STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505252	A. BUILDING _____ B. WING _____	08/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BURIEN NURSING AND REHABILITATION CENTER	1031 SOUTHWEST 130TH STREET BURIEN, WA 98146

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 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide complete and relevant medical information at the time of a hospital transfer for one of (#13) of one resident reviewed for hospital transfers. This failure placed the resident at risk for errors with care needs. Findings included . See CFR 483.25(e)(1)-(3) F690 - Bowel/Bladder Incontinence, Catheter, UTI (Urinary Tract Infection) Review of a 07/18/2020 progress note timed at 1:19 PM showed the resident stated, I feel like I have not been peeing. Upon assessment his catheter bag was empty and abdomen felt distended . new IFC (indwelling foley catheter) inserted and currently patent and draining. Approximately 900cc (cubic centimeters) output of urine was noted upon re-insertion. Placed on alert. Review of a transfer form dated 07/19/2020 and timed at 6:33 AM showed the resident was transferred to the hospital. This transfer form showed staff identified a Distended abdomen and Blood in urine and did not identify the use of an indwelling Foley catheter, or that the catheter was replaced less than 24 hours prior to transfer secondary to [MEDICAL CONDITION]. Review of Emergency Department notes of 07/19/2020 at 8:00 AM showed, Pt (Patient) arrived from Burien Nursing and Rehab (Rehabilitation) via ambulance . EMS (Emergency Medical Services) reported nursing home unable to tell why pt on foley catheter and how long it (sic) been inserted and Per patient, Foley (catheter) was changed last week. The above findings were shared with Staff D, Resident Care Manager/Licensed Practical Nurse (RCM/LPN) on 08/03/2020 at 8:55 AM, who acknowledged the facility did not provide complete and relevant information to the receiving hospital at the time of transfer and stated, Yea, this SBAR (a transfer summary) doesn't identify that. REFERENCE: WAC 388-97-0120. .
F 0690 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide catheter-related services for four (#13, #14, # 15 and #16) of four residents reviewed for indwelling Foley catheter (a flexible tube inserted into the bladder through the urethra) use. For Resident #13, the facility failed to ensure the resident did not develop worsening of a previously identified skin issue with the use of an indwelling catheter. Failure to monitor the impaired skin integrity to the penis, to include placement of a catheter strap as directed by the provider, resulted in Resident #13 developing a urethral erosion, a complication from using an indwelling catheter. Findings included . A facility policy dated 01/09/2019 and titled Catheters - Indwelling Urinary showed the facility would monitor residents who utilized indwelling catheters for changes in condition. The preventative measures included, Keeping the catheter anchored to prevent excessive tension on the catheter, which can lead to urethral tears or dislodging the catheter. Resident #13 Review of a 08/26/2019 admission skin assessment for Resident #13, showed staff identified a cath (catheter) insertion site with [MEDICATION NAME] (tear or break in the skin) open (sic) mid shaft of penis. This assessment did not show any measurements associated with the [MEDICATION NAME] opening. Review of a 05/13/2020 Quarterly Minimum Data Set (MDS - an assessment tool) showed the resident admitted to the facility on [DATE], was cognitively impaired, and used an indwelling catheter. Review of a 07/21/2020 hospital Social Worker (SW) report showed, . in the wound care note there's this just really tragic picture of how his catheter's just torn up the part of this man's private parts basically . In an interview on 07/28/2020 at 9:19 AM, the SW stated the resident's penis is split, the large part of his penis and suspecting the catheter pulling caused the ventral (the underside) erosion to the level of the scrotum. In an interview on 08/03/2020 at 8:28 AM, Staff D, Resident Care Manager/Licensed Practical Nurse (RCM/LPN) confirmed he completed the resident's skin assessment on admission and identified, It looked like the middle of the penis the catheter was coming out. It was fissured when we got him, it was mid shaft. When asked how much skin was intact below the opening of the mid-shaft, Staff D stated, . maybe two to three cm from the scrotum to the mid shaft, about an inch or inch and a half. The remainder of the skin was intact, not opened up towards the top of penis and below the fissure it was intact. When asked how large was the fissure opening, Staff D stated, The fissure itself was open I would say maybe almost 1.5 centimeters approximate. When asked if there was any drainage or opened and moist soft tissue, Staff D stated, Nothing. When asked if it was unusual to see the catheter coming out of the mid shaft of the penis and if a urology referral was considered for further evaluation, Staff D stated, He had just come from the hospital and they are the ones who put the foley catheter in so we were thinking he must have been seen by the urologist if he came with it. Review of a 03/03/2020 Care Plan (CP) showed, Use of a urinary catheter due to [MEDICAL CONDITION]. This CP also showed, Foley cath (catheter) care Q (every) shift and PRN (as needed) and Leg strap to keep catheter anchored. This CP showed no indication of the identified [MEDICATION NAME] open mid shaft of penis. A 04/23/2020 nurse practitioner (NP) progress note showed, Patient is seen lying in bed . has a chronic Foley catheter in place . catheter exit at the base of the penis shaft . Unclear if he is being seen by an (sic) urologist. Urologist referral given the tip of his catheter ends at the base of penis. Needs strap and Foley catheter care twice daily. In an interview on 08/04/2020 at 9:32 AM, when asked to describe where the catheter was coming out from the penis, the NP stated, In the middle of his penis, not really at the end, it was at the middle of the penis. When asked if the remaining skin integrity was intact below or above where the catheter was coming out of, the NP stated, Skin was intact yes . just the opening of the middle of the penis and I wanted that evaluated. When asked if he recalled seeing an erosion all the way down the penile shaft, the NP stated, I don't think so. It (the catheter) exited mid (middle) of the shaft, not at the base. When asked how much skin was intact between the mid-shaft and the scrotum, the NP stated, I guess probably about an inch but not sure. I do not remember any erosion not that I remember. When asked why he recommended the use of a catheter strap, the NP stated, So it doesn't pull on it. When asked if he recalled seeing a catheter strap in use during this examination, the NP stated, If I wrote that it's probably he didn't have it on. In an interview on 08/03/2020 at 8:28 AM, when asked why the CP instructed the staff to use a leg catheter strap, Staff D stated, So that the catheter doesn't get pulled out and prevents trauma. The strap holds it in place. When asked how the facility ensured the leg strap was in place, Staff D stated, Check for placement every evening shift, and stated the documentation for this would be found, I would say on the treatment sheet. Review of Treatment Administration Records (TARS) between January and July 2020 showed no documentation staff applied a leg strap to keep catheter anchored to prevent catheter-associated injury. Staff D stated, It doesn't say there, when asked if the TARs showed that staff ensured the catheter tubing was securely anchored with a leg catheter strap. Staff D then stated, 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505252	A. BUILDING _____ B. WING _____	08/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BURIEN NURSING AND REHABILITATION CENTER	1031 SOUTHWEST 130TH STREET BURIEN, WA 98146

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 0690 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) CNAs (Certified Nursing Assistants) check for placement every shift. In an interview on 08/24/2020 at 11:24 AM, when asked what kind of catheter care she provided Resident #13, Staff G, CNA, stated, We just cleaned his private parts and we dumped the urine every shift. When asked if she recalled seeing a catheter strap, Staff G stated, No, the nurses did that. Review of a 01/28/2020 Individual Plan Report (IPR) showed, Bladder - Foley catheter to wear catheter strap provide Foley catheter care q (every) shift and as needed. Notify LN (Licensed Nurse) if noted with new skin breakdown. Review of a Catheter Detail Report associated with the IPR showed the absence of Catheter Care/Management between 08/26/2019 and 07/19/2020, with periods ranging from three days to two months. The IPR showed no documentation Catheter Care/Management was provided for a period of nine weeks and 3 days between 04/07/2020 to 06/12/2020, and again from 06/14/2020 to 07/19/2020 (day of discharge), a five week period. In addition, review of Bowel and Bladder Detailed Entry Reports between 05/06/2020 to 07/17/2020 showed no documentation staff ensured Resident #13's Foley catheter tubing was anchored securely with a catheter strap as instructed by the NP, the CP, and the IPR. Review of a 07/18/2020 progress note timed at 1:19 PM showed the resident stated, I feel like I have not been peeing. Upon assessment his catheter bag was empty and abdomen felt distended . new IFC (indwelling foley catheter) inserted and currently patent and draining. Approximately 900cc (cubic centimeters) output of urine was noted upon re-insertion. Placed on alert. Review of the progress notes showed no documentation staff notified the physician of the identified change in urinary status and the need for catheter reinsertion. Review of the progress notes between 07/18/2020 at 1:19 PM and 07/19/2020 at 6:30 AM showed no documentation staff monitored the resident's response to the re-inserted catheter. A transfer form showed the resident was transferred to the hospital approximately 17 hours later on 07/19/2020 for respiratory symptoms and a fever. The transfer form also showed the resident to have abdominal distention and blood in urine. The above findings were shared with Staff D on 08/03/2020 at 8:55 AM, who acknowledged the lack of monitoring after reinsertion of the catheter. Review of a 07/20/2020 hospital wound consult note timed at 3:05 PM showed, . he has a chronic foley (catheter) in place . Penile shaft - ventral (underside). Foley placement is located in an orifice (opening) at the base of the penile shaft, a fissure thin extends superiorly to the glans penis (top of the penis), Full thickness depth, wound base is 100% moist mucosa, no bruising, or [DIAGNOSES REDACTED] (redness) is noted . Review of Care Everywhere notes Urology visit note in May of 2020 with no mention of any abnormalities. NO prior surgical intervention is noted in medical history. Etiology (origin) of wound is unknown - it may be associated with pressure from his catheter, though with no a/az (sic) of ecchymosis or other trauma present - seems unlikely . Plan: urology consult. Penis - . pressure relief - place non-adhesive foam between penis and catheter tubing to prevent pressure trauma. Review of a 07/20/20 hospital urologist note timed at 6:31 PM showed, Assessment - urethral erosion . The patient has had long standing catheter drainage which is pulling downward and causing the ventral erosion to the level of the penile scrotal junction. Nursing facility needs education on how to prevent this downward pressure. In an interview on 08/21/2020 at 3:31 PM, when asked if he recalled if Resident #13 had any skin issues, Staff GG, LPN, stated, Skin issues . not that I remember. When asked if he recalled Resident #13 using a catheter, Staff GG stated, Yes, he was. When asked if he performed any catheter care and what that entailed, Staff GG stated, We just gonna' clean it up the foley catheter. When asked if he recalled where the catheter was coming out from, Staff GG stated, So, actually, he was a little bit weird. It's kind of like a little bit of split like the tip of the penis was split. He had it when he was admitted . When asked if it was split all the way to the scrotum, Staff GG stated, I never measured it but it's just a little bit of a split, superficial, like a tear, it doesn't go all the way down, just open, hard to describe. When asked how long the split from the tip of the penis was, Staff G stated, Between 1 cm. When asked how much skin was intact from the scrotum upwards, Staff GG stated, I can't tell maybe two centimeters to two and a half centimeters. When asked when was the last time he had been assigned to Resident #13, Staff GG stated, Long time ago, two or three months ago, can't recall. In an interview on 08/03/2020 at 11:30 AM, when asked about Resident #13's skin integrity, Staff E, LPN, stated, Umm, I know from working with him he had a rash on his buttocks, and then the tip of his penis where his catheter was at, it was just like split. The catheter wasn't at the tip, it's not inserted in the tip because the tip is split. When asked how long had the tip of his penis been split, Staff E stated, since two or three months ago which Staff E stated was also the time she was first assigned to the resident's care and, The first time I saw it they said he came with it so I didn't think anything was new. The top part was intact, the split was at the bottom below the top of the penis towards the scrotum, split all the way down to the scrotum. The split ended near the scrotum so that's where the catheter insertion was at. Staff E stated she did not recall seeing any moist open tissue of a fresh wound or trauma. When asked if the resident used a leg strap, Staff E stated, Yes, when I did catheter care I see that it's on and stays on. Review of June and July 2020 TARs showed Staff E assessed Resident #13 to have non-intact skin on 06/01/2020, 06/08/2020, 06/15/2020, 06/22/2020, 06/29/2020, 07/06/2020 and 07/13/2020. Review of the medical record showed no documentation Staff E identified the non-intact skin. In a follow up interview on 8/24/2020 at 11:48 AM, when asked about the non-intact skin, Staff E stated, I was referencing to the penis because it was not intact. When asked what the nurse was supposed to do when non-intact skin was identified, Staff E stated, What I would do is find out if it's something new or not, and ask the RCM, and do a skin incident report. And then alert the nurse practitioner and put them on alert charting for three days. He wasn't bleeding or anything, that's why it didn't alarm me. They said he was admitted with that. That wasn't something new. I just checked it as non-intact skin because the penis is split. I don't consider that intact skin. That's why I went to ask when I first saw it, and was told he came in with it. It was the supervisor for sure who told me, yes, since he's the RCM. I wish I would have done some measurements for it. Review of the resident's medical record showed no documentation staff monitored a [MEDICATION NAME] open mid shaft identified on admission, or prevented its progression to a ventral erosion to the level of the penile scrotal junction. The above findings were shared with Staff B, Director of Nursing Services on 08/13/2020 at 3:30 PM. Staff B stated she expected staff to check the catheter strap at least every 8 hours to make sure it is securely anchored, and acknowledged that catheter-related trauma can be prevented by, that's why we always have a leg strap to the catheter or the weight will pull it down from the bag, can have a split when it pulls down, can also damage the urethra. We make sure the leg strap is secured right and is always on. When you move you don't want pulling. When asked if the medical record showed staff securely anchored Resident #13's catheter tubing with a leg strap, since admission through discharge to the hospital (a period of 11 months), Staff B stated, No. I see a gap here. SIMILAR FINDINGS Review of IPRs for Residents #14, #15 and #16 showed, Foley cath leg strap in place and change as needed. Review of Catheter Detail Reports showed an absence of Catheter Care/Management (Resident # 15 with periods of two days to two months of no documentation between 12/21/2019 and 08/12/2020; Resident #14 with periods of two days to two and a half months with no documentation between 10/15/2019 to 08/12/2020; for Resident #16 with periods of three days to one month of no documentation between 03/23/2020 to 08/12/2020). The above findings were also shared with Staff B. No further information was provided. REFERENCE: WAC 388-97-1060 (3)(c). .
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 ensure residents were protected from COVID-19 (Coronavirus - a contagious disease). (1) The facility did not have a system in place to ensure staff followed Infection Control (IC) practices to prevent exposure to or the spread of COVID-19. (2) The facility failed to ensure potentially exposed residents were isolated in a prompt manner. (3) The facility failed to ensure employees screened as having one or more symptoms of COVID-19 did not expose other residents and staff, or follow up on questionable employee symptoms. (4) The facility failed to prevent staff from working between sets or units, increasing the likelihood for the spread of COVID-19 between staff and other residents. (5) The facility failed to conduct a root-cause analysis and identify where a breech in IC practices occurred in order to remedy actual or potential areas of concern and prevent further COVID-19 transmission to the residents. These failures placed the residents and staff at risk for infection with COVID-19, displacement to another nursing home, and death. On 08/06/2020, the facility was notified of an Immediate Jeopardy related to Infection Control. On 08/21/2020, the validation of the IJ removal occurred through observations and review of records, including staff education, audits, staff schedules, employee screening logs, policies and procedures, and medical records. Findings included . FAILURE TO CONDUCT A ROOT-CAUSE ANALYSIS Review of a COVID-19 Policy and Procedure, updated 07/20/2020, showed the facility would develop and implement strategies to reduce the risk of resident and staff exposure to COVID-19, to include processes for visitors and staff screening and restrictions, training and education of staff, and environmental cleaning and disinfection. This policy showed that, during COVID-19 outbreaks in the facility or the surrounding community, the facility would practice social distancing and cancel group activities, instruct residents to remain in their rooms as much as possible and to maintain at least six feet apart from one another. This policy also showed the facility would provide training for all employees to include hand hygiene, use of Personal Protective Equipment (PPE - gloves, mask, gown,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505252	A. BUILDING _____ B. WING _____	08/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BURIEN NURSING AND REHABILITATION CENTER	1031 SOUTHWEST 130TH STREET BURIEN, WA 98146

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 -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) face shield), types of precautions, and environmental cleaning and disinfection, and that training may include observations of staff during provision of care. On 08/19/2020 at 2:07 PM, Staff B, Director of Nursing Services confirmed 12 residents participated in a smoking group activity through 07/31/2020. Review of a 05/08/2020 policy titled CORONAVIRUS (COVID-19) MANAGEMENT showed that COVID-19 was thought to spread via droplets requiring close contact with others for a prolonged period of time and that, Droplets generally travel only short distances (approximately six (6) feet or less) through the air. If close contact occurs while not wearing all PPE, healthcare personnel may be at risk for infection. This policy also showed, We do not yet know how long COVID-19 remains infectious in the air. Review of a revised 10/05/2017 Smoking Policy and Procedure did not address how the staff would prevent COVID-19 transmission during smoking, to include social distancing, sanitation of smoking supplies like smoking aprons, lighters, e-cigarettes/vaping, storage, or use of PPE. Review of a 07/27/2020 Occurrence Report showed, On 7/17/20 resident (Resident #1) with temperature of 100.1, uncontrolled jerking arm and leg, unresponsive, stiff and wide open fixed eye that lasted for two minutes. Provider in house who saw resident and ordered stat (immediate) labs, COVID 19 test and to quarantine resident. This report showed that on 07/17/2020, the resident was placed in a single room, and on Transmission Based Precautions (TBP - used when contact with the resident, their body fluids, or their environment presents a substantial transmission risk despite adherence to standard precautions), and resulted positive with COVID-19 infection on 07/21/2020. This report also showed that, All residents with possible exposure due to Resident's (sic) smoker placed on Droplet/Contact precautions (a TBP) on 07/21/2020, and that on 07/23/2020, the facility instructed staff to start wearing face shield in addition to mask for all staff while in the building. This report showed that on 07/24/2020, Staff H, Activities Aide, resulted positive for COVID-19 infection and that, This particular positive staff (tested [DATE]) works in the Activity Department with multiple contacts with residents and supervise (sic) smokers It is highly probable that the resident positive with COVID 19 on 07/21/2020 may be infected by an exposure from the Activity Staff whom she came in contact with during smoking or doing activity in room. Review of a 07/31/2020 Occurrence Report addendum, completed 14 days after the initial case of COVID-19 symptoms, showed, (Resident #1) is a supervised smoker. (Staff H) supervises smoking most of the time and has multiple contacts with residents including 1:1 activities. (Resident #1) has not gone outside of the facility for any appointments. She has been in the facility with no outside visitors since March 2020. It is highly probably (sic) that (Resident #1) may have been infected by an exposure to the Activity Aide with whom she had multiple contact with during smoking or 1:1 visits. Review of the Occurrence Report and addendum did not show the facility evaluated potential breeches in IC practices or processes in place like visitors and staff screening, environmental cleaning and disinfection, appropriate use of PPE, compliance with social distancing, hand hygiene or sanitation, or current group activities. In an interview on 08/03/2020 at 3:13 PM when asked what measures were taken to prevent COVID-19 transmission during smoking sessions, Staff H stated, What we did was only a certain amount of residents could come out at a certain time. Make sure they are masked when they come out of their rooms, sanitize their hands and then we put the apron on and give them the ashtray along with the six feet distance. After they are done everything is sanitized from the ash trays and their hands and wipe down the aprons. When asked who was also designated to take the residents out to smoke apart from Activities Staff, Staff H stated, Concierge and also nursing at 6:30 PM. When asked if she had to come closer than six feet from the resident, Staff H stated, Only when lighting their cigarettes. Staff H stated a designated lighter was being used by Activities Staff to light the cigarettes for all the residents. When asked if the facility had asked her how she thought the COVID-19 transmission occurred, Staff H stated, That's a good question. I couldn't even tell you. They haven't asked me. When asked if any other group activities took place, Staff H stated, Bingo on Friday. Only a certain amount of residents came to the dining room, only a certain number, and then everything is sanitized. In an interview on 07/31/2020 at 3:31 PM, when asked if the facility continued with a Smokers Group from February through July, Staff I, Activities Director, stated, Yes, when we learned they were positive we stopped it. Staff I also stated, We had the six feet apart and made a schedule no more than six people at a time, but also we would be able to accommodate eight but to be safe we just did six (residents). Staff I stated, Everybody had assigned aprons. Cigarettes and lighters were in a plastic zipper bag, and that sometimes Activities Staff assisted the residents to light their cigarettes. Staff I stated the residents had their own lighters and that smoking supplies were kept at the Nurses Station. Staff I stated the residents were taken out to smoke four times daily and that Activities Staff supervised all but the evening smoke break at 6:30 PM, which some breaks were supervised by the nursing department or the concierge. When asked if she ever had to come closer than six feet of the resident when she supervised smoking, Staff I stated, Yes, we do because we have to help to wheel them in and to wheel them out and anybody you had to help light a cigarette, but not all the time. Staff I added, It (the COVD-19 outbreak) just happened. It's so sad. When asked if she had any idea how COVID-19 was transmitted to the resident or if the facility had asked for her input into the outbreak analysis, Staff I stated, I have no idea and No, they didn't interview me. In a joint interview with Staff C, Infection Preventionist/Registered Nurse (IP/RN) and Staff B on 08/06/2020 at 1:32 PM, when asked how the facility ensured the residents who smoked were protected from COVID-19 exposure, Staff C stated, The first thing we did was to make sure they have the right to smoke, and that there is a risk involved, and their consent to participate. Review of 07/21/2020 Risk and Benefit forms for Residents #4, #5, #6, #7, #8, #9, #10, #11, and #12 showed, Issue: Continuing to smoke after being exposed to a COVID-19 diagnosis. The form showed no documentation of steps the facility would take to ensure residents were protected from COVID-19 during smoking. The form showed the question Changes made to plan of care was blank for Resident #4, #7, #8, #9, #10, #11, and #12. A No was indicated for Resident #5 and #6. Review of the resident Care Plans showed, Notice of smoking suspension on 08/11/2020 due to facility COVD outbreak. Interventions to prevent COVID-19 infection were not included in any of the care plans. Eight of the 12 residents who smoked contracted COVID-19. On 08/26/2020 at 9:22 AM, when asked if any risks and benefits to continue smoking were reviewed with the residents at the time the COVID-19 pandemic ensued and the facility allowed the high-risk group activity to continue, Staff A, Administrator, stated The facility provided for social distancing from the start of the pandemic. There were no risks and benefits done at that time because limiting smokers was thought to be adequate. All other facilities that we were aware of continued to allow smoking. When asked if the risks and benefits form showed how the facility protected the residents when it allowed a high risk group activity to continue and, if not on the form, where would those interventions be found, Staff A stated, No care plan changes were made at the time. All residents wanted to continue to smoke. In the continued joint interview with Staff B and C on 08/06/2020, when asked what was the maximum amount of residents allowed to smoke at once, Staff C stated, We have up to 8 residents, up to six, sometimes we have three or four. When asked how the facility ensured the residents who participated in the smoking group were protected from COVID-19, Staff C stated, We have the smoking materials and products kept in a box which is zip locked where everyone has their lighters and cigarettes and contained separately. Hand sanitizers are used for the residents and they grab their own cigarettes out after hand sanitizing and they have aprons and are disinfected after smoking. Each ash tray is individually used and then the supervisor would take those ash trays and dump it into cigarette bin and sanitized again and locked up. Aprons are taken away after sanitized and hung back. The supervisors were wearing gowns and masks. When asked if the smoker's group continued after suspecting Resident #1 of COVID-19 infection, Staff C stated, The minute we find out Resident #1 is positive we stopped the smokers group on July 21st (four days after suspected of COVID-19). When asked if the smokers group resumed, Staff C stated, The RCMs (Resident Care Managers) reassessed the smokers to make sure they can hold and light it for themselves and restarted the smoking group on 07/28/2020. Review of a NOVEL CORONAVIRUS 2019 SURVEILLANCE LOG showed, 7/21/20 All residents with possible exposure due to Resident's (sic) smoker placed on Droplet/Contact Isolation precautions. This log showed resident #1 was transferred to another nursing home. When asked how IC practices or processes changed to prevent further spread of COVID-19 when Resident #1 was suspected and then identified as positive for COVID-19, Staff C stated, Wearing a mask was already in place. Review of the log showed on 07/24/2020, (Resident #2) and staff tested positive for COVID-19 . positive staff notified of her result and self-isolated. This log showed the resident was transferred to another nursing home. When asked how IC practices or processes changed to control the spread of COVID-19 in the facility when the second resident and first staff case were identified on 07/24/2020, Staff C stated, Staff self-isolated and face shields started being used and that was for all the staff. Review of the log showed on 07/27/2020, Two staff results came back positive. Both positive staff members home on self-isolation. Review of the log showed on 07/28/2020, 1 (One) symptomatic resident . received positive result today and transferred to (another nursing home) the same day. Review of the log showed on 07/29/2020, Results came back positive and all 3 three residents) were transferred to (another nursing home) on the same day. Review of the log showed on 07/30/2020, 15 (fifteen) residents and 9 (nine) staff member results were positive for COVID-19. All positive residents were placed on Special Droplet/Contact isolation. Staff members who were notified of their results and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505252	A. BUILDING _____ B. WING _____	08/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BURIEN NURSING AND REHABILITATION CENTER	1031 SOUTHWEST 130TH STREET BURIEN, WA 98146

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 -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 3) isolating themselves at home. Full PPE, Universal, to be worn by all staff during care and when entering resident rooms. When asked what processes changed to address the spread of COVID-19 on 07/30/2020, Staff C stated, Exactly what we were doing with the face shield. On July 30th we became totally PPE, a gown was added, and each and every room is considered as a COVID room and full gown before entering. Review of the log showed on 07/31/2020, 5 (five) staff member results came back positive for Covid-19. Staff members notified and isolating at home. When asked if IC processes changed on 07/31/2020, day 14 after the first initial symptoms of COVID-19 and when an additional five staff members resulted positive, Staff C stated, No changes, full PPE. When asked if all communal activities had stopped, Staff C stated, Smoking going on. Staff C failed to demonstrate the facility conducted or considered an analysis of how and why COVID-19 was spreading, to include a review of employee symptoms, staff allocation, staff competency and compliance with IC practices, and review of current group activities. By 08/06/2020, the facility had a total of 31 residents and 19 staff infected with COVID-19. In this joint interview on 08/06/2020 at 1:32 PM with Staff B and C, when asked if the analysis and investigation of the COVID-19 outbreak was complete, Staff B stated, Yes, and that no further information was forthcoming. FAILURE TO MONITOR INFECTION CONTROL PRACTICES Review of facility records showed audits were completed on staff PPE Competency Validation on March 25, 2020. This review showed no additional monitoring of staff compliance and competency with PPE usage was conducted until after the outbreak started, four months later. Also, there was no documentation to show the facility assessed Activities Staff on an ongoing or regular basis after March 25, 2020 to ascertain sustained compliance and competence with PPE usage, hand hygiene, social distancing and disinfecting of smoking materials. In an interview on 08/06/2020 at 9:22 AM, when asked when was the last time she recalled being assessed for IC practices for COVID-19 prevention, Staff H stated, I'd say the last time they did it was two or three weeks ago, a date range coinciding when the outbreak occurred. In the continued joint interview on 08/06/2020 at 1:32 PM with Staff B and C, when asked how the facility ensured staff complied with IC practices for COVID-19 prevention recommendations, to include Activities Staff during smoke breaks, Staff C stated, First of all, we do surveillance daily. We (IP and DNS) make sure people follow the right way of using PPE and handwashing and sanitizers. That's daily and ongoing. We did have a PPE video that we watched and a return demo (demonstration) that we did at the beginning of the outbreak of the COVID and it included the whole house (staff) including therapists, everybody. They watched the video and then after that we asked one by one to do a return demo. When asked when the last time staff competency and compliance was conducted, Staff C stated, March 25 (2020), and Then after that it's a random thing we have been doing with staff and new hires. No further documentation was provided by Staff B or C to show the facility monitored staff competency and compliance with IC practices for COVID-19 prevention between March 25, 2020 and July 23, 2020. FAILURE TO ENSURE PROMPT ISOLATION OF RESIDENTS Review of a NOVEL CORONAVIRUS 2019 SURVEILLANCE LOG showed that on 07/21/2020 the facility placed all residents with possible exposure to Resident #1 on Droplet/Contact precautions (a TBP). In an interview on 08/06/2020 at 1:32 PM, when asked if the facility already knew who was likely exposed to Resident #1 when she showed signs or symptoms of COVID-19 infection on 07/17/2020, Staff C stated, The only thing that triggered right away was the smoking. We didn't know exactly, but the people that are suspected is her roommate. They (the roommate) was put on quarantine. When asked if other residents who participated in the smoking group should have been quarantined on 07/17/2020 instead of four days later, Staff C stated, No. At that moment we don't know if they're going to be positive or not. Staff C acknowledged other residents who participated in the smoking group should have been quarantined on 07/17/2020 due to their potential exposure to COVID-19. Review of a facility infection surveillance map received 07/31/2020 showed a cluster of COVID-19 infections between Rooms 47 to 56 located in the North Unit. By 07/31/2020, 21 residents had become infected with COVID-19 in the facility. Of those 21 infected residents, 15 lived in the North Unit (where three residents who participated in smoking resided), one lived in the East Unit (where four residents who participated in smoking resided), two lived in the West Unit (where four residents who participated in smoking resided, including Resident #1) and three lived in the Medicare Unit (where one resident who participated in smoking and also Resident #2, the second positive resident case, resided). FAILURE TO ADDRESS STAFF MOVEMENT BETWEEN RESIDENTS In this continued interview of 08/06/2020 at 1:32 PM, when asked how the facility allocated staff with positive COVID-19 cases in the building, Staff C stated, Yes, we try our best as possible to make sure people stay in one unit but sometimes they have to float. We try to contain all the staff to working one unit as much as possible. We do our diligence that floating does not happen but if it does, it's a very small chance that the staff is floated. When asked if nursing staff were also assigned to supervise the smoking group, Staff C stated, Yes, it's assigned on our schedule. No records were provided by the facility to show which and when nursing staff were assigned to supervise the smoking activity. Review of staff schedules between 07/17/2020 and 07/31/2020 showed the facility allowed a pattern of staff working from one job description to another (shower aide to nursing assistant, restorative aide to nursing assistant, treatment nurse to floor nurse) or work between sets or units of residents that did not participate in the smoking group, to other sets or units with potentially exposed residents or residents who participated in the smoking group (07/17/2020, 07/18/2020, 07/19/2020, 07/20/2020, 07/21/2020, 07/22/2020, 07/24/2020, 07/25/2020, 07/26/2020, 07/27/2020, and 07/30/2020). By 07/30/2020, 17 staff had tested positive for COVID-19 infection, including a Treatment Nurse (Staff F) who floated to the floors, both Restorative Aides (Staff J and K), both shower aides (Staff L and M), and nursing assistants noted to work between sets or units or duties (Staff N, Staff O, Staff P, Staff Q). In addition, a facility policy dated 05/08/2020 and titled CORONAVIRUS (COVID-19) MANAGEMENT showed that for residents suspected with COVID-19, The facility will keep a log of all persons who care for or enter the rooms or care area of these patients. An observation on 07/27/2020 at 8:30 AM showed Resident #3 (roommate of Resident #1 who showed signs and symptoms of COVID-19 on 07/17/2020 and resulted positive on 07/21/2020) was on isolation. Review of a staff tracking log for Resident #3 showed no documentation the facility monitored staff coming in and out of the room for six days between 07/22/2020 and 07/27/2020. In addition, this tracking log showed a start date of 07/04/2020 when there was no COVID-19 outbreak in the facility. For Resident #2, who was suspected of COVID-19 infection and placed on isolation until 07/27/2020, the tracking log showed a start date of 07/09/2020, when there was no COVD-19 outbreak in the facility. Similarly, the tracking log for Resident # 1 also showed a start date of 07/04/2020, when there was no COVD-19 outbreak in the facility. Review of the tracking logs showed the same handwriting across every single shift. The tracking logs did not show non-nursing staff who could have possibly entered the rooms throughout the time of isolation, like housekeepers, kitchen staff, social workers or activities staff. In this continued joint interview with Staff B and C on 08/06/2020 at 1:32 PM, when asked why the tracking logs had a start date prior to the outbreak, the same handwriting every single day and shift, and only included nursing staff, Staff B stated they did not use any tracking logs and she had them created by a staff member when the Surveyor requested them. When asked if the facility tracked staff in and out of suspected COVID-19 resident rooms as stated in their 05/2020 policy, Staff B stated, We do not have a time log to show who went in and out. We don't have actual logs in writing. When asked if the facility should have tracked staff movement, Staff B stated, We just created it (the log), and acknowledged staff movement in and out of suspected COVID-19 resident rooms was not monitored. FAILURE TO ENSURE EMPLOYEE HEALTH AND SCREENING In an interview with Staff B and C on 08/06/2020 at 1:32 PM, when asked what was expected from staff when they felt ill at home, Staff C answered, The expectation is first of all not to come to work, stay at home. It's all about self quarantine. When asked what the facility would do if an employee reported they were sick at work, Staff C answered, Immediately their temp is checked, put on a mask and sent home. Right away sent home. When asked how low grade temperatures were addressed by the facility, Staff C stated, Anything above 99 has to be looked at and they will call me and try to figure out what's going on. They call me and I check it out, and if I am not available then there is the DNS or the RCMs or the nurses on night shift. When asked where the follow-up for temperatures above 99 degrees was documented, Staff C stated, The follow up assessment is documented on the same screening sheet. Staff C added, I don't recall having any problems. They (the screening logs) are reviewed daily by me. Review of an undated facility employee screening procedure showed, If employee/Visitors have a temp (temperature) or answer yes to any of the questions, provide them with a mask and have them exit the facility. This procedure did not identify what qualified as a temperature. Review of the screening logs asked the screener to Check Temperature but did not show when a temperature should be questioned in order to determine whether to send the staff home or not. Review of education records dated 03/17/2020 and 05/11/2020 showed Medical Records staff, Unit Secretaries and a Nursing Assistant employed as a Staffing Coordinator, were trained on employee screening for COVID-19 signs/symptoms. Review of employee screening logs showed the facility identified Staff H with COVID-19 symptoms of Cough and Headache on 07/23/2020. This screening log instructed the employee to answer if they were Asked to Go Home (if yes to any of the screening questions). Y/N (Yes/No). Staff H indicated N. In an interview on 08/06/2020 at 9:22 AM, when asked if she was trained on what to do if she was sick, Staff H stated, Yes, somewhere around June (2020). When asked if she had been ill preceding the time of the outbreak, Staff H confirmed she started feeling sick

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505252	A. BUILDING _____ B. WING _____	**08/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BURIEN NURSING AND REHABILITATION CENTER	**1031 SOUTHWEST 130TH STREET BURIEN, WA 98146**

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 -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 4) in the late afternoon or evening of 07/22/2020, but reported to work on 07/23/2020. Staff H stated she experienced mostly cough, a little chest phlegm, then it got worse with fatigue and shortness of breath. When asked if she had reported her symptoms to her supervisor, Staff H stated, I told (Staff I), and she told me if I feel worse, let her know and Staff C. Staff H stated she left work around 3:30 or 4:00 PM. Review of employee pay roll hours showed Staff H reported to work at 7:11 AM and left at 3:40 PM on 07/23/2020. Staff H stated she resulted positive for COVID-19 the following day on 07/24/2020. In an interview with Staff I on 08/05/2020 at 12:17 PM, when asked if Staff H reported to her she was sick on 07/23/2020, Staff I stated, She said she had a kidney stone and that her back was hurting. She said she had some allergies [REDACTED]. She had a runny nose, sniffling, and (Staff H) said 'It's just my allergies [REDACTED]. Staff I also resulted positive for COVID-19 on 07/30/2020. Review of other July 2020 employee screening logs showed temperatures 99 degrees and above, and lower than usual body temperatures (below 97 degrees) with no documentation to show facility follow-up, and lack of screening on days worked: Review of payroll hours showed Staff R, Certified Nursing Assistant (CNA) worked 07/04/2020, 07/09/2020 and 07/18/2020, Staff X, CNA, worked on 07/09/2020, 07/17/2020 and 07/18/2020, and Staff S, Cook, worked on 07/01/2020, 07/02/2020, 07/08/2020, 07/09/2020, 07/10/2020, 07/12/2020, 07/15/2020, 07/16/2020, 07/19/2020, 07/20/2020, 07/22/0220, 07/26/2020, 07/27/2020, 07/29/2020 and 07/30/2020 and no information was documented on the screening log for those days. Staff with low-grade temperatures included: Staff U, RN, on 07/07/2020; Staff V, Licensed Practical Nurse (LPN) on 07/13/2020; Staff W, RN, on 07/07/2020, 07/08/2020, 07/13/2020, 07/14/2020, 07/16/2020, 07/21/2020, 07/30/2020, and 07/31/2020; Staff CC, RN, on 07/10/2020; Staff DD, Dietary Staff, on 07/21/2020, 07/23/2020, and 07/26/2020; Staff EE, CNA, on 07/26/2020 and 07/30/2020; Staff FF, CNA, on 07/04/2020; Staff GG, LPN, on 07/07/2020 and 07/27/2020; Staff HH, Therapist, on 07/27/2020; Staff II, CNA, on 07/07/2020 and 07/20/2020. Staff with lower than usual body temperatures and no follow-up included: Staff Y, Admissions, 95.3 on 07/01/2020 and 94.7 on 07/08/2020; Staff Z, Dietary Director, 91.0 on 07/03/2020 and 92.2 on 07/22/2020; Staff AA, Dietary Staff, 95 on 07/03/2020, 94 on 07/07/2020, 95 on 07/09/2020, 94 on 07/10/2020, 94 on 07/21/2020 and 93 on 07/26/2020; Staff J 93.8 on 07/22/2020; Staff BB, Dietary Staff, 79.5 on 07/23/2020. Staff T's, CNA, answers to the screening questions were illegible, some with check marks and others blank or with a line across, and Staff DD's screening log also showed he answered with a scribbled line across the COVID-19 screening questions instead of a Yes or No between 07/07/2020 and 07/30/2020, with no follow-up by the facility to ensure COVID-19 signs and symptoms were not present. ADDITIONAL OBSERVATION An observation on 07/27/2020 at 8:30 AM showed signage next to Resident #2's room that showed, Special/Droplet/Contact Precautions. The door to her room was open, contrary to the sign saying, Keep Door Closed. In an interview on 07/27/2020 at 8:40 AM, when asked why the resident was on precautions, Staff E, LPN stated, She was exposed to her roommate (Resident #1). When asked if the door should be closed as instructed by the signage, Staff E, LPN, stated, Yes, it should be closed. The facility failed to follow its 05/08/2020 COVID-19 policy to, Place a patient with suspected COVID-19 on isolation . isolate him/her in a private room with the door closed. FAILED TO IMPLEMENT AN INFECTION CONTROL QAPI PROCESS A 03/20/2020 QAPI (Quality Assurance Performance Improvement) Plan showed, the QAPI program will aim for safety and high quality with all clinical interventions and service delivery . by ensuring our data collection tools and monitoring systems are in place and are consistent for proactive analysis, system failure analysis, and corrective action. In an interview on 08/18/2020 at 1:04 PM, when asked what tools and monitoring systems the facility developed and implemented to ensure sustained and effective IC processes with the advent of the COVID-19 pandemic, Staff A stated, First, the IC policy was reviewed and implemented. We spent a lot of time on what to do when there is an outbreak. Updated the facility exposure plan in March 2020, the COVID-19 checklist, the Department of Health also assessed us in April 2020. Developed the screening log, the cleaning logs rounds, daily team meetings, tracking of PPE supplies. When asked how the facility ensured sustained compliance with IC practices for prevention of COVID-19 infection, Staff A stated, I know he (Infection Preventionist) had PPE observations in June (2020). When asked if the COVID-19 pandemic was considered a high risk or problem-prone issue that the facility should have known about and ensured sustained compliance, Staff A stated, That's what we are talking about, status meetings a couple times a month, and those should be in with the QAPI, that's how we review our systems, and review our screening logs. There wasn't a lot of evidence of him (the IP) looking at that. When asked if the lack of monitoring staff compliance and competency with IC practices detracted the facility from identifying and correcting potential or actual IC issues, Staff A stated, Yes. In an interview on 08/28/2020 at 8:11 PM, Staff C confirmed a total of 53 out of 92 residents and 29 staff had contracted COVID-19 since 07/21/2020. Six residents had since passed away. REFERENCE: WAC 388-07-1320(1)(a)(c). .