware.</p> <p>Monitor: Staff Development Coordinator to observe 2 staff interactions weekly for 4 weeks, then 2 staff interactions every other week for 8 weeks for proper kitchenware replacement/exchange. The review will be documented on audit tool. Any concerns will be addressed immediately and will be reviewed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Compliance 7/30/2020</p> <p>#2.Resident Specific: Resident #7 was affected by this practice of no barrier on the table.</p>		

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F 880	Continued From page 4 The administrator entered the dining room at 12:23 PM. The administrator immediately obtained a paper towel and spread it out on the dining table. The administrator redirected R7, removed the face cover from R7's arm, and placed the face cover with the outside of the face cover down on the paper towel. The administrator confirmed it was the facility expectation that a barrier be used when masks or cloth face covers were placed on tables in the communal dining room to prevent contamination of the table by the mask/face cover or contamination of the mask/face cover by the table surface. Licensed nurse LN1 was in the dining room. She said she was a charge nurse. LN1 said she was aware masks and face covers should be placed on barriers to prevent cross contamination. LN1 said she did not notice the masks/face covers on the tables without barriers until questioned by the surveyor. In an interview on 6/10/20 at 1:40 PM the facility Infection Control Preventionist (ICP) was informed of the observations regarding face covers on dining tables with no barriers and staff filled a soiled water pitcher directly from the communal ice/water dispenser. ICP said all staff were educated on proper storage of face masks/covers intended to be re-used. ICP said barriers should be first placed on the table and then the face mask should be placed with the outside of the mask/face cover down on the barrier. ICP said the masks/ face covers could be hung by the ties if not in contact with objects but ideally the facemasks should be stored in a breathable paper bag.	F 880	Other Residents: Facility residents have the potential of being affected by this practice. Facility System: Staff development Coordinator reeducated staff on providing a proper storage of face masks/covers intended to be reused. Barriers will be used on dining room tables and then the face mask should be placed appropriately on the barrier. Monitor: Staff Development Coordinator to observe 2 meals weekly for 4 weeks, then 2 meals every other week for 8 weeks for proper barrier placement. The review will be documented on audit tool. Any concerns will be addressed immediately and will be reviewed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Compliance 7/30/2020		

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F 880	Continued From page 5 Regarding the water pitcher, ICP said HK1 did not provide resident care and was trying to give prompt service to R6 by responding to his request.. When asked what she expected HK1 and others to do when a resident asked for ice water; ICP said staff should get a new water pitcher to change out with the used/soiled pitcher. ICP said; or staff could bring ice and water to the resident's room to refresh the water pitcher. ICP confirmed the resident's water pitcher was considered soiled or contaminated and it should not have been taken into the nourishment center. ICP further stated; the used or soiled water pitcher definitely should not contact surfaces of the ice/water dispenser. ICP concluded both the dining room practices with the face coverings and the re-filling process for the water pitcher created potential for cross contamination. ICP said the facility expected all staff in all disciplines to practice and implement infection control standards at all times.	F 880			