STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135058	A. Building B. Wing	08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silverton Health and Rehabilitation of Cascadia	405 West Seventh Street Silverton, ID 83867

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents were provided with a safe and sanitary environment. This was true for 1 of 12 residents (Resident #3) whose environment was observed. Resident #3, who was unable to express herself, experienced psychosocial harm when she was consistently exposed to a strong odor of urine in her room due to her roommate's lack of compliance with personal hygiene. Findings include: * Resident #3 was admitted to the facility on [DATE], with multiple diagnoses which included Alzheimer's disease. A quarterly MDS assessment, dated 7/22/21, documented Resident #3 was severely cognitively impaired. * Resident #16 was admitted to the facility on [DATE], with multiple diagnoses which included diabetes mellitus, morbid obesity, and dementia. A quarterly MDS assessment, dated 5/21/21, documented Resident #16 was moderately cognitively impaired. The facility's Tracking Rooms record, documented Resident #3 and Resident #16 were transferred to room [ROOM NUMBER] on 7/19/21 and were roommates. On 8/2/21 at 12:05 PM, a urine odor was noted outside room [ROOM NUMBER]. On 8/2/21 at 3:46 PM, when a surveyor entered room [ROOM NUMBER], a strong odor of urine was noted. Resident #3 was in bed, awake. The privacy curtain was drawn between Resident #3 and Resident #16. When asked how Resident #3 was doing, Resident #3 replied Are you [name of her representative]. On 8/3/21 at 5:41 AM and 8/5/21 at 11:28 AM, Resident #3 was observed in the dining room and no urine odor was noted. (continued on next page)

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.

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

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F 0584 Level of Harm - Actual harm Residents Affected - Few	On 8/5/21 at 111:28 AM, LPN #3 stated the urine odor in room [ROOM NUMBER] was due to Resident #16. LPN #3 said Resident #16 was non-compliant and would only allow certain staff members to change her incontinence briefs. LPN #3 said Resident #16 refused a lot of peri-care and got angry with staff when they asked to change her incontinence brief. LPN #3 also said Resident #16 was able to go to the bathroom on her own and there were times she urinated on her way to the bathroom. On 8/6/21 at 7:46 AM, when a surveyor entered room [ROOM NUMBER] there was a strong odor of urine noted. Resident #3 was not in the room. The privacy curtain was drawn and behind the privacy curtain was Resident #16. She was eating her breakfast and looked appropriately groomed. Resident #16 said she was fine and being assisted by the staff as needed. The urine odor was more pronounced closer to Resident #16's area. On 8/6/21 at 7:52 AM, CNA #10 said Resident #16 had been educated and staff offered many times to change her incontinence briefs, as needed. CNA #10 said Resident #16 got angry when staff approached her to change her incontinence brief. CNA #10 said there were times Resident #16 would wear her regular underwear and staff applied a sanitary pad, but Resident #16 removed it. CNA #10 said the room was always cleaned but the smell lingered in the room because of Resident #16 being non-compliant with her peri-care. On 8/6/21 at 7:57 AM, the DON said Resident #3 was moved to room [ROOM NUMBER] about three weeks ago when the facility had an outbreak with COVID-19 and Resident #16 was also moved to room [ROOM NUMBER] at the same time. The DON said Resident #16 was incontinent of urine and wore incontinence briefs but was non-compliant with her personal hygiene. The DON said Resident #16 would remove her incontinence brief and urinate on the floor at bedside. The DON said Resident #16 was educated many times by the staff and her representative was also informed of her being non-compliant with personal hygiene. When asked about Resident #3 being in the same room with Resident #16, the DON said Resident #3 did not express any concern being in room [ROOM NUMBER] with Resident #16. Resident #3 was unable to express herself appropriately and experienced psychosocial harm when she was placed in a room with another resident who was non-complaint with her personal hygiene causing a strong odor of urine.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42371 Based on observation, staff interview, policy review, and record review, it was determined the facility failed to ensure professional standards of practice were met related to management of skin conditions. This was true for 2 of 12 residents (#8 and #191) reviewed for treatment and care. This placed residents at risk of adverse outcomes if cares and/or services were not provided appropriately. Findings include: The facility's skin assessment pressure ulcer prevention and documentation requirements policy, revised 4/21/21, defined a skin tear as an injury to the skin which resulted in separation of outer layers of the skin. It further stated a skin tear should be reported to a nurse and it should be monitored weekly, with documentation on the skin observation form and in the resident's care plan. This policy was not followed. 1. Resident #191 was admitted to the facility on [DATE], with multiple diagnoses of chronic obstructive pulmonary disease (a progressive lung disease characterized by increasing breathlessness), dementia, pruritis (itchy skin), chronic pain, and muscle weakness. a. Resident #191's care plan, revised 8/28/18, documented she had the potential for skin concerns due to pruritis and fragile skin. Interventions included monitoring the location, size and treatment of the injury, and reporting abnormalities, failure to heal, signs and symptoms of infection, maceration (skin breakdown due to moisture), etc. to the healthcare provider and weekly skin observations by a licensed nurse. Resident #191's care plan was not followed. A nursing progress note, dated 11/14/18, documented, Patient had some bloody spots on her blanket & sheets today. She has a scabbed over skin tear in a triangle measuring 1.5 cm by 1.3 cm. No blood as [sic] draining from that one. There are also two spots to her right shoulder that have scabbed over except the more distal one did break open again & there was some bloody faintly [sic] around the wound and through her shirt. The bleeding did stop already. No signs or symptoms of wound infection. An order for a wound culture for Resident #191's scabs on her back was entered in the MAR on 1/28/19. An order for Mupirocin ointment 2% was ordered on 1/31/19 for a staphylococcus (a bacterial infection) infection of the skin. Resident #191's record did not include documentation skin observations were performed from 11/14/18 to 2/26/19, 13 weeks after skin issues were documented. It could not be determined what care was rendered for Resident #191's identified skin issues during these 13 weeks. b. A skin observation form, dated 2/26/19, documented no skin conditions were observed for Resident #191. A skin observation form, dated 3/5/19, documented no skin conditions observed and Areas on bilateral arms remain & continue with treatment with mupirocin. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A skin observation form, dated 3/12/19, no skin conditions observed for Resident #191 and Continues treatment with bactoban on scabbed areas on arms. A skin observation form, dated 3/19/19, stated, Skin check Left hand (palm) areas scabbed. Right shoulder (front) Area 1 cm x 1 cm scabbed area no surrounding redness. A skin observation form, dated 3/26/19, stated a skin check was completed for Resident #191 and no skin conditions observed. However, the form documented Resident #191 was covered with multiple open eruption areas on both arms, upper and lower back, legs, waist, and both shoulders. The form further documented Resident #191 was constantly scratching reachable areas and remained on precautions for a skin staph infection and treatment with bactoban ointment to the areas was continued. The DON was interviewed on 8/6/21 at 9:20 AM, and Resident #191's record was reviewed in her presence. She confirmed there was no documentation of weekly skin assessments for 13 weeks as documented in Resident #191's care plan. She was not able to confirm what nursing care was provided from 2/26/21 to 3/26/19, when a staph infection had spread over most of Resident #191's body. The facility failed to ensure professional standards of practice were met related to management of Resident #191's skin conditions. 44886 2. Resident #8 was admitted to the facility on [DATE] with multiple diagnoses including vascular dementia and chronic atrial fibrillation (irregular heart beat). Resident #8's care plan documented she had potential skin impairment due to fragile skin. It stated her skin should be monitored for abnormalities and weekly skin observations should be conducted. On 8/4/21 at 2:45 PM, Resident #8 was observed sitting in her wheelchair in the day room. She had two skin tears on her left forearm which were dark-scabbed and appeared to be healing. They were partially covered with bandage strips. Resident #8's weekly skin observation forms, dated 7/28/21 and 8/4/21, documented no adverse skin conditions were observed on her or reported. On 8/5/21 at 11:50 AM, LPN #3 stated she did not know why Resident #8's skin tears were not documented during the skin observations. The facility failed to ensure Resident #8's skin condition was thoroughly assessed and abnormalities documented as noted in her care plan.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents received treatment and services to prevent further decrease in range of motion (ROM). This was true for 1 of 12 resident (Resident #3) reviewed for treatment and services related to ROM. This failed practice created the potential for harm when Resident #3 did not receive her restorative program as care planned to prevent deterioration of existing ROM limitations. Findings include: Resident #3 was admitted to the facility on [DATE], with multiple diagnoses which included Alzheimer's disease. A quarterly MDS assessment, dated 7/22/21, documented Resident #3 was severely cognitively impaired. Resident #3's care plan for restorative nursing, initiated 4/20/21, documented she was to receive the following: *Active range of motion (AROM): The goal was 15 minutes a week 6 days/week, finger AROM 10 repetitions and 10 repetitions of abduction and adduction thumb opposition. *AROM: thera-putty yellow (a type of soft therapy putty for strengthening). Encourage bilateral (both) hand manipulation, pulling, stretching and plastic piece removal, 15 minutes a day 6 days per week. *AROM: bilateral shoulder flexion/extension (move arm from side to above head), internal/external rotation, hands together 5-10 repetitions, 2-3 sets a day 6 days a week. *Passive/AROM: in soapy warm water for 5-10 minutes. Use plastic board and basin. Encourage her to open left hand frequently. Do not force stretch. Dry hand and apply splint to keep hand open for 30 minutes. *Apply soft splint to left hand 3-4 hours at a time. 2-3 hours breaks in the middle check for redness or discomfort. Splint to be stored in bedside table. On 8/4/21 at 5:20 PM, Resident #3's left fingers were observed to be contracted (tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) into a fist. CNA #3 and CNA #8 were present at the time. CNA #3 said Resident #3 should have a carrot shaped pad (positions the finger away from the palm to protect the skin from moisture, pressure and nail puncture) in her left hand when she was up and removed when she was in bed. CNA #8 said the carrot shaped pad should be in Resident #3's drawer. CNA #8 then looked for the carrot shaped pad in Resident #3's drawer. CNA #8 said the carrot shaped pad was not in Resident #3's drawer. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/5/21 at 12:12 PM, CNA #9 said she performed the restorative nursing program for the residents. CNA #9 said she soaked Resident #3's left hand in warm soapy water for 30 minutes every day. When asked about Resident #3's restorative nursing program, CNA #9 said she had not done Resident #3's restorative nursing program since the start of the COVID-19 program. When asked why, CNA #9 did not provide an answer. On 8/5/21 at 12:24 PM, the DON said Resident #3's restorative nursing program could be done in her room and should not have stopped even during the COVID-19 outbreak. The facility failed to implement Resident #3's restorative nursing program.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44886 Based on record review, policy review, and staff interview, it was determined the facility failed to provide adequate supervision to prevent falls. This was true for 1 of 2 residents (Resident #192) reviewed for falls. This failure created the potential for residents to experience bone fractures and other serious injury due falls. Findings include: The facility's fall prevention and management policy, revised on 4/6/21, documented the following: * The facility provided resident well-being by developing and implementing a fall prevention and management program. * The facility would identify risk factors and implement interventions before a fall occurred. * The facility would identify and review resident information for fall risk factors upon admission. * The facility would complete fall screening and identify fall risk factors. * The facility would update and personalize the resident's care plan with appropriate interventions. * The facility would communicate fall risks and interventions to staff members. * The facility would identify and communicate environmental changes or referral needs for the resident. This policy was not followed. Resident #192 was admitted to the facility on [DATE], with multiple diagnoses including type II diabetes, history of falling and unspecified dementia. Resident #192 sustained 8 falls between her admission on 1/20/21 and her discharge on 3/11/21, 7 unwitnessed falls and 1 witnessed fall. Resident #192's care plan stated she was at high risk for falls related to poor safety awareness and attempting to self-transfer, confusion, and gait/balance problems. Staff interventions initiated 2/9/21, included ensuring she was wearing slip-resistant shoes and not leaving her alone in her room while she was awake due to risk for attempting to self-transfer without calling for assistance. *An Incident and Accident (I&A) report, dated 1/20/21 at 8:15 PM, documented Resident #192 was found on the floor beside her bed, with a bump on her left forehead and a bruise on her left shoulder. A request was made for an alarm mat to be placed on the floor beside her bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An I&A report, dated 1/23/21 at 10:33 AM, documented Resident #192 was found seated on the floor next to her wheelchair. She had a golf ball-sized bump above her right eye. Following the IDT meeting, an alarm mat was placed in the resident's room and increased supervision was recommended. She was placed on one-to-one (1:1) monitoring with a CNA in her room. She was to be provided with frequent snacks and independent activities in her room. Sleep aids were requested from her physician. Resident #192's care plan was not updated with instructions for 1:1 monitoring with a CNA. An I&A report, dated 2/2/21 at 6:22 AM, documented Resident #192 was found on the floor lying next to her closet door. She had a l centimeter laceration on the back of her head which was bleeding. There was no documentation the resident was being monitored. An I&A report, dated 2/8/21 at 2:56 AM, documented Resident #192 was found on the floor in her room She had bruising and swelling on the right side of her face near her eyebrow. There was no documentation the resident was being monitored. On 2/9/21, the care plan documented an alarm mat was placed by the bed in Resident #192's room. The care plan was to be reviewed for changes in Resident #192's cognition, safety awareness, and decision-making capacity. An I&A report, dated 2/16/21 at 3:08 PM, documented Resident #192 stood up from her wheelchair in the activity room, fell to the floor and hit the right side of the back of her head, sustaining a lump on her head. There was no documentation the resident was being monitored. An I&A report, dated 3/4/21 at 9:00 PM, documented Resident #192 sustained an unwitnessed fall in the dayroom. She attempted to sit in her wheel chair without the brakes locked and fell on her buttocks. There was no documentation Resident #192 was being monitored. The IDT met, and anti-roll-back stabilizers were installed on her wheel chair. There was no mention of anti-roll-back stabilizers in Resident #192's care plan. An I&A report, dated 3/10/21 at 4:40 PM, documented Resident #192 had a witnessed fall in the dining room and hit her head. The IDT noted she needed increased supervision in her room. There was no documentation the resident was being monitored. On 3/10/21, Resident #191's care plan was updated to state staff were to observe her frequently when she was in her room. On 8/6/21 at 11:00 AM, the DON stated Resident #192 was very impulsive and would not call staff for assistance or wait for assistance even when staff members were near. She stated the facility provided 1:1 monitoring when they had available staff, but they did not have sufficient staff to provide continual 1:1 monitoring for Resident #192. Resident #192 experienced multiple falls with bruising and lacerations to her head and face as a result of the falls. The facility failed to ensure adequate supervision for Resident #192 to prevent falls.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40733 Based on observation, resident and staff interview, and review of resident records, facility policies, nursing schedules, and manufacturers' instructions, it was determined the facility failed to ensure infection control measures were consistently implemented when: - There was no designated staff working only with COVID-19 positive residents. - The physical barrier separating the COVID-19 positive unit from other units was not kept closed as required. - A COVID-19 negative resident was placed in the facility's COVID-19 positive unit. - Clinical staff failed to perform hand hygiene between glove changes. - PPE was improperly doffed and donned by clinical staff. - Residents were not offered hand hygiene before meals. - The facility used a cleaning agent that was not EPA-registered. These deficient practices created the potential for the spread of infectious organisms, including COVID-19, from cross contamination (the inadvertent transfer of harmful bacteria, virus, or another microorganism, from one person, object, or place, to another). COVID-19 is a new coronavirus caused by a virus that can spread person to person. This new virus has currently spread throughout the world. Symptoms range from mild to severe illness and even death. The failure of the facility to designate staff to work only with residents who were COVID-19 positive, placed all staff who tested negative for COVID-19 and all residents residing in the facility who tested negative for COVID-19, in immediate jeopardy of serious harm, impairment, or death related to COVID-19 infection. Findings include: 1. According to a typed document, undated, the facility documented a COVID-19 positive resident was identified on 7/12/21. The facility began testing all staff and residents every 6 days beginning on 7/16/21. Seventeen residents tested positive for COVID-19 between 7/12/21 and 7/27/21, 15 days. The facility did not implement infection prevention and control measures to prevent the spread of infection with COVID-19 as follows: a. The Centers for Disease Control and Prevention (CDC) website, accessed on 8/11/21, included the following guidance in the section Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes, updated 3/29/21, states: Identify HCP who will be assigned to work only on the COVID-19 care unit when it is in use. At a minimum this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents. If possible, HCP should avoid working on both the COVID-19 care unit and other units during the same shift. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility did not have dedicated nursing staff to work in the COVID-19 positive unit only. On 8/2/21, at 3:40 PM, a plastic barrier was in the facility's 200 hall, which covered floor to ceiling and wall-to-wall. The plastic barrier separated rooms 201 through 206 (the yellow zone) from rooms 207 through 214 (the red zone). Clinical staff were exiting the barrier from the red zone to the yellow zone to care for residents in both areas, creating the potential for the spread of COVID-19. On 8/2/21 at 4:45 PM, CNA #9 was observed exiting the barrier, from the red zone to the yellow zone. She then assisted LPN #1 with delivering a meal to Resident #28 in a third hall, who was negative for COVID-19. On 8/2/21, at 3:45 PM, LPN #1 was observed exiting the barrier from the red zone to the yellow zone. At 4:45 PM, she delivered a meal to Resident #33 in her room in the yellow zone. On 8/3/21, beginning at 3:06 PM, the DNS was interviewed. She confirmed LPN #1 and CNA #9 delivered care to COVID-19 negative residents in the yellow zone and COVID-19 positive residents in the red zone during the same shift. Daily Nursing Staffing schedules for 7/13/21 to 7/31/21 were reviewed. During this time the staffing schedules documented there was 1 licensed nurse scheduled to work at the facility during the following shifts: - On night shift, 10:00 PM to 6:00 AM, there was 1 licensed nurse working from 7/13/21 to 7/31/21. - On night shift, there was 1 CNA working on 7/21/21. - On evening shift, 2:00 PM to 10:00 PM, there was 1 licensed nurse working from 6:00 PM to 10:00 PM from 7/13/21 to 7/31/21. - On evening shift, there was 1 CNA working from 6:00 PM to 10:00 PM on 7/13/21, 7/14/21, 7/19/21, 7/20/21, and 7/28/21. - On evening shift there were no CNAs working from 6:00 PM to 10:00 PM on 7/21/21, 7/26/21, and 7/27/21. The DON and the Administrator were interviewed on 8/4/21, beginning at 9:47 AM. The DON stated she had not immediately designated staff for the COVID-19 positive unit when the outbreak began due to following corporate guidelines. The DON stated that they did not have the staffing resources to dedicate a night nurse for the red zone. The DON stated that mitigation efforts included asking for corporate assistance on 7/16/21, 4 days after the outbreak began, working 3 extra shifts herself, and to ask staff to work extra shifts. The DON stated that a travel nurse was to begin taking shifts on 8/5/21 but that nurse was only scheduled to be at the facility for 6 shifts. Documentation was not provided concerning asking staff to work extra shifts. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. The CDC's Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes, updated 3/29/21, states, Residents should only be placed in a COVID-19 care unit if they have confirmed [NAME]-CoV-2 infection. The facility policy Cohorting Plan for SNFs (Skilled Nursing Facilities), updated 4/17/20, documented to place residents who were symptomatic and suspected or tested positive for COVID-19 in the isolation area (red zone). Additionally, asymptomatic residents who had suspected exposure to COVID-19 were to be placed in the quarantine area (yellow zone). This policy and guidance was not followed. Resident #28 was admitted to the facility on [DATE], with multiple diagnoses including dementia and hypertension. On 7/23/21, she was transferred to room [ROOM NUMBER], in the yellow zone for quarantine due to possible exposure to COVID-19. Resident #28 tested negative for COVID-19 on 8/1/21 and was asymptomatic. On 8/3/21 at 2:45 PM, Resident #28 was no longer in room [ROOM NUMBER], in the yellow zone, and was transferred to room [ROOM NUMBER], in the red zone. In an interview on 8/3/21 at 4:43 PM, the DON confirmed Resident #28 was transferred to the red zone and stated a resident in the red zone, who had completed her isolation period, was having difficulty being away from her previous room, #201. She added there were no available beds in the facility for Resident #28, other than in the red zone, so she was transferred there. The DON also stated rooms #203 and #205, in the yellow zone, were unoccupied due to drywall repairs being performed. c. The following infection control breaches of the barrier separating the red zone from the yellow zone were observed: - On 8/3/21 at 5:05 PM, the plastic barrier separating the red and yellow zones was observed to be unzipped and partially open, allowing airflow from the red zone to the rest of the facility. When asked if the barrier was supposed to be closed, LPN #1, who was assigned to the red and yellow zones, stated, It should stay zipped all the time. On 8/3/21 at 6:10 PM, the plastic barrier was observed unzipped and partially open. CNA #1, who was working in the red zone, was asked about the open barrier and stated, I think it's supposed to be zipped up when we aren't using it. She then zipped the barrier closed. - On 8/4/21 at 4:27 PM Maintenance Staff #1 was standing in front of the barrier. The barrier was unzipped, and a folder was handed to the staff member. It was unknown if that folder had been sanitized. Maintenance Staff #1 stepped away from barrier for approximately 1 minute to place the folder out of sight, leaving the barrier unzipped. Maintenance Staff #1 returned to the plastic barrier and spoke to person behind barrier for approximately 2 minutes without zipping the barrier closed. The IP was interviewed on 8/3/21, beginning at 3:15 PM. She stated the barrier was to remain zipped closed when not in use. On 8/4/21 at 3:06 PM, the Administrator and the DON were informed by written and verbal notification of a determination of Immediate Jeopardy (IJ). (continued on next page)

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	135058	A. Building B. Wing	08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silverton Health and Rehabilitation of Cascadia	405 West Seventh Street Silverton, ID 83867

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/6/21 at 9:36 AM, the facility provided a plan to remove the immediacy which was accepted. The facility alleged compliance of removal of the immediacy on 8/5/21 at 4:30 PM. The facility's removal plan documented the facility would: (a) assign dedicated nursing staff to the COVID-19 positive unit, (b) transfer the COVID-19 negative resident out of the COVID-19 unit to a quarantine room (c) educate staff on CDC guidelines for co-horting residents. Surveyors completed an onsite verification of the implementation of the facility's Immediate Jeopardy removal plan and confirmed the immediacy was removed as of 8/5/21 at 4:30 PM. On 8/5/21 at 4:30 PM, the Administrator was notified the immediacy was removed based on onsite verification the IJ removal plan was implemented. Following the removal of the immediacy, noncompliance remained at no actual harm with the potential for more than minimal harm which was a pattern. 2. The CDC website, accessed on 8/12/21 and last reviewed on 1/8/21, stated, Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: - Immediately before touching a patient - Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices - Before moving from work on a soiled body site to a clean body site on the same patient - After touching a patient or the patient's immediate environment - After contact with blood, body fluids, or contaminated surfaces - Immediately after glove removal The CDC Hand Hygiene Recommendations, updated 5/17/20, documented hands should also be washed before eating, and after using the restroom. These guidelines were not followed. Examples include: a. On 8/2/21 at 4:50 PM, LPN #1 delivered and set-up Resident #4 and Resident #32's meals for them in their room. Before exiting the room, LPN #1 removed her gloves without performing hand hygiene afterward. She confirmed she did not perform hand hygiene after removing her gloves. b. On 8/4/21 at 4:00 PM, CNA #3 and CNA #8 performed hand hygiene and put on gloves. CNA #3 unfastened Resident #3's incontinence brief, took a wipe and cleaned Resident #3's suprapubic catheter around the insertion site and assisted her to turn on her left side towards CNA #8. CNA #8 supported Resident #3 by holding her left hip and left shoulder as CNA #3 then wiped the stool from Resident #3's bottom. CNA #3 removed the soiled incontinence brief and applied a new incontinence brief to Resident #3. CNA #3 did not change her gloves prior to putting a new incontinence brief on Resident #3. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA #8 assisted Resident #3 to lie on her back and CNA #3 fastened the incontinence brief. CNA #3 and #8 removed their gloves, performed hand hygiene and put on new gloves. CNA #3 and CNA #8 then helped Resident #3 to sit at her bedside. CNA #8 took Resident #3's shoes and applied it to Resident #3's feet. CNA #8 then looked for Resident #3's gait belt in her drawer, touched the folded clothes inside the drawer with her gloved hand she used when she applied the shoes to Resident #3. CNA #8 said she did not find Resident #3's gait belt and used the gait belt that was with her. CNA #3 and CNA #8 transferred Resident #3 to her wheelchair with the gait belt. On 8/4/21 beginning at 4:48 PM, CNA #3 and CNA #8 were interviewed regarding the observation of care for Resident #3. CNA #3 said she did not change her gloves before applying a new incontinence brief to Resident #3. CNA #3 said she should have changed her gloves, performed hand hygiene and put on new gloves before applying the new incontinence brief. CNA #8 said she assisted Resident #3 to put on her shoes and did not change her gloves when she looked for Resident #3's gait belt in her drawer. CNA #8 said she should have change her gloves before looking for the gait belt in Resident #3's drawer. c. On 8/2/21 from 11:25 AM to 1:10 PM, lunch trays in the 300 hall were being served to residents. The following was observed: - At 11:35 AM, CNA #5 delivered and set up a lunch tray for Resident #. CNA #5 did not offer Resident #19 hand hygiene prior to eating her lunch. - At 12:07 PM, CNA #3 delivered and set up a lunch tray for Resident #. CNA #3 did not offer Resident #40 hand hygiene prior to eating her lunch. - At 12:13 PM, CNA #5 exited room [ROOM NUMBER] without performing hand hygiene, grabbed 2 cups of coffee from the delivery cart, placed one cup back on the cart and re-entered room [ROOM NUMBER] without performing hand hygiene. - At 12:26 PM, CNA #7 delivered and set up a lunch tray for Resident #35. CNA #3 did not offer Resident #35 hand hygiene prior to eating him eating lunch. - At 12:29 PM, CNA #5 performed hand hygiene prior to entering Resident #15's room, but then exited without performing hand hygiene, touched 2 food delivery carts while selecting Resident #15's meal, then re-entered his room. CNA #5 did not offer hand hygiene to Resident #15 prior to eating his lunch. - At 12:30 PM, CNA #3 entered Resident #7's room to provide a beverage and did not perform hand hygiene prior to entering her room. - At 12:32 PM, CNA #7 entered Resident #15's room and did not perform hand hygiene prior to entering his room. d. On 8/2/21 beginning at 4:50 PM, dinner trays in the 200 hall were being served to residents. The following was observed: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- At 4:50 PM, LPN #1 delivered and set-up Resident #4 and Resident #32's meals for them in their room. LPN #1 did not offer hand hygiene to Resident #4 and Resident #32 prior to eating their dinner. -At 4:55 PM, CNA #9 delivered and set-up Resident #28 and Resident #33's meals for them in their room. CNA #9 did not offer hand hygiene to Resident #28 and Resident #33 prior to eating their dinner. On 8/2/21 at 5:00 PM, LPN #1 and CNA #9 said they did not offer hand hygiene to the residents when they delivered their meal trays. e. On 8/3/21 from 12:16 PM to 12:30 PM, lunch trays in the 100 and 300 halls were being served to residents. The following was observed: - At 12:16 PM, CNA #1 delivered and set-up Resident #11 and Resident #36's meal for them in their room. CNA #1 did not offer hand hygiene to Resident #11 and Resident #36 prior to eating their lunch. - At 12:21 PM, CNA #6 delivered and set-up Resident #16's meal for her in her room. CNA #6 did not offer hand hygiene to Resident #16 prior to eating her lunch. - At 12;24 PM, CNA #3 delivered and set-up Resident #31's meal for him in his room. CNA #3 did not offer hand hygiene to Resident #31 prior to eating his meal. - At 12:26 PM, CNA #3 delivered and set-up Resident #9's meal for him in his room. CNA #3 did not offer hand hygiene to Resident #9 prior to eating his meal. -At 12:30 PM, CNA#6 delivered and set-up Resident #21's meal for her in her room. CNA #6 did not offer hand hygiene to Resident #21 prior to eating her meal. On 8/3/21 at 12:33 PM, CNA #3 and CNA #6 said they did not offer hand hygiene to the residents when they delivered their meal trays. f. On 8/3/21 from 11:25 AM to 1:10 PM, lunch trays in the 300 hall were being served to residents. The following was observed: - At 12:18 PM, CNA #1 delivered and set up a lunch tray to Resident #. CNA #1 did not offer Resident #15 hand hygiene prior to eating him eating lunch. - At 12:23 PM, CNA #1 delivered and set up a lunch tray to Resident #. CNA #1 did not offer Resident #26 hand hygiene prior to eating her eating lunch. - At 12:25 PM, CNA #1 delivered and set up a lunch tray to Resident #. CNA #1 did not offer Resident #25 hand hygiene prior to eating her eating lunch. - At 12:28 PM, CNA #3 delivered and set up a lunch tray to Resident #27. CNA #3 did not offer Resident #27 hand hygiene prior to eating her eating lunch. - At 12:29 PM, CNA #1 delivered and set up a lunch tray to Resident #. CNA #1 did not offer Resident #7 hand hygiene to her prior to eating her eating lunch. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- At 12:31 PM, CNA #1 delivered and set up a lunch tray to Resident #29. CNA #1 did not offer Resident #29 hand hygiene prior to eating her eating lunch. - At 12:33 PM, CNA #5 delivered and set up a lunch tray to Resident #. CNA #5 did not offer Resident #19 hand hygiene prior to eating her eating lunch. Resident #15 was interviewed on 8/2/21, beginning at 12:36 PM. He stated that staff did not offer him hand hygiene prior to eating meals and sometimes did not wear masks. On 8/2/21 at 1:00 PM, Resident #27 stated that staff had never offered her hand hygiene prior to meals before today. On 8/3/21 at 1:38 PM, Resident #24 stated he was not offered hand hygiene or hand sanitizer prior to eating his lunch. On 8/3/21 at 1:40 PM, Resident #17 stated she was not offered hand hygiene or hand sanitizer prior to eating her lunch. She stated she kept her own bottle of hand sanitizer and performed her own hand hygiene. On 8/3/21 at 1:44 PM, Resident #21 stated she was not offered hand hygiene or hand sanitizer prior to eating her lunch. On 8/3/21 at 1:45 PM, Resident #40 stated she was not offered hand hygiene or hand sanitizer prior to eating her lunch. The DON was interviewed on 8/3/21, beginning at 1:38 PM. She stated the expectation was for staff to perform hand hygiene following CDC guidance. She stated staff should offer hand hygiene to residents prior to eating their meals. 3. The CDC website, accessed on 8/16/21, included a section Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes, updated on 3/29/21, which stated when caring for residents with suspected exposure and under quarantine HCP should wear an N95 or higher-level respirator, eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. This guidance was not followed. a. At 12:22 PM, LPN #1 donned a gown to enter Resident #11's room. Resident #11 was in quarantine from potential exposure to COVID-19. LPN #1's gown did not cover most of her back and LPN #1 did not don (put on) protective eyewear. b. At 12:10 PM, CNA #7 delivered and set up a lunch tray to Resident #11 who was in quarantine for potentially being exposed to COVID-19. CNA #7 did not don protective eyewear prior to entering Resident #11's room. c. At 8/4/21 at 4:55 PM, Maintenance Staff #1 was observed entering room [ROOM NUMBER], a quarantine room, wearing a mask. On the front of the door was a PPE kit. Maintenance Staff #1 did not don additional PPE prior to entering room [ROOM NUMBER]. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The DON was interviewed on 8/4/21, beginning at 5:00 PM. She confirmed all personnel entering rooms with residents under quarantine should don a gown, gloves, and protective eyewear. 4. The CDC guidance for environmental cleaning procedures for healthcare facilities to prevent the spread of COVID-19, website accessed on 8/12/21, documented all high-touch surfaces and floors should be cleaned and disinfected with an EPA-registered disinfectant from List N of disinfectants for COVID-19. This guideline was not followed. On 8/6/21 at 9:50 AM, the Environmental Services Director was interviewed and stated that the facility floors, including resident rooms, were cleaned daily with a cleaning agent labeled Neutral Floor Cleaner. When asked if the cleaning agent was EPA-registered on List N for COVID-19, she stated, after conferring with the vendor, that it was not. 36193 42371 44886