STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505488	A. BUILDING _____ B. WING _____	04/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RICHMOND BEACH REHAB	19235 - 15TH AVENUE NORTHWEST SHORELINE, WA 98177

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, interview, and record review, the facility failed to implement infection control procedures to provide a safe sanitary environment to help prevent the development and transmission of communicable diseases and infections while providing resident care and services without hand hygiene for residents on droplet precautions for possible respiratory illness for six of six residents sampled during observation, (Resident #1, 2, 3, 4, 5, 6), and on 2 of 5 facility units; the facility failed to provide disinfection of non-disposable resident care equipment after care of a resident on droplet precautions for possible respiratory illness (Resident #1). The facility also failed to provide evidence of visitor assessment screening to prevent communicable diseases in the facility. These failures placed residents and staff at risk of possible widespread infection of a communicable disease/infection in the facility. Findings included . VISITOR SCREENING FOR COVID-19 Record review of the facility COVID-19 Screening Form provided by the facility for screening of anyone who visits the facility showed the form required the visitor to complete the following questions: Purpose of visit, Temperature, Do you have symptoms of fever, cough, shortness of breath?, Have you travelled within last 14 days?, Have you had close contact with anyone with confirmed COVID-19 within 24 days? Upon entrance to the facility on [DATE] at 10:30 a.m., Staff D, a receptionist, did not complete a visitor assessment with screening questions for the surveyor. The surveyor then asked the facility Administrator (when she arrived shortly afterwards to the front desk) if there was an assessment/screening process. The Administrator stated there was a process, and provided a copy of the assessment for the surveyor at that time, and instructed the receptionist that every visitor needed a screening assessment. Also at that time, the surveyor requested to see the assessment/screenings for the visitors in the facility (visitor log) for [DATE], but the facility was unable to locate them. The facility did not have a visitor assessment/screening for a [DATE] visitor from the lab, [DATE] visitor from x-ray, and [DATE] visitor (nurse practitioner). The facility still could not produce the visitor screening assessments asked for above at 1:50 p.m. The Administrator stated that the facility had 23 staff out with either COVID-19 symptoms or COVID-19 positive tests, and some were in the hospital. The facility Administrator also stated that all residents on isolation were on droplet precautions for infection control. Per the Center for Disease Control dated 2020 definition: COVID-19 is a new disease caused by a novel coronavirus that has not been previously seen in humans) INFECTION CONTROL PRACTICE FAILURES RESDENT #1 and RESIDENT #2 Review of facility medical records showed Resident #1 resided in the facility for long term care and was [AGE] years old. The facility infection control log, dated [DATE], showed Resident #1 had not been tested for COVID-19 and was being monitored for temperature elevations: On [DATE], the temperature was 100 degrees Fahrenheit(F). Resident #1 was on Droplet precautions. During an interview on [DATE] at 1:50 p.m., the Director of Nursing(DNS) stated that Resident #1 had had intermittent fevers and had been roommates with Resident #2 for a long time. Resident #2 also resided in the facility for long term care and was [AGE] years old, and had no signs or symptoms of COVID-19, had not been tested for COVID-19, and was also on Droplet precautions due to possible exposure. Record review of the facility Droplet Precautions signage provided by the Director of Nursing showed everyone must clean their hands when entering and leaving the resident room, and wear a mask. In addition, staff must also wear eye protection, gloves, and gown. Review of the facility Droplet Precautions procedure showed the staff should wash or gel hands, don(put on) a gown if needed, eye cover if needed, put on a mask to enter room, gloves if needed, and wash or gel hands when leaving room. Review of the facility Hand Hygiene policy, dated [DATE], provided by the facility showed the following was included in the required hand hygiene list by staff: Hand hygiene is performed before and after entering isolation rooms, after direct resident contact, after handling resident equipment, after removing gloves. Observation on [DATE] at 12:05 p.m. showed Staff A, a nurse aide, bring a meal tray to Resident #1 wearing a mask, but not wearing gloves, gown or eyewear. Staff A set the meal tray down, adjusted the bedside table and bed controls, and then went back to cart in hall. Staff A got another meal tray, went to another room, but did not perform any Hand hygiene and then went to the tray cart. Staff A took a meal tray to Resident #2 and placed it on the bedside table, without performing Hand Hygiene, went to the linen cart, got linen, and took the linen to Resident #2. Staff A then brought a hot plate cover from Resident #2's meal tray out to the hall, and placed the plate cover inside the tray cart with other dining trays. Staff A pulled his mask down off his face in the hallway, and was readjusting trays in the dining cart with the mask not covering his nose. During an interview 12:45 p.m., Staff A stated, When delivering trays, we only need a mask and only apply gown and gloves for direct resident care, nothing else is done between delivering residents' meal trays in between residents. Observation on [DATE] at 12:32 p.m. of Resident #1's room showed Staff B, a licensed nurse, enter the the resident's room with the vital signs machine. At that time, Staff B was only wearing gloves and a mask tied only at the top with the mask bottom untied and strings hanging down on his shoulders. Staff B took an oral temperature for Resident #1 without wearing a gown or eye wear, and left the room with the same gloves still on. During an interview at that time, Staff B stated that the resident's temperature was 99.2 degrees F and he gave [MED] to Resident #1 who has had previous temperatures of 101 degrees F or 102 degrees F. Staff B then walked back to the nurses station and put the vital sign equipment at the station without cleaning it, went back to the medication cart and removed his gloves, put the gloves in the trash, touched the computer keyboard on the medication cart, and did not perform any Hand Hygiene and still wearing the untied mask. Staff B then pulled his mask down to his chin in the hallway. During an interview at 12:45 p.m. Staff C, a nurse aide, stated that they usually had one person do vitals and disinfect equipment after use with wipes from the container with the red top on the cart, and then store the equipment for next person. During an interview on [DATE] at around 12:50 p.m., Staff E, a nurse aide, also stated that the procedure was to clean the vital signs machine, including the thermometer and the [MED]gen machine, with wipes in a disinfectant container with a red top. During an interview on [DATE] at 2:00 p.m. the facility DNS stated that Resident #1 had since deceased in the hospital on [DATE] with a COVID-19 positive test. RESIDENT #3 and RESIDENT #4 Review of facility record showed Resident #3 resided in the facility for long term care and was [AGE] years old. The facility infection control log, dated [DATE], showed Resident #3 was being monitored for elevated temperatures, last temperature of 99.6 degrees F, had an inconclusive COVID-19 test, and was on Droplet Precautions. Resident #4 resided in the facility for long term care and was [AGE] years old. Resident #4 had no signs or symptoms of illness, had one temperature slightly elevated, and was not listed in the infection control log. Observation on [DATE] at 12:02 p.m. showed Staff C, a nurse aide, had only a mask on when she entered the room of Resident #3 (who was on Droplet Precautions), and placed the tray on bedside table. Staff C then moved the table closer to the bed, so the tray was directly in front of the resident, and touched the bed controls to raise the head of the bed as Resident #3 coughed over the tray with the plate cover on it. Staff C removed the plate cover with no gloves, took the cover to the dining cart in hall, put the cover inside cart with other trays, and removed another tray and delivered it to another room for Resident #4 without performing hand hygiene in-between rooms. In addition, Staff C placed the tray on the sink in the room of Resident #4, picked a glove up off floor, and put it in the trash. Staff C still did not perform Hand hygiene, and went back to dining cart in the hall. During an interview on [DATE] at 10:15 a.m., the DNS stated that Resident #4 had not had a COVID-19 test, had only one elevated temperature, and no other previous symptoms.

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) However, the DNS stated that on [DATE], Resident #4 did have some symptoms of illness, had a temperature of 101.3 degrees F, and went out to the hospital. During an interview on [DATE] at 2:00 p.m., ten days later, the Director of Nursing stated that Resident #4 was coming back to the facility for comfort care and had a positive COVID-19 test at the hospital. RESIDENT #5 Observation on [DATE] at 12:02 p.m. showed Staff C, a nurse aide, take a dining tray from the hall dining cart, and entered the room for Resident #5, who had tested positive for COVID-19 per the infection control log. Staff C wore only a mask and did not wear gloves, delivered the tray, did not perform Hand hygiene, went back to the hall dining cart, removed a tray, and delivered it to Resident #6, who was not COVID-19 positive and in another room. During an interview on [DATE] at 1:50 p.m., the surveyor notified the DNS, who was also the acting Staff Development and Infection Control Preventionist for the facility, that staff were not doing hand hygiene in-between residents when delivering lunch trays going from isolation rooms to non-isolation rooms, and then returning to the dining cart to pick up more trays. The DNS stated that the staff should be performing hand hygiene before entering and exiting resident rooms, and in-between tray deliveries. The facility staff failed to provide care and services to prevent infection spread in the facility and placed residents at risk for infection from COVID-19 or other illnesses. On [DATE], the DNS stated that the facility totals for COVID-19 were as follows: Eleven residents in the facility were COVID-19 positive; fifteen resident deaths from COVID-19; six residents in the facility with suspected illness, and one resident in the hospital. Reference (WAC) [DATE](1)(c)(3)(5)(6)