STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505470	A. BUILDING _____ B. WING _____	**06/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COLUMBIA LUTHERAN HOME	**4700 PHINNEY AVENUE NORTH SEATTLE, WA 98103**

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 -** Some	**Provide and implement an infection prevention and control program.** Based on observations, interviews, and record reviews, the facility failed to ensure staff consistently followed isolation and droplet precautions for three of four residents (# 1, #2, #3) who the facility determined needed to have isolation (droplet) precautions in place. Failure to ensure facility protocols to minimize the risk for transmission of airborne droplets were consistently followed increased the risk for community transmission of the COVID 19 infection. Findings included . During an entrance conference on 06/26/2020 at 11:45 AM, the Administrator, the Director of Nursing Services (DNS), and the Infection Control Preventionist (ICP) stated that the facility currently had two residents who had just admitted from the hospital were on quarantine. When asked to describe what quarantine meant for these residents, the ICP stated that even though the two residents had tested negative for COVID 19 prior to admission, these residents remained in isolation and droplet precautions for 14 days after admission or readmission from a hospital. An observation during a tour of the first floor on 06/25/2020 at 11:55 AM showed the hall doors were closed on either side/end of the hall, partitioning off the administrative offices and reception area from the residents' rooms. A sign posted on the doors notifying anyone entering the area should be wearing a face mask. An observation on 06/25/2020 at 12:00 PM, found Staff A, an activities staff, seated at the bed side, feeding Resident # 1. There was approximately 1 to 1.5 feet between the resident and staff. Staff A had a face mask hanging from one ear and the face mask was not covering his nose & mouth. Staff B, a Resident Care Manager, walked by the room during the observation, and when asked, he stated that all staff should be wearing a face mask. After he was directed to Resident #1's room (where Staff A was assisting with the meal) he entered the room to advise the staff to place the face mask on. An observation on 06/25/2020 at 12:05 PM showed a sign posted on Resident #2's doorway indicating the resident was on isolation and droplet precautions, and staff were directed to sanitize their hands, and wear mask, gown, gloves and face-shield/goggles prior to entering the room. There was also a cart by the doorway that contained isolation supplies (gowns, goggles, hand sanitizer, and sanitizing wipes). Staff C, a Social Worker, approached Resident #2's room, and knocked on the resident's closed door. Staff C then opened the door and verbally requested to enter the room. Although Staff C was wearing a mask, Staff C did not sanitize their hands, wear a gown or a face-shield upon entering the resident's room. After exiting the room, Staff C, acknowledged the precautions posted outside the door and stated that she had entered the room to take a picture of Resident #2 for the clinical record. Staff C then displayed the small camera she had taken into the room. When asked if she was going to sanitize the device, she stated it was a good idea, but exited the area without cleaning the equipment or sanitizing her hands. During an interview on 06/25/2020 at 12:25 pm, Staff D, a Licensed Nurse assigned to provide care for Resident #3 was asked about isolation and droplet precautions. Staff D stated Resident #3 was a new admission to the facility and was currently under quarantine and droplet precautions. Staff D stated that the precautions for entering the resident room were posted on the door frame. Staff D stated that hand hygiene was completed first, and then a clothing protector (gown) and gloves. Staff D stated that staff entering the room would also wear a N 95 respirator mask and place a surgical mask over the respirator, and place eye protection. Staff D stated that when exiting the room, the gown and gloves were removed and discarded in the room, then the surgical mask was discarded, hand hygiene was completed, and new surgical mask was placed over the N 95 respirator mask. An observation on 06/25/2020 at 12:40 PM showed Staff E, an Occupational Therapist (OT) entered Resident #3's room. The OT did not perform hand hygiene, put on a gown, an eye shield, or put on gloves prior to entering the room. The OT approached the resident and engaged in conversation while standing within 2 feet of the resident. Although a surgical face mask was worn, the staff was not wearing an N95 respirator or an eye shield. After exiting the room, the face mask remained in place. When asked about the precautions posted on the door, Staff E stated she had removed her gloves, gown, and washed her hands prior to exiting the room (previously), but then had returned to the room to talk with the resident. Not ensuring the infection control policy concerning isolation and droplet precautions were followed consistently to mitigate the risk for community transmission of COVID 19 placed the residents residing in the facility at risk for the infection. Reference (WAC) 388-97-1320 (2)(a)

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.