STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505485	A. BUILDING _____ B. WING _____	05/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LINDEN GROVE HEALTH CARE CENTER	400 - 29TH STREET NORTHEAST PUYALLUP, WA 98373

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

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F 0880 **Level of harm -** Immediate jeopardy **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, interview and record review, the facility failed to effectively implement actions to contain the spread of COVID-19, a [MEDICAL CONDITION] causing a respiratory illness with symptoms of a cough, fever, and in severe cases, difficulty breathing and/or death. 1. The facility staff failed to follow transmission-based precautions (using personal protective equipment including gown, gloves, masks, and eye protection). The facility infection control policy for COVID-19 dated 03/27/2020 included directives for staff to wear face masks, gloves, isolation gown and eye protection. 2. The facility staff demonstrated consistent cross-contamination while using PPE (Personal Protective Equipment) making it ineffective at protecting the person wearing it. This practice created exposure to staff which then could spread [MEDICAL CONDITION] to other residents if staff became infected. 3. The staff did not demonstrate consistent hand hygiene. Hand hygiene is instrumental in preventing the spread of pathogens and infections in healthcare settings. 4. The facility failed to consistently screen all visitors, therefore increasing the risk of virus exposure to staff and residents. 5. The facility failed to report the outbreak to the state agency. 6. The facility did not keep an accurate and clear infection control line list (surveillance tool) to track the residents/employees who may have been affected by the COVID-19 outbreak. The information gathered on this worksheet is used to determine duration of the outbreak, support monitoring for and rapid identification of new cases, and assist with implementation of infection control measures. Combination of these failures created a delay in containing COVID-19 outbreak and increased exposure to residents resulting in high likelihood of serious injury, serious harm, or death and required immediate action to prevent transmission of [MEDICAL CONDITION]. This constituted an Immediate Jeopardy. Findings included: Facility line listing provided on 05/12/2020 showed that on 05/04/2020 the facility had 12 staff and two residents who tested positive for COVID-19. An interview with a Collateral Contact (CC) from the local health department was conducted on 05/18/2020 at 4:56 PM. On 5/06/20, after testing South Hall the local health department confirmed and informed the facility of 52 COVID-19. On 5/08/2020 residents who lived on the North Hall were showing symptoms of possible respiratory infections. On 5/14/2020, six days later the facility tested residents and employees on the North Unit. On 05/19/2020 nine more residents and one employee were positive for COVID-19 on the North Side. The outbreak was no longer contained on one unit. As of 5/21/2020 the facility had 71 COVID-19 cases. SURVEILLANCE Record review on 05/19/2020 at 1:37 PM of an undated facility COVID-19 outbreak check list stated that suspected residents/staff will be immediately placed on the line listing (tracking document). CROSS-CONTAMINATION AND LACK OF HAND HYGIENE According to the Center for Disease Control (CDC) and Center for Medicare and Medicaid Services (CMS), the available evidence shows that the elderly are among those most likely to be affected by severe forms of the Covid-19 disease. The elderly have the highest percent of death after contracting [MEDICAL CONDITION]. The key factors in decreasing the transmission include but are not limited to staff knowledge of proper transmission precautions, hand hygiene, and appropriate PPE usage. Record review of the facility's policy titled Interim Policy for Suspected or Confirmed Coronavirus (COVID-19), dated 03/11/20 stated that modes of transmission include person to person spread via droplets, direct contact with infectious secretions from a patient with COVID-19, and indirect contact transmission via hand transfer of COVID-19 virus [MEDICAL CONDITION]-contaminating surfaces. The same policy identified expectations of performing hand hygiene before and after all patient contact, contact with infectious material, before and after removal of PPE. PPE USE policy provided on 05/12/2020 at 12:00 PM, included the following guidance: -Healthcare providers must take care not to touch their facemask. If they touch or adjust their facemask they must immediately perform hand hygiene. -When caring for residents suspected of having COVID-19, staff will use masks and eye protection. -Extended use of isolation gown includes wearing the same gown by a healthcare provider (HCP) when interacting with more than one patient known to be infected with the same infectious diseases when these patients are housed in the same location. Record review and interview with Staff B, DNS (Director of Nursing) on 05/12/2020 at 9:11 AM identified that as of 05/12/2020 29 residents tested positive for COVID-19 and 24 staff tested positive for COVID-19. The facility census was 100 on 05/12/20, indicating more than 25% of resident population was positive for [MEDICAL CONDITION]. Observations and interviews were completed on 05/11/2020 between 6:35 PM and 7:20 PM and 05/12/2020 between 5:12 AM and 7:10 AM with Staff A, Administrator, Staff B, Director of Nursing (DNS), Staff M, LPN, Staff J, LPN and Staff G, LPN. The facility set up a closed-off COVID-19 unit. This unit consisted of three hallways. Two of the hallways, Halls #2 and #3, housed COVID-19 positive residents. Hall #1, rooms 101-111, housed eight residents who had COVID-19 results pending and were a high exposure risk. The three hallways shared one nurses' station, a clean utility room, a staff break room, and a medication room. The signage in the COVID-19 unit instructed staff to wear N-95 masks and eye protection at all times while in direct care areas/hallways. The facility plan allowed using the same gown, mask, and eye-protection between residents' rooms and in Halls #2 and #3 (positive COVID-19 residents) to conserve PPE supply. Staff were expected to change the gowns and perform hand hygiene when going from Halls #2 and #3 to Hall #1. Observations of the COVID-19 unit on 05/11/2020 at 6:40 PM and 05/12/2020 at 5:15 AM revealed there was no clear physical and/or visual separation border between COVID-19 positive halls (#2 &#3) and COVID-19 hall (#1) with pending results. The physical layout of the unit did not have an identifiable or designated area for staff to safely change PPE and perform hand hygiene when going from Halls #2 and/or #3 to Hall #1. This set up allowed for ongoing cross-contamination. -Intermittent observations on 05/11/2020: On 05/11/2020 at 6:39 PM Staff F, LPN was wearing a disposable gown and assisted Staff H, NAR (Nursing Assistant Registered) helping Resident #2 in a TBP (transmission based precautions) room. Staff F, LPN and Staff H, NAR moved the resident in bed and positioned a dinner tray over the bedside table. Staff F, LPN left the room wearing contaminated gown and sat at the nurses' station. The gown came into contact with various inanimate objects at the nurses' station. At 7:00 PM Resident #1(from Hall #1) came up to the nurses' station and requested medication from Staff F, LPN. Staff F, LPN walked to the Hall #1 medication cart wearing the same contaminated gown and without performing hand hygiene started preparing medication administration for Resident #1 who did not have COVID-19 diagnosis. During the same observations the employee's contaminated gown came into contact with the medication cart and contaminated hands touched the resident's medicine cup which was lifted to the resident's mouth, where he would inhale through his mouth in order to get the pills from the cup into his mouth to swallow. During an interview with Staff G, LPN, and Staff F, LPN, on 05/11/2020 between 7:03 PM and 7:10 PM it was identified that Staff F, LPN, and Staff G, LPN floated to other units besides COVID-19 unit. Both staff also confirmed that there were only two nurses on duty on the COVID-19 unit today, but there should have been three nurses. One nurse for each hall. Staff G, LPN, and Staff F, LPN said they had 20 residents assigned each and had to cross over between Halls # 2 and #3 (COVID-19 positive unit) and Hall # 1 (pending COVID-19 results.) Both nurses verified that as of 5/11/2020 all Residents on Hall #1 are pending COVID-19 results. Both staff members explained that having 20 residents assigned to each nurse was difficult to manage due to the full PPE usage requirement. On 05/11/2020 at 6:37 PM Staff H, NAR entered Resident #2' room without performing hand hygiene. Resident #2 was on transmission-based precaution (TBP), according to the sign posted outside of the room, and based on the information on the [DIAGNOSES REDACTED]. Staff H, NAR contaminated her hands and left the room without performing hand hygiene. On 05/11/2020 at 6:41 PM

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 -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) Staff H, NAR entered a TBP room (Resident #3) without performing hand hygiene then touched inanimate objects in the room, and then left the room without performing hand hygiene. Staff H, NAR entered a second TBP room (Resident #4) with contaminated hands, moved items around the sink area, and left the room without performing hand hygiene. Staff H, NAR then walked over to the clean utility room and opened the door and removed clean linen with contaminated hands. This clean utility room was shared between all three halls. Staff H, NAR placed gloves onto the contaminated hands and entered the third TBP room (Resident # 5 &#6). Staff H, NAR walked over to the fourth TBP room, (Resident #7) and removed the gown outside of the room. Staff H, NAR grabbed the gown by the neckties and pulled it over her head contaminating herself. No hand hygiene was performed after the gown removal. With contaminated hands Staff H, NAR reached into a plastic container and removed a new gown, then walked over to the medication cart to get a pair of gloves. Staff H, NAR placed gloves over the contaminated hands. -Intermittent observations on 05/12/2020: On 05/12/2020 at 5:47 AM Staff I, NAC donned gown and gloves without performing hand hygiene first. Wearing a contaminated gown staff was observed pushing a gray bin labeled biohazard through Hall #1 and through the double doors into the facility lobby area, essentially taking contaminated material out of the designated COVID-19 wing and into the main entrance of the non COVID-19 area. On 05/12/2020 at 5:31 AM Staff I, NAC, and Staff L, NAC entered TBP room (Resident #8 and #9) to provide personal care. Both were wearing gowns and gloves. At 5:38 AM both staff members left the room after performing personal care. Both staff wore the same gowns. Both Staff I, NAC and L, NAC did not perform hand hygiene after removing contaminated gloves. At this time Staff I, NAC reached for a clean gown with contaminated hands then placed a second gown over a contaminated gown with the contaminated hands. Staff I, NAC at 5:41 AM removed the extra gown, did not perform hand hygiene and entered room [ROOM NUMBER] (Hall #1). Observation on 05/12/2020 at 6:05 AM, Staff M, LPN was at the nurses' station wearing an isolation gown. The gown came into contact with inanimate objects. At 6:07 AM Staff M, LPN walked over to Hall #1 without removing/changing the contaminated gown and without performing hand hygiene. Staff M, LPN's contaminated gown came into contact with a medication cart and the contaminated hands came into contact with inanimate items on the medication cart. Continued observations on 5/12/2020 at 6:14 AM, showed that Staff M, LPN was at the nurses' station wearing the same contaminated gown. The gown came into contact with inanimate objects again. At 6:17 AM Staff M, LPN did not remove/change the contaminated gown and did not perform hang hygiene and walked over to Hall #1 medication cart again. The contaminated gown and the contaminated hands came into contact with the medication cart on Hall #1. On 5/12/2020, Staff M, LPN at 6:32 AM was at the nurses' station wearing the same contaminated gown which came into contact with items at the nurses' station. Staff M, LPN used a computer shared between staff for documenting resident care. At approximately 6:35 AM Staff M, LPN again walked over to Hall #1 from the nurses' station wearing the same contaminated gown and with contaminated hands touched inanimate objections on the medication cart. On 5/12/2020, Staff L, NAC at 5:50 AM was within six feet of the nurses' station. The employee removed eyewear and adjusted the mask with her hands and without performing hand hygiene donned gloves onto the contaminated hands. Staff L, NAC removed gray bins labeled biohazard from Hall #2 &#3 and pushed those across Hall #1. Halfway through the hallway, Staff L, NAC returned to the nurses' station and removed the gown, and without performing hand hygiene placed another gown then returned to the bins and moved them outside of the COVID-19 unit and into the lobby area. On 5/12/2020 at 5:25 AM Staff I, NAC placed gloves on without performing hand hygiene. Staff I, NAC contaminated gloved hands by touching inanimate objects on Hall #2 and then touched her facemask and failed to perform hand hygiene. At 5:28 AM Staff I, NAC entered TBS room (Resident #8 &#9) then left the room without removing gloves and cleansing hands and walked into a clean utility room and removed linens with contaminated hands. On 5/12/2020 at 5:45 AM Staff J, LPN was at the nurses' station and used the shared computer and then proceeded to the med cart. Staff J, LPN donned a pair of gloves without cleansing hands first and started removing medications from the medication cart. On 5/12/2020 at 5:47 AM Staff I, NAC did not perform hand hygiene after removing a contaminated gown and then donned a clean gown and gloves using contaminated hands. On 5/12/2020, Staff N, NAC at 6:10 AM was observed touching a small cart with blood pressure cuff, thermometer and devices that is placed on residents' finger to measure the pulse and oxygen level. The cart is pushed into each room on every shift to check the status of each resident. The employee's gown came into contact with the equipment. At 6:13 AM staff entered the breakroom without removing his gown and performing hand hygiene, contaminating the area. On 5/12/2020, Staff O, NAC at 6:15 AM removed her gown and hung it outside of the break room, which was shared between the three units. Staff O, NAC entered the breakroom without performing hand hygiene, contaminating the shared breakroom. Observations conducted on 5/11/2020 and 5/12/2020 identified at least 20 missed opportunities to perform hand hygiene. FAILURE TO WEAR PROTECTIVE EYEWEAR (PPE) On 5/11/2020 at 7:03 PM Staff G, LPN said all residents on Hall 2 and 3 were positive for COVID-19, and staff wore PPE (gowns, masks, and eye-wear) inside and outside of the resident rooms to conserve supplies. On 5/11/2020 at 6:37 PM Staff F, LPN was observed without eye protection in the hallway with confirmed COVID-19 cases. At 6:39 PM Staff F, LPN was not wearing eye-protection and entered a TBP room (Resident #2). Observations on 5/12/2020 between 5:15 AM and 6:30 AM identified five nursing employees; Staff Me, NAC, Staff J, LPN, Staff K, LPN, Staff O, NAC and Staff L, NAC not wearing eye-protection (PPE) in the residents' rooms and/or care areas on the COVID-19 unit. SCREENING Review of facility policy titled Infection Control Policies and Procedures dated 3/27/2020 stated that active screening of employees, visitors, and other health care workers will be done upon entry into the center. The facility would screened for temperature, symptoms, and exposure risk, in attempt to limit the potential exposure to the COVID-19 virus. The surveyor was not immediately screened at the time of entrance to the facility on [DATE] at 6:35 PM and on 5/12/2020 at 5:10 AM. REPORTING OUTBREAK According to the facility infection control line listing, Resident #10 was tested on [DATE] with positive results for COVID-19 on 5/03/2020. Staff Q was tested on [DATE] with positive results on 4/30/2020. Record review of the agency reporting system Tracking Incidents in Vulnerable Adults on 5/19/2020 at 11:42 AM did not show that the above cases were reported to the state agency. According to the CDC the fatality rate among people age 65 and older is estimated to be between 11% - 27%. Long-Term care facilities are high risk settings for severe outcomes from COVID-19. The facility did not ensure that staff were [MEDICATION NAME] the basic infection control practices they had control over such as hand- hygiene and prevent cross-contamination. This contributed to failure to decrease the spread of the transmission, resulting in 71 COVID-19 cases. WAC Reference 388-97-1320(1)(a)(c)(2)(a)(b)(c)(5)