STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135146		**07/23/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADIA OF BOISE	**6000 W DENTON ST** **BOISE, ID 83704**

(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	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted on July 22, 2020 through July 23, 2020. The facility was found to be in compliance with CFR §483.73 related to E-0024 (b)(6). The survey was conducted by: Cecilia Stockdill, RN, Team Coordinator Sallie Schwartzkopf, LCSW	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/17/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135146		07/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADIA OF BOISE	6000 W DENTON ST BOISE, ID 83704

(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
F 000	INITIAL COMMENTS The following deficiency was cited during a COVID-19 Focused Infection Control survey which was conducted on July 22, 2020 through July 23, 2020. The survey was conducted by: Cecilia Stockdill, RN, Team Coordinator Sallie Schwartzkopf, LCSW Survey Abbreviations: CNA = Certified Nursing Assistant DON = Director of Nursing PPE = Personal Protective Equipment RN = Registered Nurse	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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. §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: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		9/1/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Electronically Signed — 08/17/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135146		07/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADIA OF BOISE	6000 W DENTON ST BOISE, ID 83704

(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
F 880	Continued From page 1 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; §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: (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 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135146		07/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADIA OF BOISE	6000 W DENTON ST BOISE, ID 83704

(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
F 880	Continued From page 2 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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, and staff interview, it was determined the facility failed to ensure infection control prevention practices were consistently implemented 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 policy for PPE Donning (putting on) and Doffing (taking off), dated 4/6/20, provided the following directions regarding use of PPE: * When putting on a gown, position the top of the gown around the neck, then fasten and secure the ties around the neck and around the waist with the ties at the back of the gown. * When putting on a face mask, secure the ties or elastic bands at the middle of the head and at the neck. Ensure the fit to the bridge of the nose and fit the face mask snugly to the face and below the chin. The front of the face mask is contaminated, and staff should not touch it. The facility's policy for Hand Hygiene, dated 3/3/20, directed staff to perform hand hygiene	F 880	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 2567 exist, nor does the facility admit to any statements, findings, factors 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. Corrective action for those residents found to have been affected by the deficient practice 1) A. Resident # 2 was evaluated for s/s of adverse effect post cited event with no findings noted. Resident #2 COVID symptoms management record for the last 14 days from 8/6 was reviewed with no s/s of COVID19 or infection noted. The Respiratory Therapist identified in cited event was educated on facility policy	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135146		07/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADIA OF BOISE	6000 W DENTON ST BOISE, ID 83704

(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
F 880	Continued From page 3 after touching contaminated items. These policies were not followed. a. On 7/22/20 at 9:00 AM, Resident #2's room had a red sign posted on the door. The sign indicated Resident #2 was on enhanced droplet precautions, and a gown, respirator face mask, eye protection, and gloves were required. On 7/22/20 at 9:06 AM, the Respiratory Therapist put on PPE, including a blue isolation gown, and then he carried respiratory supplies into Resident #2's room. The Respiratory Therapist did not tie the lower ties on the gown, leaving his back exposed as he entered the room. The Respiratory Therapist replaced the respiratory equipment on the far side of Resident #2's bed, and Resident #2 was sitting on the opposite edge of the bed facing the door. After several minutes, the Respiratory Therapist obtained a trash can and disposed of the used respiratory equipment in the room. The Respiratory Therapist's gown remained untied below the neck, and as he leaned forward over the trash can the gown became more open, exposing his sides as well as his back. The Respiratory Therapist then removed the trash bag from the trash can, put a new trash bag in the trash can, removed his gloves and gown, and sanitized his hands. The Respiratory Therapist said Resident #2 was on precautions and was quarantined due to either being a new admission or being out of the facility. The Respiratory Therapist said prior to entering the room, staff should put on a gown, gloves, respirator face mask, and eye protection. The Respiratory Therapist said the gown should have been tied, and he did not tie it because he was changing out equipment that was not near	F 880	regarding donning of PPE which includes tying the back of isolation gowns. A competency was completed to include 3 observations with no further findings. B. Resident # 2 was evaluated for s/s of adverse effect post cited event with no findings noted. Resident #2 COVID symptoms management record for the last 14 days from 8/6 was reviewed with no s/s of COVID19 or infection noted CNA #1 was in-serviced regarding the deficient practices. CNA is no longer an employee at the facility. C. No specific resident was identified. RN#2 was re-educated on the facility infection control and prevention policy regarding isolation precautions to include donning PPE as ordered and/or facility policy consistently. Facemasks should be worn over the nose and mouth, minimal contact with facemask during use, to obtain a new mask that fits if not secure, and sanitize hands once contact is made with the mask. Computer keyboard was sanitized. D. Resident # 2 was evaluated for s/s of adverse effect post cited event with no findings noted. Resident #2 COVID symptoms management record for the last 14 days from 8/6 was reviewed with no s/s of COVID19 or infection noted. RN#2 was re-educated on the facility infection control and prevention policy regarding isolation precautions to include donning PPE as ordered and/or facility policy consistently. The need to don gown and gloves per isolation precaution as indicated each time entry is made into a resident room on enhanced droplet	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135146		07/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADIA OF BOISE	6000 W DENTON ST BOISE, ID 83704

(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
F 880	Continued From page 4 Resident #2. b. On 7/22/20 at 10:54 AM, CNA #1 was in the hall at a computer kiosk near Resident #2's room. CNA #1 was wearing a respirator face mask and goggles. The bottom strap of the respirator face mask was hanging over the front of CNA #1's face below the face mask. The top strap of the face mask was in place on the top of CNA #1's head. CNA #1 said that was not the correct way to wear the face mask, and she was wearing it that way because it hurt her face. CNA #1 said staff were to wear a face mask and eye protection at all times. c. On 7/22/20 at 12:45 PM, RN #2 was sitting at the nurse's station, and he was wearing a respirator face mask below his nose. He adjusted the face mask by touching it on the outside, and he began typing on the computer keyboard. RN #2 touched the outside of the face mask 4 times as he continued typing on the computer keyboard and talking to the surveyor. RN #2 did not perform hand hygiene at any time after he touched the outside of his face mask. RN #2 said his face mask kept dropping below his nose, and it should cover his face and nose. RN #2 said he should have obtained a new face mask or washed his hands. d. On 7/22/20 at 1:47 PM, Resident #2's room had a red sign posted on the door. The sign indicated Resident #2 was on enhanced droplet precautions, and a gown, respirator face mask, eye protection, and gloves were required. RN #2 performed hand hygiene and entered the room. RN #2 was wearing a face shield and respirator face mask, and he did not put on a gown or gloves. RN #2 spoke to Resident #2 for	F 880	precautions. 2) A. Resident #1, #2, #3, and #4, isolation precautions were reviewed with door signs revised to reflect resident safety needs and personal choice as indicated. B. The Physical Therapist identified in cited event was educated on the need to comply with posted isolation precautions directives. How other residents who have the potential to be affected by the same deficient practice will be identified Currents residents have the potential to be affected. Clinical nursing team made rounds to validate and re-educate regarding " Fully donning PPE □ both ties on isolation gowns are secured and both straps on mask are in place. " Validating that masks fit appropriately to prevent readjustments. Hand hygiene is evident if mask is touched. " Keyboards are cleansed " Following the signage for gown and glove use with each entry into resident rooms. " Directives placed on the resident door are updated to address resident safety and personal choice and is also reflected on the resident care plan. Adjustments were made as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135146		07/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADIA OF BOISE	6000 W DENTON ST BOISE, ID 83704

(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
F 880	Continued From page 5 approximately 2 minutes, exited the room, and performed hand hygiene. RN #2 said he should have put on a gown and gloves before he entered Resident #2's room. On 7/22/20 at 3:35 PM, the Interim DON said when staff put on an isolation gown it should be tied, and when putting on a face mask it should be secured over the mouth and nose with the straps in place. The Interim DON said it was not appropriate for a face mask to be worn with the lower strap over the front the face, staff should avoid touching the front of the face mask, and if they touched the front of the face mask they should clean their hands. The Interim DON said staff should put on a gown and gloves in addition to their face mask and face shield prior to entering an isolation room. 2. a. On 7/22/20 at 10:09 AM, a red sign was posted on the room doors of Resident #1, Resident #2, and Resident #3. The sign indicated each resident was on enhanced droplet precautions, and it directed staff to keep the door closed. At that time, the doors were fully open or mostly open for each of the mentioned residents. The doors were observed in the same position on 7/22/20 at 10:54 AM, 11:15 AM, and 12:59 PM. b. On 7/22/20 at 12:54 PM, Resident #4's door was wide open while working with the Physical Therapist in the room. On 7/22/20 at 1:06 PM, the door to Room A15 was open 12 inches. The Physical Therapist said the residents' doors were supposed to be closed. She said she was in Room A15 with Resident #4 and she did not close the door.	F 880	Measures put in place and systemic changes made Root Cause Analysis (RCA) was completed with the assistance of the facility Infection Control Preventionist, Quality Assurance and Performance Improvement Committee and Governing Body to address breakdown in the system. Infection control policies were reviewed with adjustments made as indicated based upon the RCA. Chief Nursing Officer (DON) developed training based on the RCA and infection control and prevention policies to include donning and doffing of PPE, hand hygiene when touching PPE, keyboard cleansing, isolation directives, and transmission-based precautions. In coordination with the facility Infection Preventionist a plan is included for implementation to include a post test. The IDT was educated by the CNO with department training. Staff meeting was conducted with education provided to facility staff to include licensed and unlicensed nursing staff, respiratory therapy and therapy staff on infections control and prevention to include donning and doffing of PPE, hand hygiene after touching PPE, transmission based precautions, and the need to follow process regarding door open and close by the Chief Nursing Officer and Infection Preventionist. Increased staff surveillance and monitoring by the IDT during rounds throughout the facility to ensure staff is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135146		07/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADIA OF BOISE	6000 W DENTON ST BOISE, ID 83704

(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
F 880	Continued From page 6	F 880	exercising appropriate use of PPE and to ensure infection control procedures are followed. Ad hoc education will be provided to staff who are observed with a breech in practice. Staff education on peer-to-peer accountability for infection control compliance. Plans to monitor performance Review will occur through observation and audits to determine effectiveness and sustained compliance. " The CNO and/or designee will complete observation audits for at least 5 staff members, 3 times a week for 4 weeks, then reduce to weekly provided staff demonstrate sound practices, for 8 weeks. " The IDT will report findings during morning stand up meeting. " The Infection Control Preventionist will compile the observation and audit results and corrective action. Staff with patterns of deficient practices will be addressed. Starting the week of 08/17/2020, the review will be documented in the Quality Assurance and Performance Improvement Committee (QAPI)minutes. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI Committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135146		**07/23/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADIA OF BOISE	**6000 W DENTON ST** **BOISE, ID 83704**

(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
F 880	Continued From page 7	F 880	September 1, 2020	