STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505528	A. BUILDING _____ B. WING _____	04/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEA HILL REHABILITATION AND CARE CENTER	32049 109TH PL SE AUBURN, WA 98092

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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews the facility failed to take appropriate actions related to a COVID-19 outbreak. These failed practices may have contributed to multiple residents and staff contracting COVID-19. As of 04/01/2020, based upon observation and staff interviews, three residents tested positive for Coronavirus disease (COVID-19) and 10 residents had pending lab results. Additionally the facility failed to operationalize their infection prevention and control program to provide a safe, sanitary environment, and to help prevent the development and transmission of communicable diseases and infections, in particular COVID-19. Findings included . On March 4th CMS (Center for Medicare & Medicaid Services) released a transmittal to nursing homes that directed nursing homes to monitor the CDC (Center for Disease Control) website which included a link to CDC. Upon clicking on the link it directs the facility to a Coronavirus Disease 2019 (COVID-19) Preparedness Checklist for Nursing Homes and other Long-Term Care Settings This checklist should be used as one tool in developing a comprehensive COVID-19 response plan. The checklist did not describe mandatory requirements or standards; rather, it highlights important areas to review to prepare for the possibility of residents with COVID-19. In general, when caring for residents with undiagnosed respiratory infection use Standard, Contact, and Droplet Precautions with eye protection unless the suspected [DIAGNOSES REDACTED].g., [MEDICAL CONDITION]). This includes restricting residents with respiratory infection to their rooms. If they leave the room, residents should wear a facemask (if tolerated) or use tissues to cover their mouth and nose. Continue to assess the need for Transmission-Based Precautions as more information about the resident's suspected [DIAGNOSES REDACTED]. On 03/29/2020 the facility reported to the Department three Residents (#1, 2, & 3) tested positive for COVID-19. On 04/01/2020 Residents #1, 2 & 3 were observed in rooms at the end of a hall, in what Staff B called the Red Zone. The area was secured behind a drop cloth with zippered entrance. All three resident rooms were on posted droplet precautions, with an Infection Control (IC) cart outside their rooms with Personal Protective Equipment (PPE). On a bench outside Resident #1's room was a pair of goggles. When questioned, Staff B stated, I don't know who put them there or if used or not. After exiting the Red Zone, there was no alcohol based hand sanitizer (ABHS) in the vicinity. Staff B moved an ABHS stand that was located at the end of the hallway, to be positioned outside the Red Zone. RESIDENT #4 Record review showed a 03/30/2020 progress note that resident was noted with fever on prior day and was to have COVID-19 test performed upon lab arrival on Tuesday (03/31/2020). Review of notes and temperature log showed no temperature above 98 degrees Fahrenheit (dF) on 03/29/2020. On 03/31/2020 Resident #4 had a dry non productive cough. On 04/01/2020 Resident #4 had an elevated temperature of 100.2 dF. Review of the progress notes and Care Plan (CP) showed no indication of if, when or why the resident was placed on precautions. Observations of the West Unit were conducted on 04/01/2020 with Staff B. Resident #4's door was posted with Contact Precautions with instructions to staff to clean hands when enter and exit, and donn gown and gloves. Staff B stated that Resident #4 was on precautions for an increased temperature, COVID-19 testing was planned for later in the day. RESIDENT #5 Record review showed on 03/28/2020 Resident #5 appears to be confused, and had an elevated temperature of 100.3 dF. Medical Doctor (MD) was notified. On 03/29/2020 an order was obtained for COVID-19 testing. On 03/31/2020 the head of bed was elevated slightly to ease breathing and COVID-19 test obtained. On 04/01/2020 the resident was noted with abnormal lunch sounds. Review of the progress notes and CP showed no indication of if, when or why the resident was placed on precautions. Observations on 04/01/2020 showed Resident #5's room was posted with Contact Precautions. Staff B stated that Resident #5 was on precautions for an elevated temperature and COVID-19 testing was collected 03/31/2020. RESIDENT #6 Record review showed on 03/29/2020 Resident #6 had a fever of 99.1 dF, was given Tylenol, and temperature dropped to 97.6 dF. Resident #6's Power of Attorney was notified an order was obtained for COVID-19 testing. On 03/31/2020 Resident #6 was on alert related to temperature greater than 99 dF in past 72 hours. Resident #6 exhibited some confusion and called 911. The COVID-19 test was collected on 04/01/2020. Review of the progress notes and CP showed no indication of if, when or why the resident was placed on precautions. Observations on 04/01/2020 showed Resident #6's room was posted with Contact Precautions. Staff B stated that Resident #6 was tested for COVID-19 on 03/31/2020 and results were pending. RESIDENT #7 Record review showed Resident #7 exhibited temperatures between 99.2 -99.4 dF on 03/29, 03/30, 03/31 and 04/01/2020. A 03/29/2020 progress note showed an order was obtained from the Medical Doctor for COVID-19 testing. The COVID-19 test was collected on 04/01/2020. Review of the progress notes and CP showed no indication of if, when or why the resident was placed on precautions. In addition, according to 03/29/2020 progress notes, resident requires constant reminder to stay in room as she forgets a lot and attempts to come out of room. Review of progress notes and care plan showed no indication the staff encouraged Resident #7 to wear a mask. Observations on 04/01/2020 showed Resident #7's room was posted with Contact Precautions. Staff B stated that Resident #7 was tested for COVID-19 on 03/31/2020 and results were pending. At 04:30 PM Resident #7 was observed not wearing a mask, to self propel her wheelchair, through closed double doors at the end of a hallway. Resident #7 stated, I don't know where I am. Staff A, Administrator assisted the resident back into her room. Resident #7 was later observed trying to leave the room again, and Staff C, Nursing Assistant, verbally cued the resident to stay in her room. RESIDENT #8 Record review showed Resident #8 was admitted to the facility on [DATE]. A Social Services Note on 03/30/2020 showed that Resident #8's spouse was told by Resident #8's ortho physician that the resident would not be able to complete follow up appointments due to positive COVID cases in the building. A late entry on 03/30/2020 showed a MD order was obtained for COVID-19 testing. Review of the progress notes and CP showed no indication of if, when or why the resident was placed on precautions. Observations on 04/01/2020 showed Resident #8's room was posted with Contact Precautions. Staff B stated that Resident #8 was placed on precautions on 04/01/2020 for an elevated temperature. On 04/01/2020 Staff C was observed to open Resident #8's door and step into the resident's room wearing a mask and no additional PPE. Staff B cued Staff C to stop and donn PPE. Staff C put on a disposable gown and gloves, but not a eye protection. Staff C asked Staff B, Do you want me to discard in the room?, and Staff B instructed Staff C to discard the PPE in the room, wash hands and exit. Staff C, notified Staff E Licensed Practical Nurse (LPN) that Resident #8 requested pain medications. Observations on 04/02/2020 showed Staff E opened Resident #8's door and began to enter the room to administer medications. Staff B directed Staff E to stop and donn PPE. Staff E donned gloves before the gown rather than gown before gloves. RESIDENT #9 Record review showed Resident #9 exhibited a fever of 99.6 dF on 03/26/2020, 100.0 dF on 03/28/2020, 99.3 on 03/29/2020, and on 03/30/2020 temperatures of 99.0, 99.7, 99.7, 99.1 dF, on 03/31/2020 of 99.5 dF. A 03/31/2020 progress note showed Resident #9 was on alert related to a temperature greater than 99 dF in 72 hours and COVID-19 testing to be completed on 03/31/2020. Review of the progress notes and CP showed no indication of if, when or why the resident was placed on precautions. Observations on 04/01/2020 showed Resident #9's room was posted with Contact Precautions. Staff B stated that Resident #9's baseline was a low grade temperature of 99 degrees Fahrenheit (dF), was immunocompromised so was placed on precautions. Staff B stated that a COVID-19 sample was collected for testing. On 04/01/2020 Staff E was observed wearing a mask, to donn a gown and gloves to serve Resident #9's dinner. Staff E did not wear eye protection. RESIDENT #10 Record review showed on Resident #10 exhibited a fever of 100.2 on 03/23/2020, and 99.6

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

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) dF on 03/24/2020. On 03/24/2020 the resident received Tylenol, and the MD was notified. Review of the progress notes, and CP showed no indication of if, when or why the resident was placed on precautions. Observations on 04/01/2020 showed Resident #10's room was posted with Contact Precautions. Staff B stated that Resident #10's oxygen saturation level (Sa02) was down around 89% so was placed on precautions with the plan to obtain COVID-19 testing. On 04/01/2020 Staff B was observed wearing a mask, to donn gloves and gown to serve Resident #10 dinner, but did not donn eye protection. Staff B doffed PPE out of sequence; mask, then gloves, then gown, then performed hand hygiene. RESIDENT #11 Observations on 04/01/2020 showed Resident #11's room was posted with Droplet Precautions. Staff D, Nursing Assistant, was observed to exit the room, remove the washable gown and walk away from the room. Staff B instructed Staff D to wash hands. In addition, Staff D had not worn goggles, which were located in the IC cart in front of the room. RESIDENT #13 Observations on 04/01/2020 showed Resident #13's room was posted with Droplet Precautions. Staff B stated that Resident #13 was tested on [DATE] and was COVID-19 negative, but the resident continued with symptoms of a fever or low Sa02, so another COVID-19 test was planned. RESIDENT #14 On 04/01/2020 at 4:04 PM Staff F, Nurse was observed to perform a blood glucose check on Resident #14. Resident #14 did not have posted precautions, and did not present with symptoms. Staff F was observed to take the whole bottle of strips into and out of the resident room, rather than only the one strip required for use. Observations on 04/01/2020 showed one IC cart was present for Residents #4, 5, 6 &7. The cart did not contain eye protection or a face shield. One IC cart was present for Residents # 8, 9, & 10. The cart did not contain eye protection or a face shield. When questioned, Staff A retrieved face shields from Staff B's office to be placed in the cart. Staff B located a face shield located on the mobile vital sign monitor. During an interview on 04/01/2020 when asked why Residents #s 4, 5, 6, 7, 8, 9, & 10 were not on Droplet Precautions, Staff B stated, They are. When informed the rooms were posted for Contact Precautions, Staff A stated, I'll go get the right ones. Staff B stated that he had asked Staff G, LPN to post Droplet Precautions. On 04/01/2020 when informed Staff B, C, and D were observed to incorrectly donn and/or doff PPE, Staff A stated that he arranged for Staff H, LPN to come and provide staff training. Refer to WAC 388-97-1320(1)(a)(2)(a)(b)(c) .