STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505280	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RENTON NURSING AND REHABILITATION CENTER	**80 SOUTHWEST SECOND STREET RENTON, WA 98057**

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 -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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 COVID-19 precautions for six (#s 1, 2, 3, 4, 5, & 6) of nine newly admitted residents, and three (#s 7, 8, & 9) residents who went out of the facility. The facility failed to monitor Resident #10 following potential exposure. In addition, the facility failed to implement a surveillance plan for six (#s 13, 14, 15, 11, 4 & 8) of 24 sample residents reviewed. Failure of the facility to implement and maintain infection control procedures placed residents and staff at risk for the development and transmission of disease and infection. Findings included . Record review of the facility's policy titled, Coronavirus (COVID-19), dated 05/06/2020, showed that the facility would place all admitted residents (including readmissions) under droplet and contact precautions with eye protection for 14 days. Cloth face coverings are not considered PPE (Personal Protective Equipment) and should not be worn by HCP (Health Care Personnel) when PPE is indicated. NEW ADMISSIONS RESIDENT #1 On 06/22/2020 at 1:30 PM, an Infection Control (IC) cart with PPE was observed in front of Resident #1's room. During an interview on 06/22/2020 at 1:35 PM, Staff D, Registered Nurse (RN) stated that Resident #1 was a New Admit (NA) and was on precautions Like COVID. No sign was present indicating the resident was on precautions, or what precautions were to be used. On 06/22/2020 at 1:45 PM, Staff D was observed wearing a surgical mask, then donned a disposable gown and gloves, and entered Resident #1's room in response to the call light being on. Staff D did not don eye protection. Observation at that time of the IC cart in front of Resident #1's room showed it did not include a face shield or goggles for eye protection. Review of Resident #1's record showed the resident had admitted to the facility five days prior to the 06/22/2020 onsite visit, with [DIAGNOSES REDACTED]. RESIDENT #2 On 06/22/2020 at 1:30 PM, an IC cart with PPE was observed in front of Resident #2's room. The IC cart was not observed to have goggles or a face shield for eye protection. No sign was present indicating the resident was on precautions, or what precautions were to be used. During an interview on 06/22/2020 at 1:35 PM, Staff E, RN stated, I'm going to put the sign. Staff E stated Resident #2 was a NA and was on precautions. When asked when Resident #2 was admitted , Staff E stated, last week. Review of Resident #2's record showed the resident had admitted to the facility six days prior to the onsite visit, with [DIAGNOSES REDACTED]. Review of the record did not show that the resident was on precautions. RESIDENT #3 On 06/22/2020 at 1:30 PM, an IC cart with PPE was observed in front of Resident #3's room. The IC cart was observed to not contain goggles or a face shield for eye protection. No sign was present indicating the resident was on precautions, or what precautions were to be used. During an interview on 06/22/2020 at 1:35 PM, Staff E noted the lack of posted precautions, Sign again. Staff E stated that Resident #3 was a NA, admitted the week prior and on precautions. On 06/22/2020 at 1:50 PM Resident #3's call light was observed on. Staff F, Certified Nursing Assistant (CNA) was observed wearing a surgical mask to don a disposable gown, and gloves. Staff E was observed to provide Staff F with a face shield which Staff E stated that she had gotten the face shield from Central Supply. Review of Resident #3's record showed the resident had admitted to the facility eleven days prior to the onsite visit, with [DIAGNOSES REDACTED]. Review of the record did not show that the resident was on precautions. RESIDENT #4 & 5 On 06/22/2020 at 1:30 PM, an IC cart with PPE was observed in front of Resident #4 & 5's room. The posted sign showed the residents were on Droplet Precautions. The IC cart was observed to not contain goggles or a face shield for eye protection. During an interview on 06/22/2020 at 1:35 PM, Staff D stated that Resident #4 & #5 were NA's. On 06/22/2020 at 1:45 PM Staff G, Physical Therapy Assistant was observed to respond to the call light for the room of Residents #4 & #5. Staff G, wearing a surgical mask, donned a disposable gown and gloves. Staff G told Staff D, I don't have a face shield in here .I need a face shield. Staff D was observed to go talk to Staff B, Director of Nursing and returned. Staff D was observed to tell Staff G that the resident tested negative at discharge, so she didn't need to don a face shield. When asked who told her that, Staff D stated that was what Staff B said. RESIDENT #6 Similar findings for Resident #6, a NA who was on posted Droplet Precautions, but the IC cart did not contain eye protection. During an interview on 06/22/2020 at 2:06 PM Staff H, Resident Care Manager stated that he had been instructed that all NAs are placed on 14 day isolation. Staff H stated, We used to use face shield but now that we don't have any (COVID-19) positive we don't. During an interview on 06/22/2020 at 2:06 PM Staff I, Resident Care Manager agreed with Staff H and stated We use mask, and that prior to being admitted to the facility the residents have two negative COVID tests. During an interview on 06/22/2020 at 2:18 PM Staff C, Infection Control Nurse, stated that prior to admission residents are tested for COVID-19, and upon arrival placed on 14 day precautions. Staff C stated that the staff only wear eye protection if they have to do direct patient care such as suctioning, wound care with an infection, and if the resident is COVID-19 positive. When asked how the staff know if they are to wear eye protection, Staff C stated that there were posted signs, droplet precautions, and to check with nurse before entering. Staff C was directed to read a posted Special Droplet/Contact Precautions sign and when asked what staff were to don, Staff C stated Gown, masks, gloves. When pointed to the directives to wear eye protection, Staff C stated, I know the standard is to have goggles, face shield but . When prompted, Staff C continued and stated that if the staff were doing direct patient care, then they had to. When asked where she obtained this information, Staff C stated that, when the facility had COVID positive residents, staff wearing eye protection, but as far as I know if no droplets, no need. During an interview on 06/22/2020 at 2:30 PM Staff B stated that newly admitted residents were placed on Contact precautions for 14 days. Staff B stated that for those residents, the precautions should be posted. APPOINTMENTS During an interview on 06/22/2020 at 2:06 PM Staff H, stated that he had been instructed that all residents who go to an appointment are placed on 14 day isolation after their return. RESIDENT #7 On 06/22/2020 at 1:30 PM, an IC cart with PPE was observed in front of Resident #7's room. The posted sign showed the resident was on Special Droplet Precautions. During an interview on 06/22/2020 at that time, Staff K, Licensed Practical Nurse (LPN) stated that Resident #7 went to a doctor appointment and was on 14 day quarantine. On 06/22/2020 at 2:00 PM, the Case Manager (CM) was observed preparing to enter Resident #7's room for a scheduled phone call. The CM was wearing a cloth mask. Unable to find a gown in the IC cart, the CM was observed to retrieve a gown from an IC cart outside an adjacent room. The CM donned gloves and entered Resident #7's room without applying a surgical mask or eye protection. Review of Resident #7's record showed the resident had previously tested positive for COVID-19, and later removed from droplet precautions on 05/11/2020. Review of a 06/12/2020 progress note showed Resident #7 was on Isolation precautions due to roommate going out to appointment. RESIDENT #8 On 06/22/2020 at 1:40 PM, an IC cart with PPE was observed in front of Resident #8's room. There were no precautions posted. During an interview on 06/22/2020 at 1:40 PM, Staff L, RN stated that the resident had gone to the doctor, so was placed on 14 day precautions, which had been discontinued today. Review of Resident #8's record showed a 06/04/2020 progress note that the resident was placed on precautionary isolation related to potential COVID-19 exposure from provider. There was no documented rationale indicating why Resident #8 remained on precautions for 19 days. Similar findings were noted for Resident #12, who was observed on Droplet Precautions on 06/22/2020 at 1:30 PM. Review of of Resident #12's record showed the resident was admitted [DATE], and there was no documented rationale indicating why Resident #12 remained on precautions past the 14 day period. RESIDENT #9 On 06/22/2020 at 1:30 PM, an IC cart with PPE was observed in front of Resident #9's room. The posted sign showed the

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** - Some	(continued... from page 1) resident was on Special Droplet Precautions. The IC cart was observed without a face shield or goggles for eye protection. During an interview on 06/22/2020 at 1:30 PM, Staff K stated that Resident #9 went out to [MEDICAL TREATMENT] so was on precautions. During an interview on 06/22/2020 at 2:18 PM Staff C, stated that residents who went out to [MEDICAL TREATMENT] were on precautions to protect the resident. The facility staff don PPE with mask and the resident wears a gown and a mask when out at [MEDICAL TREATMENT]. RESIDENT #10 On 06/22/2020 at 1:30 PM Resident #10's room was observed with Special Droplet Precautions and an IC cart. The IC cart was observed without a face shield or goggles for eye protection. Review of progress notes dated 06/04/2020 showed Resident #10 was placed on precautionary isolation related to potential COVID-19 exposure from provider. The documented plan was the Resident would be on alert status to assess for potential signs and symptoms of COVID-19 until further treatment course developed. Further review of the progress notes showed resident assessment for symptoms was not documented as done on 06/06/2020, 06/09/2020 through 06/14/2020, 06/18/2020 through 06/22/2020. Review of documentation showed no reason why Resident #10 remained on precautions 19 days after placement. During an interview on 07/01/2020 at 10:00 A.M. Staff B stated that the expectation was for documentation to be present in the progress notes for every shift. Review of the facility IC Surveillance listing showed Resident #10 was not listed. During an interview on 07/01/2020 at 10:00 A.M. when asked why not, Staff B stated that the facility investigation determined that Resident #10 was not actually seen (exposed) by a provider. During an interview on 06/22/2020 at 2:06 PM when asked who follows up with the postings, stocking IC carts, Staff H stated mostly the Infection Control Nurse, Staff C. During an interview on 06/22/2020 at 2:18 PM, Staff C was asked who placed the posted precaution signs and IC boxes outside resident's room. She stated the nurses would provide for those residents in isolation. When asked what she or the RCM would do if she knew there was a new admission, and stated it was a team effort. When asked who stocked the IC carts, Staff C stated that the nurses who work on the floor, who had keys to Central Supply. Staff C also stated she would if, when she checked the cart, they had run out of supplies. Staff C stated that she checked the cart at the beginning of shift. During an interview on 06/22/2020 at 2:06 PM when asked who stocked the IC carts, Staff I stated that the nurses went to Central Supply and got the items needed. During an interview on 06/22/2020 at 2:30 PM, when asked who posted the precautions and placed the IC carts outside of resident's room Staff B stated that whoever received the new admission puts it in place. When asked who stocked the IC carts, Staff B stated, Usually Central Supply. During an interview on 06/22/2020 at 2:05 PM when asked who stocked the IC carts, Staff M, Central Supply (CS) stated that everybody did. Staff M stated that the IC carts were usually already stocked when she came on duty. Staff M stated that the facility had sufficient PPE, and multiple face shields were observed on the CS shelves. SURVEILLANCE RESIDENT #13 For Resident #13, a lab result from the University of Washington Medical Center showed a positive COVID-19 test on 04/15/2020. Review of the facility's line listing of potential/actual COVID -19 positive resident, by the Department of Health (DOH) showed Resident #13 had on onset of COVID-19 symptoms on 04/26/2020, even though initial testing on 04/16/2020 had identified the resident as positive for COVID-19 as of 04/15/2020. On 07/01/2020 at 10:00 AM Staff B said she would look into it this. No further documentation was provided. RESIDENT #14 Review of the DOH line listing showed the resident had a temperature of 100 degrees on 04/26/2020 and tested positive for COVID-19 on 05/01/2020, according to tests results received on 05/04/2020. As of 05/12/2020, the resident was removed from isolation. Review of the resident's record showed a temperature of 100 degrees on 04/27/2020 which was documented in the vital signs section of the electronic medical record. A 04/29/2020 physician note stated Also remain highly suspect of the CO VID?19 (sic) infection .Will repeat the swab this afternoon. The swab was not performed until 05/01/2020. There were no progress notes to state why the test was delayed until 05/01/2020. Further review of the resident record showed the resident was removed from isolation on 05/12/2020. Until this note there was no documentation the resident was on isolation for being COVID-19 positive except a note that stated the resident moved rooms on 05/04/2020. On 07/01/2020 Staff B stated she would look into this. No further documentation was provided. RESIDENT #15 Review of the Resident #15's progress notes showed the resident discharged from the facility on 04/21/2020. Review of the DOH line listing showed the resident had a temperature of 101 degrees on 04/23/2020 and tested positive for COVID-19 on 05/04/2020. Review of the resident's progress notes did not address the above inconsistencies. On 07/01/2020 at 10:00 AM, Staff B stated she would look into this. No further documentation was provided. RESIDENT #11 On 06/22/2020 at 1:30 PM, an Infection Control (IC) cart with PPE was observed in front of Resident #11's room. The posted sign showed the resident was on Droplet Precautions. Review of the resident's record included a 06/08/2020 progress note that showed Resident #11 was placed on contact isolation on 06/08/2020. During an interview on 06/22/2020 at 1:35 PM, Staff D stated that Resident #11 was on precautions for shingles. During an interview on 07/01/2020 at 10:00 AM Staff C stated that Resident #11 was on Contact Precautions for shingles. When asked what PPE staff were expected to wear, Staff C stated mask, face shield, gown and gloves. Review of the facility June IC Surveillance showed Resident #11 was not listed on the log. During an interview on 07/01/2020 at 10:00 AM when asked if Resident #11 should have been on the log, Staff B stated yes. SIMILAR FINDINGS FOR RESIDENTS #4 & #8 RESIDENT #4 Review of Resident #4's June 2020 Medication Administration Record [REDACTED].for Cellultitis. Review of the June 2020 IC Surveillance did not include Resident #4's [MEDICAL CONDITION] infection. RESIDENT #8 Review of Resident #8's June 2020 MAR indicated [REDACTED].for lower extremity [MEDICAL CONDITION] . Review of the June 2020 IC Surveillance did not include Resident #8's [MEDICAL CONDITION] infection. REFERENCE WAC 388-97-1320(1)(a)(2)(a)(b)(c) .