



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

August 12, 2020

Bryan McNeil, Administrator
Caldwell Care of Cascadia
210 Cleveland Boulevard
Caldwell, ID 83605-3622

Provider #: 135014

Dear Mr. McNeil:

On **July 28, 2020**, a survey was conducted at Caldwell Care of Cascadia by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was 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 in your facility to be **WIDESPREAD PATTERN** and to constitute immediate jeopardy to residents' health and safety. You were informed of the immediate jeopardy situation(s) in writing on **July 28, 2020**.

On **July 29, 2020**, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your Plan of Correction and a revisit, it was determined that the immediate jeopardy to the residents had been removed. However, the deficiencies as identified on the revised Form CMS-2567 remain and require a Plan of Correction.

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. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **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. Waiver renewals may be requested on the Plan of Correction.

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After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 24, 2020**. Failure to submit an acceptable PoC by , may result in the imposition of additional civil monetary penalties by **September 14, 2020**.

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.
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction is imposed on the facility.

Imposition of Denial of Payment for New Admissions (DPNA):

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Payment will be denied for all NEW Medicare and Medicaid admissions, beginning 15 days after the date the enforcement letter is sent, on **August 27, 2020**, in accordance with the statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal regulations at 42 CFR §488.417. Your Medicare Administrative Contractor will be notified of the date the denial of payment begins. DPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated.

• **Imposition of Directed Plan of Correction (DPOC):**

In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the letter, on **August 27, 2020**. The DPOC may be completed before or after that date. The effective date is not a deadline for completion of the DPOC. However, the State Agency will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice. Please send all documentation to the State Agency via ePOC.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567.

Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate).

We must recommend to the CMS Seattle location and/or State Medicaid Agency that your provider agreement be terminated on **January 28, 2021**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Belinda Day, RN or Laura Thompson, RN, Supervisors Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means.

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Additionally, the CMS Seattle location or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

Go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)
[2001-10 IDR Request Form](#)

This request must be received by **August 24, 2020**. If your request for informal dispute resolution is received after **August 24, 2020**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in regulations at 42 CFR §498.40, et. seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than 60 days after receiving this letter.

Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

The Interim Manager, Julius Bunch; LTC Certification and Enforcement Branch;
Centers for Medicare and Medicaid Services, 701 5th Ave., Suite 1600, Seattle, WA
98104 or via email: Julius.Bunch@cms.hhs.gov.

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Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically, or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health and Human Services,
Department Appeals Board,
MS 6132, Director, Civil Remedies Division, 330
Independence Ave., S.W., Cohen Building - Room G-644,
Washington, D.C. 20201,
(202) 565-9462

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208)334-6626, option #2.

Sincerely,



Laura Thompson, RN
LCT Supervisor

lt/lj

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

PRINTED: 09/18/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2020
NAME OF PROVIDER OR SUPPLIER CALDWELL CARE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
(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 on July 27, 2020 through July 28, 2020. The facility was found to be in compliance with CFR §483.73 related to E-0024 (b)(6).</p> <p>The survey was conducted by:</p> <p>Cecilia Stockdill, RN, Team Coordinator Belinda Day, RN Sallie Schwartzkopf, LCSW</p>	E 000			

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

TITLE

(X6) DATE

Electronically Signed

08/12/2020

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>The following deficiency was cited during a COVID-19 Focused Infection Control survey which was conducted on July 27, 2020 through July 28, 2020.</p> <p>The survey was conducted by:</p> <p>Cecilia Stockdill, RN, Team Coordinator Belinda Day, RN Sallie Schwartzkopf, LCSW</p> <p>Survey Abbreviations:</p> <p>CDC = Centers for Disease Control CNA = Certified Nursing Assistant DON = Director of Nursing IP = Infection Preventionist NA = Nursing Assistant PPE = Personal Protective Equipment PTA = Physical Therapy Assistant RN = Registered Nurse</p>	F 000		
F 880 SS=L	<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</p>	F 880		9/15/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 08/12/2020
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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 880	Continued From page 1 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, 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.	F 880			

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F 880	<p>Continued From page 2</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, 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 7/28/20 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 6/25/20. The DON confirmed 11 residents died, and she said another resident died the previous night related to COVID-19.</p> <p>1. The facility's policy for Screening and Management of COVID-19, revised 7/21/20, documented the following:</p>	F 880	<p>All residents were screened for respiratory illness.</p> <p>The Interdisciplinary team reviews infection control practices for consistent implementation, during ongoing contacts each day. Staff re-education and adjustments to care are made as indicated.</p> <p>A consulting Infection Control Nurse (ICN) has been contracted with for at least 6 months. The ICN will work with the Quality Assurance and Performance Improvement (QAPI) committee and the governing body on completing a Root Cause Analysis (RCA) based on survey findings. The RCA findings are incorporated into training and the intervention plan. Infection Control and prevention program including policies and procedures will be reviewed with recommendations made to the Medical Director, QAPI committee, and the</p>		

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F 880	<p>Continued From page 3</p> <p>* 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.</p> <p>* 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.</p> <p>* Asymptomatic staff who had unprotected exposure to COVID-19 may be excluded from work for 14 days after the last exposure.</p> <p>The CDC Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19, dated 5/8/20, stated, "HCP should self-monitor when they are not at work and be actively screened upon entering the facility."</p> <p>The facility policy and CDC guidelines were not followed.</p> <p>The facility's employee screenings logs and timesheets, dated 6/25/20 through 6/26/20 and from 7/20/20 through 7/23/20, were reviewed for</p>	F 880	<p>governing body for changes.</p> <p>The consulting ICN with assistance from the Director of Nursing and the facility ICN will develop, train, and confirm understanding through scenario-based competency for all licensed and unlicensed staff, including nursing, social services, therapy, activity, dietary, laundry, and housekeeping related to donning and doffing PPE, reuse of PPE, cleaning of resident care/ medical equipment, and hand hygiene. A posttest will follow for validation of knowledge based understanding. In addition, laundry service will be trained with a scenario-based competency related to movement of clean and dirty laundry through the facility.</p> <p>The consulting ICN with the assistance from the Director of Nursing and other nursing leadership, will conduct rounds throughout the facility to validate staff and contractors are competent and consistent with implementation of the infection control and prevention program. Ad hoc education will be provided to the person(s) who are not correctly utilizing equipment and/or infection prevention and control practices.</p> <p>The consulting ICN and Director of Nursing rounds will continue until the facility has been infection free for at least 4 weeks. Any increase in infections will result in communication with the Medical Director, Public Health District, and State Survey Agency in order to obtain further assistance to control infection.</p>		

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F 880	<p>Continued From page 4</p> <p>all employees of the facility. There were inconsistencies between the timesheets and the staff screening logs.</p> <p>a. The following staff were not screened prior to working their shift:</p> <ul style="list-style-type: none"> * The screening logs and timesheets, dated 6/25/20, did not include screening for 6 CNAs, 1 LPN, 1 Dietary Staff, and the Maintenance Director. * The screening logs and timesheets, dated 6/26/20, did not include screening for 2 CNAs, 1 LPN, 1 RN and the Maintenance Director. * The screening logs and timesheets, dated 7/20/20, did not include screening for 8 CNAs, 2 LPNs, 1 RN, 1 Housekeeper, and 1 Social Worker. <p>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."</p> <p>The employee screening logs did not include documentation of an action taken when staff answered "yes" to potential symptoms of COVID-19.</p> <ul style="list-style-type: none"> * The screening logs and timesheets, dated 6/29/20, 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 	F 880	<p>Facility entrances are restricted to a single access point. A staff member is assigned to monitor the entrance to the facility and screen all staff members, contractors, or visitors prior to entering the patient care areas. When a staff member is not assigned to monitor the entrance, then the door is locked. Incoming staff members will ring the doorbell to gain entrance to the facility. They will be screened by the staff member who opens the door to allow entrance. A Licensed Nurse will assess staff members who answer Yes to one or more of the screening questions. If the staff member does not pass the screening, then they are sent home. Rounds occur to validate that staff on duty have been screened.</p> <p>The Director of Nursing and/or designee educated staff and contractors on the screening process, including what to do if no screener is present and what will occur if they answer Yes to one or more of the screening questions.</p> <p>The Administrator and/or designee will audit the staff screening log three times a week for completion and accuracy for 4 weeks, starting the week of August 30. Based on successful implementation, the audit will be reduced to once weekly for 4 more weeks. Weekly observations and staff interviews will be performed to monitor performance of staff screening process, including checking locked door and doorbell function. The review will be documented on the audit tool. Any</p>		

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F 880	<p>Continued From page 5</p> <p>6/30/20, documented 1 Social Worker worked when they answered "yes" to the questions of symptoms associated with COVID-19.</p> <p>* The screening logs and timesheets, dated 7/20/20, documented 1 CNA, 1 LPN, and 1 PTA worked when they answered "yes" to the questions of symptoms associated with COVID-19.</p> <p>* The screening logs and timesheets, dated 7/21/20, documented 3 CNAs, and 1 NA worked when they answered "yes" to the questions of symptoms associated with COVID-19.</p> <p>* The screening logs and timesheets, dated 7/22/20, documented 1 PTA and 1 Dietary Staff worked when they answered "yes" to the questions of symptoms associated with COVID-19.</p> <p>* The screening logs and timesheets, dated 7/23/20, documented 1 CNA and 1 PTA worked when they answered "yes" to the questions of symptoms associated with COVID-19.</p> <p>On 7/27/20 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.</p> <p>On 7/27/20 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.</p>	F 880	<p>concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 4 weeks, as it deems appropriate.</p> <p>Door precaution signs were adjusted to clarify required PPE necessary prior to entering resident room.</p> <p>The Director of Nursing and/or designee reeducated staff and contractors on door precaution signage and the importance of following as indicated regardless of reason for entering the room.</p> <p>The Director of Nursing and/or designee will audit 5 staff members entering resident rooms with precautions three times a week for 4 weeks, starting the week of August 30. Based on successful implementation, the audit will be reduced to once weekly for 4 more weeks. The review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 4 weeks, as it deems appropriate.</p> <p>The Director of Nursing and/or designee reeducated staff and contractors on wearing PPE correctly, to include but not limited to, eye protection, and securing all straps/ties during mask use.</p> <p>The Director of Nursing and/or designee will audit 5 staff members correctly wearing PPE three times a week for 4</p>		

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F 880	<p>Continued From page 6</p> <p>On 7/27/20 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.</p> <p>On 7/27/20 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.</p> <p>On 7/27/20 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.</p> <p>On 7/27/20 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."</p> <p>2. The facility's policy for Screening and Management of COVID-19, revised 7/21/20, documented staff were to use the following guidelines for PPE:</p>	F 880	<p>weeks, starting the week of August 30. Based on successful implementation, the audit will be reduced to once weekly for 4 more weeks. The review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 4 weeks, as it deems appropriate.</p> <p>The Director of Nursing and/or designee reeducated staff and contractors on proper hand hygiene and glove use, including how, when, and how often.</p> <p>The Director of Nursing and/or designee will audit 5 staff members for practicing proper hand hygiene three times a week for 4 weeks, starting the week of August 30. Based on successful implementation, the audit will be reduced to once weekly for 4 more weeks. The review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 4 weeks, as it deems appropriate.</p> <p>Protective coverings were installed on clothing racks containing PPE gowns.</p> <p>The Director of Nursing and/or designee reeducated staff and contractors on covering clean linen while transporting or storing, including keeping clean isolation gowns covered while being transported or stored.</p>		

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F 880	<p>Continued From page 7</p> <p>* Use of PPE in the COVID-19 unit (Red Zone): Continuously wear a gown, respirator face mask, eye protection, and gloves.</p> <p>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.</p> <p>Staff were observed not following the Enhanced Droplet Precautions and wearing all PPE indicated on the sign when entering resident rooms. Examples include:</p> <p>a. On 7/27/20 at 10:20 AM, CNA #1 entered room 111. 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.</p> <p>On 7/27/20 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."</p> <p>b. On 7/27/20 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</p>	F 880	<p>The Administrator and/or designee will audit that clean linen, including gowns, are transported and stored in a way that ensures cleanliness until use. Audits will be performed three times a week for 4 weeks, starting the week of August 30. Based on successful implementation, the audit will be reduced to once weekly for 4 more weeks. The review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 4 weeks, as it deems appropriate.</p> <p>The Director of Nursing and/or designee reeducated staff on cleaning/disinfecting resident care equipment, including using a barrier when placing equipment on resident furniture, and cleaning between residents.</p> <p>The Director of Nursing and/or designee will audit 5 staff members that are cleaning/disinfecting resident care equipment, including using a barrier when placing equipment on resident furniture, and cleaning between residents. Audits will be performed three times a week for 4 weeks, starting the week of August 30. Based on successful implementation, the audit will be reduced to once weekly for 4 more weeks. The review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the</p>		

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F 880	<p>Continued From page 8</p> <p>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.</p> <p>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.</p> <p>c. On 7/27/20 at 10:39 AM, CNA #4 entered room 214 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 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.</p> <p>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.</p> <p>d. On 7/27/20 at 12:25 PM, CNA #2 was providing</p>	F 880	<p>frequency of the monitoring after 4 weeks, as it deems appropriate.</p> <p>Facility policy was updated to include guidance on required PPE for each zone. Two-gown system is designated for residents on a COVID-19 Unit, who are positive for COVID-19 with an additional alternate infection, such as c-diff where significant gown soiling may occur.</p> <p>The Director of Nursing and/or designee reeducated staff and contractors on PPE Zones for COVID-19, including using the two-gown system for residents on a COVID-19 Unit, who are positive for COVID-19 with an additional alternate infection, such as c-diff.</p> <p>The Director of Nursing and/or designee will audit 5 staff members that are following PPE Zones for COVID-19 three times a week for 4 weeks, starting the week of August 30. Based on successful implementation, the audit will be reduced to once weekly for 4 more weeks. The review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 4 weeks, as it deems appropriate.</p> <p>The Director of Nursing and/or designee reeducated staff and contractors on keeping food trays covered during transport and between residents during meal pass.</p>		

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F 880	<p>Continued From page 9</p> <p>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.</p> <p>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.</p> <p>e. On 7/27/20 at 1:56 PM, CNA #4 went into room 102 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.</p> <p>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.</p> <p>f. On 7/27/20 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</p>	F 880	<p>The Administrator and/or designee will audit 5 staff members are keeping food trays covered during transport and between residents during meal pass. These audits will be performed three times a week for 4 weeks, starting the week of August 30. The review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 4 weeks, as it deems appropriate.</p>		

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F 880	<p>Continued From page 10</p> <p>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.</p> <p>On 7/27/20 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.</p> <p>On 7/27/20 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.</p> <p>3. The facility's policy for PPE Donning and Doffing, revised 7/21/20, 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."</p> <p>This policy was not followed.</p> <p>a. On 7/27/20 at 10:26 AM, RN #1 was wearing regular eyeglasses with small clear pieces attached on each side behind the lenses. The</p>	F 880			

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F 880	<p>Continued From page 11</p> <p>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.</p> <p>On 7/28/20 at 11:00 AM, the DON said she could not find information regarding the appropriate use of the eyeglass attachments as eye protection.</p> <p>b. On 7/27/20 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.</p> <p>On 7/27/20 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.</p> <p>4. The facility's policy for Hand Hygiene, dated 3/3/20, stated hand hygiene was to be performed:</p> <ul style="list-style-type: none"> * 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 	F 880			

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F 880	<p>Continued From page 12 gloves.</p> <p>* After gloves are removed between resident contacts, and when otherwise indicated to avoid transfer of microorganisms to other residents or environments.</p> <p>This policy was not followed.</p> <p>a. On 7/27/20 beginning at 10:27 AM, Housekeeper #2 was in room 210 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 210 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.</p> <p>Housekeeper #2 then entered room 209. 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 209 and opened the bathroom door and proceeded to clean surfaces in the bathroom.</p> <p>Housekeeper #2 exited the bathroom in room 209, removed her gloves, put them in the trash and put new gloves on without performing hand</p>	F 880			

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F 880	<p>Continued From page 13</p> <p>hygiene. She went to her cart outside of the room and took a toilet brush into the bathroom in room 209 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.</p> <p>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 209. 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 209. 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.</p> <p>On 7/27/20 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.</p> <p>b. The facility's policy for PPE Donning and Doffing, dated 4/6/20, stated hands were to be washed prior to putting on a new gown.</p>	F 880			

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F 880	<p>Continued From page 14 This policy was not followed.</p> <p>On 7/27/20 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.</p> <p>On 7/27/20 at 11:13 AM, CNA #6 said she should have performed hand hygiene before putting on her PPE.</p> <p>On 7/27/20 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.</p> <p>5. The facility's policy for Handling, Transport, and Storage of Laundry, updated 7/22/20, stated the following:</p> <ul style="list-style-type: none"> * 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, 	F 880			

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F 880	<p>Continued From page 15 transport, and unloading.</p> <p>* 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.</p> <p>This policy was not followed.</p> <p>On 7/27/20 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.</p> <p>On 7/27/20 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 218. 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.</p> <p>On 7/27/20 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 218, her left shoulder lightly brushed against some of the gowns.</p> <p>On 7/27/20 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</p>	F 880			

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F 880	<p>Continued From page 16</p> <p>contaminated. She said the gowns were considered clean linen and should be covered when transported or stored in the hall.</p> <p>On 7/27/20 at 3:16 PM, the IP said the gowns should be covered when stored in the hall.</p> <p>6. The facility's Transmission-Based Precautions Conventional Plan, updated 5/19/20, stated resident care equipment was to be cleaned and disinfected before use on another resident using an Environmental Protection Agency (EPA) registered disinfectant.</p> <p>This policy was not followed.</p> <p>On 7/27/20 at 10:52 AM, CNA #3 was in room 112 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 113 and placed the clip board onto Resident #18's dresser. CNA #3 did not sanitize the clipboard prior to leaving room 112 and before placing it on Resident #18's dresser.</p> <p>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</p>	F 880			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2020
NAME OF PROVIDER OR SUPPLIER CALDWELL CARE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
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F 880	<p>Continued From page 17</p> <p>thermometer that was on Resident #18's dresser before taking Resident #19's temperature.</p> <p>On 7/27/20 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.</p> <p>On 7/27/20 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.</p> <p>7. The facility's PPE Conservation Plan, dated 4/6/20, stated:</p> <p>* 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).</p> <p>* 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.</p> <p>This policy was not followed.</p> <p>The facility's policy for Screening and Management of COVID-19, revised 7/21/20,</p>	F 880			

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F 880	<p>Continued From page 18</p> <p>documented staff were to use the following guidelines for PPE:</p> <p>* 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.</p> <p>On 7/27/20 at 11:49 AM, CNA #2 took a yellow gown hanging on a rack outside of room 103 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 103 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.</p> <p>On 7/27/20 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.</p> <p>On 7/27/20 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</p>	F 880			

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F 880	<p>Continued From page 19</p> <p>extra gown and face mask over the already donned gown and N95/respirator because the gown and N95/respirator were "already contaminated."</p> <p>On 7/28/20 at 11:44 AM, the Administrator said he was unsure what guidance was used for the two-gown system.</p> <p>On 7/29/20 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, June 16, 2020. Under the section on Zone System, the document stated for COVID-19 positive residents, staff should use:</p> <ul style="list-style-type: none"> * Full PPE - filtering facepiece respirator and face shield preferred * Two-gown system <ul style="list-style-type: none"> - Base gown to protect clothing - Disposable gown for high contact care activities <p>The guidelines did not recommend a two-gown system for residents who were negative for COVID-19.</p> <p>8. The facility's Dining Standards policy, dated 3/1/2019, stated when providing in-room dining, food being transported to resident rooms was covered. This policy was not followed. Examples include:</p> <p>On 7/27/20 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</p>	F 880			

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F 880	<p>Continued From page 20</p> <p>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.</p> <p>On 7/27/20 at 3:04 PM, the DON said the lunch trays should be transported in covered carts.</p> <p>On 7/28/20 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.</p>	F 880			