STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505434	A. BUILDING _____ B. WING _____	07/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LYNNWOOD POST ACUTE REHABILITATION CENTER	5821 188TH STREET SOUTHWEST LYNNWOOD, WA 98037

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 0835 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility Administration failed to effectively and efficiently manage the facility in compliance with state and federal regulatory requirements related to Infection Prevention and Control. This failure of the Administration resulted in an Immediate Jeopardy (IJ) on 07/01/2020, which had the likelihood to endanger the residents' safety and quality of life and had the potential to affect all residents. Additionally, the facility administration failed to ensure effective and on-going systems (administrative and clinical) were in place related to the overall Infection Control Program that resulted in a repeat citation from the last annual survey dated 12/20/19. Findings included . SCREENING HEATHCARE PERSONNEL During an interview and record review on 06/30/2020 at 12:20 PM, the Administrator stated that she was not aware that the facility's process for screening Healthcare Personnel (HCP) for COVID-19 (a highly communicable infection) was ineffective in minimizing the risk of exposure of residents and staff. According to the Administrator, she came to work around 7:00 AM on 06/30/2020, and did not notice that at least four staff and/or employees were allowed entry to the facility without being properly screened for COVID-19 symptoms. The Administrator stated that the screening documentation for HCP and visitors should have been accurately filled-out, completed and/or reviewed by the receptionist and herself at the start of each shift. The Administrator further stated that she was notified of these holes in the screening documentation earlier during the day, but had not taken action to correct the problems that were identified with screening. During an interview and record review with the Director of Nursing (DNS) on 06/30/20 at 12:30 PM, the DNS stated that four employees, Staff A, Certified Nursing Assistant/Activity Assistant, Staff B, Registered Nurse, Staff C, Licensed Practical Nurse (LPN), and Staff D, LPN were not screened accurately for COVID-19 symptoms and should have not been allowed to enter the facility per the facility policy and per the CDC guidelines as this could have increased the serious risks of residents and staff exposures to COVID-19. The DNS further stated that she was not aware of these concerns until after the surveyor had brought up the concerns with the specific staff person(s). POLICY IMPLEMENTATION AND STANDARDS OF PRACTICE Several observations on 06/30/2020 at 11:03 AM, 11:15 AM, and 12:05 PM showed Rooms #5, #12 and #41 had doorway signage indicating CONTACT PRECAUTIONS. The residents residing in these rooms were newly admitted from a local hospital: Resident #1 was admitted to the facility on [DATE]. Resident #1 had a pending COVID-19 test result and was placed on contact precaution. Resident #2 was admitted to the facility on [DATE]. Resident #2 had a pending COVID-19 test result and was placed on contact precaution. Resident #3 was admitted to the facility on [DATE]. Resident #3 had a pending COVID-19 test result and was placed on contact precaution. Resident #4 was admitted to the facility on [DATE]. Resident #4 had a pending COVID-19 test result and was placed on contact precautions. During an interview on 06/30/2020 at 11:03 AM, the Administrator stated that residents with pending COVID-19 test results should have been placed on droplet precautions but she felt that it was ok to only place them on contact precautions since it's only an extra precaution. The Administrator stated she was aware of the facility's written policy and that the Centers for Disease Control (CDC) recommended Droplet precautions. However, when asked why the facility did not implement their own written policy and the guidelines given by the CDC, the Administrator stated that she thought it was ok to just place these residents on contact precautions. HISTORY OF REPEATED CITATION During an interview on 06/30/2020 at 11:03 AM, the Administrator stated the facility had received a citation related to Infection Prevention and Control in December 2019, and a system should have been in place, including the facility's Quality Assurance Committee monitoring and/or planning to ensure continued compliance to both the state and federal regulations. A review of the facility's most recent annual survey dated 12/20/19, showed the facility failed to provide education and training to staff regarding highly contagious diseases, and had an incomplete infection control/prevention program. The facility's plan of correction showed an on-going monitoring should have been in place to ensure compliance related to this citation. See also CFR 483.80 - F880 - Infection Prevention & Control and the facility's most recent annual survey dated 12/20/19 for more information. Reference: (WAC) 388-97-1620 (1)
F 0837 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.** Based on interview and record review, the governing body failed to provide adequate oversight and monitoring of the appointed Administrator. The governing body failed to ensure the facility's Infection Prevention and Control policy was followed and implemented by the Administrator and/or the facility, which resulted to an Immediate Jeopardy (IJ) and placed all 53 residents of the facility in the likelihood for serious harm related to COVID-19 (a highly communicable infection). Findings included . A review of the facility policy titled, Governing Body dated 05/2020, showed The Governing Body is responsible for establishing and implementing policies regarding the management and operation of the facility. The facility's governing body included Staff Y, Administrative Market Leader (AML) and Staff Z, Clinical Market Leader (CML). The policy also showed, 1.The Governing Body will provide support and directions to the facility as is appropriate and consistent with applicable Federal regulations. 3. The Governing Body will receive information from the Administrator relative to the operations of the facility on a regular basis, and in any event, no less than quarterly. On 07/01/2020 at 3:00 PM, the facility was notified of the Immediate Jeopardy (IJ) situation related to CFR 483.80 F880 - Infection Prevention and Control. The facility failed to develop and implement an effective infection control program related to the required screening of healthcare personnel (HCP) for COVID-19, failed to follow and implement written policies and procedures related to the needed precautions for known and/or suspected COVID-19 residents, and failed to ensure staff maintained infection control practices to prevent the spread of infection and/or disease. During a meeting on 07/17/2020 at 11:30 AM, Staff Y, Administrative Market Leader and Staff Z, Clinical Market Leader, both Staff Y and Staff Z stated the facility's process for screening HCP prior to 06/30/2020 was not effective and they were not aware of the facility's practice of allowing HCP to enter the facility and provide direct resident care without being properly screened for COVID-19. Staff Y and Staff Z stated that they recently visited the facility on 06/04/2020 and 06/11/2020. Both Staff Y and Staff Z stated that they were not aware of any concerns during these visits related to the facility's infection prevention and control program, including any concerns with the facility's COVID-19 processes. A review of a follow-up electronic mail (email) communication from Staff Y, Administrative Market Leader dated 07/17/2020 at 3:37 PM, showed We were not aware that the screening process needed to be changed until the 6/30/2020 visit. The facility did not make us aware of a process

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

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F 0837 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) problem prior to 6/30/2020. Neither Staff Z nor I were aware that they were self-screening without verification of information at the beginning of shifts. The email also documented, As the governing body related to COVID-19 we have been providing the facilities with guidance from the CDC (Centers for Disease Control), CMS (The Centers for Medicare and Medicaid Services) and the local county jurisdictions. While we provide oversight, there are situations where we do not have firsthand knowledge of process errors. The Governing body failed to perform its duties and provide an oversight, support and directions to the facility to ensure that that the appointed Administrator and/or the facility follows and implement the written policies and procedures/standards of practice related to Infection Prevention and Control. The facility reported in April and May 2020 that there were at least 32 residents and 14 staff members tested positive for COVID-19 with 4 covid-related deaths. See also: F835 - Administration F880 - Infection Prevention and Control Reference: (WAC) 388-97-1620 (2)(c)
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure and maintain accurate clinical records for four of four residents (Resident #1, #2, #3 and #4) reviewed for transmission-based precautions. This failure placed residents at risk for harm and unmet care needs. Additionally, the facility failed to follow and implement written policies and procedures/standards of practice related to accurate documentations of the required health and/or COVID-19 screenings for Healthcare Personnel's (HCP). These failures placed all 53 residents of the facility in the likelihood for serious harm related to COVID-19 (a highly communicable infection). Findings included . COVID-19 SCREENING LOG FOR HCP A review of the facility screening log Start of Shift Employee Screening Log dated 06/30/2020, showed the facility failed to completely screen four employees from COVID-19 prior to the start of shift and prior to allowing access to the facility: Staff A, CNA/Activity Assistant (AA) COVID-19 screening questionnaire showed she had New Shortness of Breath or Difficulty Breathing at the start of her shift. Staff B, Registered Nurse (RN) COVID-19 screening questionnaire showed she only answered screening questions for temperature, cough, sore throat, and new shortness of breath or difficulty breathing. Staff B did not answer the rest of the COVID-19 screening questionnaires for symptoms of vomiting and/or diarrhea, chills and/or repeated shaking with chills, muscle pain, headache, sore throat, new loss of taste or smell, and whether she was asked to go home or was denied entry to the facility. Staff C, Licensed Practical Nurse (LPN) COVID-19 screening questionnaire showed her temperature was not taken and/or recorded prior to the start of shift and prior to allowing access to the facility. Staff D, LPN COVID-19 screening questionnaire showed he did not answer the screening question for sore throat. On 07/08/2020 at 4:29 PM, the Administrator emailed a copy of the same Start of Shift Employee Screening Log dated 06/30/2020. However, the screening log showed additional information that showed Staff B, RN and Staff C, LPN COVID-19 screening questions were answered completely. There was no indication that either information was a late entry documentation or where the information was obtained. A review of the facility's investigation report related to the COVID-19 screening process titled, LYNNWOOD PARK INVESTIGATION, dated 07/09/2020 showed, the facility's COVID-19 screening process for HCP was not effective on 06/30/20. The facility's screening process allowed a staff person (Staff A, receptionist) to enter additional COVID-19 screening responses/answers to any HCP at a later time if any symptoms were missed or omitted at the start of their shift. A process that allowed HCP to enter the facility without being properly screened for COVID-19 symptoms. The investigation also showed, Staff A, receptionist had added the temperature reading for Staff C, LPN later during the day. The investigation documented, as the receptionist had done on other days, she did update the form later in the day on 06/30/20 as was the facility process at that time. However, the investigation was not able to identify specific information on whose staff member were involved, what information was added and when these information were added. During a phone interview on 07/16/2020 at 4:30 PM, Staff B, RN stated that she could recall not answering and completing the COVID-19 screening questionnaires on 06/30/2020. Staff B also stated that no staff member had come to her and asked her about additional information related to her COVID-19 symptoms on 06/30/2020. Staff B further stated that she was not sure why the COVID-19 screening questions for her were answered or where did the information came from. During an interview on 07/17/2020 at 11:30 AM, Staff Y, Administrative Market Leader and Staff Z, Clinical Market Leader, both Staff Y and Staff Z stated they were not aware of any concerns related to the facility's infection prevention and control program, including any concerns with the facility's COVID-19 screening processes before 06/30/2020. Both Staff Y and Staff Z stated that they received additional information this morning on what could have happened regarding why the employee screening log dated 06/30/2020 had additional information from what was provided to the surveyor on 06/30/2020. A review of an electronic mail (email) communication from Staff Y, Administrative Market Leader dated 07/17/2020 at 3:37 PM, showed the facility had identified that Staff A, receptionist, added additional information to the original COVID-19 screening form dated 06/30/20 without verifying the symptoms and/or information to the appropriate staff member. CLINICAL RECORDS A review of the undated facility policy titled, Guidelines for Handling Corrections, Errors, Omissions, and other documentation problems showed when a pertinent entry was missed or not written in a timely manner, a late entry should be used to record the information in the health record. The policy directed facility staff to: A. Identify the new entry as a late entry. B. Enter the current date and time - do not try to give the appearance that the entry was made on a previous date or an earlier time. C. If the late entry is used to document omission, validate the source of additional information as much as possible (where did you get the information to write late entry. RESIDENT #2 Resident #2 was admitted to the facility on [DATE] from an acute care hospital. Resident #2 had a pending COVID-19 test result and was placed on contact precautions instead of droplet precautions. A review of Resident #2's clinical records showed no evidence of plan of care and/or care directives specific for the required infection precautions for staff to safely care and protect the residents and themselves from infection and/or COVID-19. RESIDENT #3 Resident #3 was admitted to the facility on [DATE] from an acute care hospital. Resident #3 had a pending COVID-19 test result and was placed on contact precautions instead of droplet precautions. A review of Resident #3's clinical records showed no evidence of plan of care and/or care directives specific for the required infection precautions for staff to safely care and protect the residents and themselves from infection and/or COVID-19. RESIDENT #4 Resident #4 was admitted to the facility on [DATE] from an acute care hospital. Resident #4 had a pending COVID-19 test result and was placed on contact precautions instead of droplet precautions. A review of Resident #4's clinical records showed no evidence of plan of care and/or care directives specific for the required infection precautions for staff to safely care and protect the residents and themselves from infection and/or COVID-19. RESIDENT #1 Resident #1 was admitted to the facility on [DATE] from an acute care hospital. Resident #1 had a pending COVID-19 test result and was placed on contact precautions instead of droplet precautions. A review of Resident #4's clinical records showed no evidence of plan of care and/or care directives specific for the required infection precautions for staff to safely care and protect the residents and themselves from infection and/or COVID-19. During an interview on 06/30/2020 at 11:15 AM, Staff F, Certified Nursing Assistant (CNA) stated that Resident #1's kardex (care directives) was missing information related to the required precautions that she needed to follow. During an interview on 06/30/2020 at 12:05 PM, Staff B, Registered Nurse (RN) stated Resident #2 and Resident #3's plan of care were missing information related to the required precautions that the staff needed to follow. However, on 07/01/2020 at 12:28 PM, the Administrator sent clinical records for Resident's #1, #2, #3 and #4. The clinical records and plan of care for the following residents showed documentation that these residents had specific plan of care and directive related to the required precautions and/or infection control. The care plans focus and interventions showed it was initiated before 06/30/2020. There was no evidence that the entries were made as a late entry. The surveyor requested and granted electronic medical records (EMR) access on 07/01/2020. A review of the similar records and care plans submitted by the Administrator for Resident's #1, #2, #3 and #4 showed that the care plan initiation dates were different than/dated prior to when the care plans were created and entered on the EMR. The care plan information specific for Infection control and transmission based precautions for Resident's #1, #2, #3, and #4 were created and entered to the EMR after the surveyor had requested the information (06/30/2020 and 07/01/2020). There was no documentation that the entries made for these residents were a late entry and where the information was obtained, as directed by the facility policy. During an interview on 07/07/2020 at 3:30 PM, the Administrator stated late entry documentations should be marked as late entry and should indicate the actual date it was created and/or entered in to the EMR. During a phone interview and record review on 07/17/2020 at 3:00 PM with the Administrator, Staff Y, Administrative Market Leader and Staff Z, Clinical Market Leader, the clinical records for

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) Resident's #1, #2, #3 and #4 were reviewed. The Administrator stated that the information should have been entered on the resident's clinical records immediately (during admission) to ensure staff have clear directives to meet the needs of each residents. Reference: WAC388-97-1720(1)(a)(i-iv)(b)
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 develop and implement an effective infection control program related to the required screening of healthcare personnel (HCP) for COVID-19 (a highly communicable infection), failed to follow and implement written policies and procedures related to the needed precautions for known and/or suspected COVID-19 residents, and failed to ensure staff maintained infection control practices to prevent the spread of infection and/or disease. These failures placed all 53 residents of the facility in the likelihood of serious harm and potentially death related to COVID-19 infection. The facility's failure to ensure healthcare personnel were adequately screened for symptoms of COVID-19 prior to entering the facility and properly apply the required personal protective equipment (PPE) and the failure to follow and implement standards of practice and written policies and procedures for infection control, constituted a situation of an immediate jeopardy (IJ). On 07/01/20 at 3:00 PM, the facility was notified of the IJ related to CFR 483.80 F880, Infection Prevention and Control. Findings included . According to the Centers for Disease Control (CDC), COVID-19 is an illness caused by [MEDICAL CONDITION] (coronavirus) that can spread from person to person. The CDC also stated that a person can become infected from respiratory droplets when an infected person coughs, sneezes or talks. Symptoms of COVID-19 included: Fever or chills, Cough, Shortness of breath or difficulty breathing, Fatigue, Muscle or body aches, Headache, New loss of taste or smell, Sore throat, Congestion or runny nose, Nausea or vomiting and Diarrhea. The CDC guidelines for COVID-19 included the following: A. Screen all Health Care Personnel (HCP) at the beginning of their shift for fever and symptoms of COVID-19. Actively take their temperature and document absence of symptoms consistent with COVID-19. If they are ill, have them keep their cloth face covering or facemask on and leave the workplace. B. HCP should wear a facemask at all times while they are in the healthcare facility, including in breakrooms or other spaces where they might encounter co-workers. C. Residents with known or suspected COVID-19 should be cared for using all recommended PPE, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. Healthcare Personnel (HCP): HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel). A review of the facility policy titled, EMERGING INFECTIOUS DISEASE (EID) EMERGENCY PLAN CORONAVIRUS 2019 (COVID-2019), dated 03/20/2020 and revised on 04/02/2020, directed facility staff to ensure facility policies and practices are in place to minimize exposures to respiratory pathogens including [DIAGNOSES REDACTED]-CoV-2, [MEDICAL CONDITION] that causes COVID-19. The policy also directed facility staff to: A. Implement active screening of residents and HCP for fever and respiratory symptoms. B. Take steps to ensure all persons with symptoms of COVID-19 or other respiratory infection (e.g., fever, cough) adhere to respiratory hygiene and etiquette and hand hygiene. C. Adhere to Standard and Transmission Based-Precautions. HCP who enters a room of a patient with known or suspected COVID-19 should adhere to Standard Precautions and use a respirator or face mask, gown, gloves and eye protection. FAILURE TO EFFECTIVELY SCREEN HCP FOR SYMPTOMS OF COVID-19 A review of the facility screening log Start of Shift Employee Screening Log dated 06/30/2020, showed the facility failed to completely screen four employees for symptoms of COVID-19 prior to the start of shift and prior to allowing access to the facility: Staff A, Certified Nursing Assistant/Activity Assistant (CNA/AA): COVID-19 screening questionnaire showed she had New Shortness of Breath or Difficulty Breathing at the start of her shift. Staff A was allowed entry to the facility even after identifying a new symptom of COVID-19. Staff B, Registered Nurse (RN): COVID-19 screening questionnaire showed she only answered the screening questions for temperature, cough, sore throat, and new shortness of breath or difficulty breathing. Staff B's screening questionnaire did not show answers on the rest of the COVID-19 screening questionnaire for symptoms of vomiting and/or diarrhea, chills and/or repeated shaking with chills, muscle pain, headache, sore throat, new loss of taste or smell, and whether she was asked to go home or was denied entry to the facility. Staff C, Licensed Practical Nurse (LPN): COVID-19 screening questionnaire showed her temperature was not taken and/or recorded prior to the start of shift and prior to allowing access to the facility. Staff C was allowed entry to the facility even without being properly screened for an elevated temperature and/or fever. Staff D, LPN: COVID-19 screening questionnaire showed he did not answer the screening question for sore throat. Staff D was allowed entry to the facility even without completing the screening of symptoms for COVID-19. During an interview on 06/30/2020 at 10:45 AM, Staff E, Receptionist, stated that healthcare personnel were only performing self-screening and that no staff member was assigned to screen visitors, staff, and/or employees specifically before and after her assigned shift. Staff E stated, her shift started at 7:00 AM and ended at 4:00 PM. Staff E also stated that all morning shift staff today (06/30/2020) had to self-screen themselves for symptoms of COVID-19 (the morning shift staff started before 7 AM). Staff E further stated that the facility policy and the CDC guidelines indicated that if any staff and/or visitors answered yes to any screenings questions, they would not be allowed to enter the facility due to the increased risk of COVID-19 exposure. During a joint record review of the Start of Shift Employee Screening Log, dated 06/30/2020, Staff E stated that she was not aware of the incomplete COVID-19 screening questionnaires for Staff A, Staff B, Staff C and Staff D. According to Staff E, she was not aware of the holes on the screening form because all of these employees came in before her shift started. During an interview on 06/30/2020 at 11:59 AM, Staff A, CNA/AA, stated that she had filled out the COVID-19 screening questions at the start of her shift indicating she had a new episode of shortness of breath and difficulty of breathing, but there was no manager or any person at the front desk to give her directions on what to do. Staff A also stated that she had not reported her symptoms to anybody as this was her first day back to work. Staff A further stated that she was one of the first employees who tested positive for COVID-19 during an earlier outbreak of COVID-19 in the facility and she was experiencing the same symptoms of the infection which had started yesterday. Staff A was assigned to unit Baker (long-term care unit) and stated that she was responsible for providing care to at least ten residents living in the unit. During an interview on 06/30/2020 at 12:02 PM, Staff D, LPN, stated that he had self-screened himself upon entry to the facility, but said he was not aware that he did not completely answer all the screening questions for symptoms of COVID-19. Staff D further stated that it was very important to accurately screen HCP for symptoms of COVID-19 prior to entering the facility for safety of the residents and staff, and to minimize the risk of exposure and spread of COVID-19. According to Staff D, there was no manager or any person at the front desk to review and/or verify his responses to the screening questions. Staff D was assigned to unit Baker and stated he was responsible for medication administration, treatment administration, and direct resident care/assessment for twenty-two residents. During an interview on 06/30/2020 at 12:05 PM, Staff B, RN stated that she self-screened herself upon entry to the facility, but she was not aware that she did not completely answer all the screening questions for COVID-19. Staff B further stated that it was very important to accurately screen HCP for COVID-19 prior entering the facility for the safety of the residents and staff, and to minimize the risk of exposure and spread of COVID-19. According to Staff B, there was no manager or any person at the front desk to review and/or verify her responses to the screening questions. Staff B was assigned to unit Puget (short-term/rehabilitation unit) and stated she was responsible for medication administration, treatment administration, and direct resident care/assessment for eighteen residents. Staff C, Minimum Data Set (MDS) assessment coordinator/LPN, was responsible for all the required MDS resident assessments and care coordination, and had access to all residents of the facility. During an interview and record review with the Administrator on 06/30/2020 at 12:20 PM, the administrator stated that Staff A, CNA/AA, Staff B, RN, Staff C, LPN and Staff D, LPN had not been properly screened for COVID-19 symptoms and should have not been allowed to enter the facility per the facility policy and per the CDC guidelines, as this could have increased the risk of resident and staff exposures to COVID-19. According to the administrator, the lack of proper screening could have been due to not having a staff member to screen the HCP at the start of their shift and allowing HCP to fill out the required COVID-19 screening questions. During an interview and record review with the Director of Nursing (DNS) on 06/30/2020 at 12:30 PM, the DNS also

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 3) stated that Staff A, CNA/AA, Staff B, RN, Staff C, LPN and Staff D, LPN had not been properly screened for COVID-19 symptoms and should have not been allowed to enter the facility per the facility policy and per the CDC guidelines, as this could have increased the serious risks of resident and staff exposures to COVID-19. A review of the facility's investigation report related to the COVID-19 screening process titled, LYNNWOOD PARK INVESTIGATION, dated 07/09/2020, showed the facility's COVID-19 screening process for HCP was not effective on 06/30/2020. A process that had allowed HCP to enter the facility without being properly screened for COVID-19 symptoms. During an interview on 07/17/2020 at 11:30 AM, Staff Y, Administrative Market Leader and Staff Z, Clinical Market Leader, both Staff Y and Staff Z stated that the facility's process for screening HCP prior to 06/30/2020 was not effective and they were not aware of the facility's practice of allowing HCP to enter the facility and provide direct resident care without being properly screened for COVID-19. The facility reported in April and May 2020 that there were at least 32 residents and 14 staff members tested positive for COVID-19 with 4 resident COVID-19 related deaths. FAILURE TO IMPLEMENT INFECTION CONTROL MEASURES RELATED TO PERSONAL PROTECTIVE EQUIPMENTS (PPE) AND HAND HYGIENE An observation on 06/30/2020 at 11:30 AM showed Staff A, CNA/AA standing in unit Baker (long-term care unit) hallway not wearing her surgical mask properly. Staff A's nose and mouth were not covered by the surgical mask. Staff A's surgical mask was placed and lowered to Staff A's neck area. Staff A was having difficulty breathing and signs of shortness of breath. Staff A then entered room [ROOM NUMBER] at 11:35 AM and room [ROOM NUMBER] at 11:48 AM to which she provided assistance to the residents by handing them their call lights and help set-up the residents' immediate environment. Additionally, Staff A was having episodes of non-productive coughing during these encounters with the residents in room [ROOM NUMBER] and room [ROOM NUMBER] while her surgical mask was lowered to her neck area. Staff A did not perform any form of hand hygiene (hand washing or hand sanitizer use) in-between residents. During a joint interview and observation on 06/30/2020 at 11:59 AM, Staff D, LPN approached Staff A, CNA/AA together with the surveyor about her improper use of the surgical mask. Staff D told Staff A that she was not wearing her surgical mask properly and that her nose and mouth should be covered at all times, especially when she was in the hallway and/or resident rooms. Staff A told Staff D that she was not able to wear the surgical mask because she had shortness of breath and was having difficulty of breathing. Staff A also stated that she knew the purpose of wearing the surgical mask was to protect the residents and others from COVID-19. Staff A stated that she had failed to protect the residents from her symptoms, but she had no other choice as she was not able to tolerate wearing a surgical mask. Staff A also stated that she had filled out the COVID-19 screening questions at the start of her shift indicating she had a new episode of shortness of breath and difficulty of breathing, but there was no manager or any person at the front desk to give her directions on what to do. Another observation on 06/30/2020 at 12:15 PM (after speaking with Staff D, LPN) showed Staff A CNA/AA again had her surgical mask lowered to her neck area with her nose and mouth uncovered. Staff A then entered room [ROOM NUMBER] and assisted the resident with her meal. FAILURE TO IMPLEMENT FACILITY POLICY AND CDC GUIDELINES RELATED TO THE REQUIRED TRANSMISSION BASED PRECAUTIONS FOR RESIDENTS WITH PENDING COVID-19 TEST RESULTS. A joint observation with the Administrator on 06/30/2020 at 11:03 AM, showed a sign on the doorway of room [ROOM NUMBER] indicating CONTACT PRECAUTIONS. The Administrator stated that the resident in room [ROOM NUMBER], Resident #1, was a newly admitted resident of the facility. Resident #1 was admitted to the facility on [DATE] from a hospital. According to the Administrator, Resident #1 was placed on contact precautions because the resident had a pending COVID-19 test result. The administrator stated that all new admissions were placed on contact precautions while waiting for their COVID-19 test results. However, when asked what was the facility's policy and what was the CDC's guidelines on the required transmission-based precautions for residents with suspected COVID-19/pending COVID-19 test results, the Administrator stated that residents with pending COVID-19 test results should have been placed on droplet precautions. The Administrator stated that she felt that it was ok to place the new residents on contact precautions since it's only an extra precaution. Similar findings were applicable to Resident #2, Resident #3 and Resident #4. Resident #2 was admitted to the facility on [DATE] from a hospital. Resident #2 had a pending COVID-19 test result and was placed on contact precautions instead of droplet precautions. Resident #3 was admitted to the facility on [DATE] from a hospital. Resident #3 had a pending COVID-19 test result and was placed on contact precautions instead of droplet precautions. Resident #4 was admitted to the facility on [DATE] from a hospital. Resident #4 had a pending COVID-19 test result and was placed on contact precautions instead of droplet precautions. During an interview and observation on 06/30/2020 at 11:15 AM, Staff F, NAC, stated that Resident #1 was on contact precautions. Staff F stated that staff were not required to wear gown, gloves, and face shields unless they provided direct resident care/contact. Staff F also stated that Resident #1's kardex (care directives) did not contain any information regarding the required infection control precautions that she needed to follow. Staff F then entered Resident #1's room and provided care without wearing a gown, gloves and face shield. During an interview and observation on 06/30/2020 at 12:05 PM, Staff B, RN stated that Resident #2 and Resident #3 were both on contact precaution due to their pending COVID-19 test results. However, when asked what was the facility policy and the CDC guidelines for residents with suspected or pending COVID-19 test results, Staff B stated that the precautions should have been droplet precautions and staff should have been wearing a complete set of PPE's such as face mask, gown, gloves, and face shield when entering the resident's room. Staff B also stated that the resident's plan of care did not include information related to the required precautions that the staff needed to follow. A review of Resident #1, Resident #2, Resident #3 and Resident #4's clinical records showed no evidence of a plan of care and/or care directives specific for the required infection precautions for staff to safely provide care and protect the residents and themselves from infection and/or COVID-19. FAILURE TO FOLLOW THE REQUIRED ISOLATION PRECAUTIONS An observation on 07/07/2020 at 3:00 PM showed Staff G, NAC/floor supervisor, enter room [ROOM NUMBER] wearing a surgical face mask. room [ROOM NUMBER] had a signage that showed, Droplet Precautions. During an interview at the time of the observation, Staff G stated that the room was on isolation due to the potential exposure of COVID-19 and that the resident in the room had a pending COVID-19 test. Staff F also stated that the isolation sign showed that staff entering the room should be wearing a complete set of Personal Protective Equipment (PPE) including a face mask, gown, gloves and a face shield. However, Staff F stated that since he was only delivering a bag of incontinent supplies to the resident, he did not think about wearing all of the required PPE and stated, I should have followed the precautions. During an interview on 07/07/2020 at 3:30 PM, both the DNS and Staff H, Infection Control Nurse (ICN) stated that Staff G should have followed the required precautions of wearing full PPE prior to entering a room with suspected and/or pending COVID-19 test results. This is a repeat citation related to F880 - Infection Prevention and Control from the last annual survey dated 12/20/19. See also: F835 - Administration F837 - Governing Body F842 - Resident Records - Identifiable Information Reference: (WAC) 388-97-1320 (1)(a)(b)(2)(a)(b)