STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505400	A. BUILDING _____ B. WING _____	**03/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ENUMCLAW HEALTH & REHAB CENTER	**2323 JENSEN STREET ENUMCLAW, WA 98022**

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 -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews the facility failed to take appropriate actions related to a COVID-19 outbreak. These failed practices may have contributed to multiple residents and staff contracting COVID-19. As of [DATE], based upon the facility's incomplete LTC (Long Term Care) Respiratory Surveillance Line List, and multiple staff interviews, 15 residents tested positive for Coronavirus disease (COVID-19) and 9 residents had pending lab results. Three residents who tested positive for COVID-19 remained at the local hospital. As of [DATE] 38 residents and 10 staff tested positive for COVID-19. Five residents expired. Additionally the facility failed to operationalize their infection prevention and control program to provide a safe, sanitary environment, and to help prevent the development and transmission of communicable diseases and infections, in particular COVID-19. These failed practices resulted in an immediate jeopardy on [DATE]. Findings included . On [DATE]th CMS (Center for Medicare & Medicaid Services) released a transmittal to nursing homes that directed nursing homes to monitor the CDC (Center for Disease Control) website which included a link to CDC. Upon clicking on the link it directs the facility to a Coronavirus Disease 2019 (COVID-19) Preparedness Checklist for Nursing Homes and other Long-Term Care Settings This checklist should be used as one tool in developing a comprehensive COVID-19 response plan. The checklist did not describe mandatory requirements or standards; rather, it highlights important areas to review to prepare for the possibility of residents with COVID-19. In general, when caring for residents with undiagnosed respiratory infection use Standard, Contact, and Droplet Precautions with eye protection unless the suspected [DIAGNOSES REDACTED].g., [MEDICAL CONDITION]). This includes restricting residents with respiratory infection to their rooms. If they leave the room, residents should wear a facemask (if tolerated) or use tissues to cover their mouth and nose. Continue to assess the need for Transmission-Based Precautions as more information about the resident's suspected [DIAGNOSES REDACTED]. VISITOR ENTRY Review of the facility February 2020 Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease (COVID-19) or Persons Under Investigation for COVID-19 policy, showed the procedure directed staff to manage visitor access and movement within the facility. The Centers of Disease Control (CDC) Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings recommended, Limit points of entry to the facility. The back door was posted with the following signs; No Admittance - Use front door only, Attention: Due to recent outbreak of COVID-19 in our nation we are trying to minimize all-essential access to the center and a second posting to those with questions, regarding the facility's management of [MEDICAL CONDITION], to call Staff C with a listed phone number. The front door had one sign posted directing those with questions, regarding the facility's management of [MEDICAL CONDITION], to call Staff C with a listed phone number. On [DATE] Staff G, Housekeeping, was observed walking down the hallway, carrying a mask, looking for assistance as they were told to spray with disinfectant and bag the mask before going home. Administrative Staff assisted Staff G, who then exited the facility out the back door. Later on, during the onsite visit, Staff G was observed in the facility without wearing a protective facial mask. Staff G was not observed to have come into the facility by either the front or back entrance, nor observed to have been screened for symptoms of COVID-19. During an interview on [DATE] at 1:04 PM, Staff D stated that she did not know how staff G re-entered the facility, but she re-educated Staff G on the process. According to Staff D, the facility doors are locked but staff have a code to unlock the door and enter the facility. When asked why Staff G returned, Staff D stated that Staff G went to get a Burrito or Taco out of the break room. The Centers of Disease Control (CDC) Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings recommended, All visitors should be actively assessed for fever and respiratory symptoms upon entry to the facility. If fever or respiratory symptoms are present, visitor should not be allowed entry into the facility. Upon entrance to the facility, on [DATE] at 1:41 PM, the facility requested the surveyor to complete a health screening form at the reception desk, located in the foyer, directly to the right of the front entrance. Located at reception was a sign in sheet with visitors listed. During an interview with Staff A, the visitors listed included two plumbers on [DATE] and a hospice staff member on [DATE]. Staff A, Administrator, then escorted the surveyor, down the hallways, past ten resident rooms,and through resident care areas, to Nursing Station #2 located in the 500 unit the epicenter of the facility's COVID-19 outbreak, to be screened for the presence of a fever. The only thermometer available, at the nurse's station, was an oral thermometer, so the surveyor had to remove their face mask to be screened for the presence of a temperature. When questioned regarding the use of an oral thermometer, Staff A stated, That's all we have. INFECTION SURVEILLANCE HealthCare Workers A [DATE] letter to Long-Term Care Facility Director, from WA (Washington) State DOH (Department of Health), instructed the facility to Immediately notify the health department about anyone with COVID-19 or if you identify two or more residents or healthcare providers who develop respiratory infections within a week. Review of the facility COVID-19 Timeline showed that on [DATE] three staff (Staff H, I, J) were identified as symptomatic. The facility failed to notify the Department or DOH of healthcare workers with symptoms. According to the facility provided Timeline, on [DATE] Staff K exhibited symptoms of a fever and cough. Review of the line listing provided by the facility on [DATE] at 9:03 AM showed, Staff K was not entered on the line list. Further review of the facility Timeline showed on [DATE], Staff L, M, B, D and N were symptomatic. Review of the line listing, provided by the facility on [DATE] at 9:03 AM, showed the results of testing conducted were not noted for Staff L, M and N. Residents On [DATE] at 4:01 PM the Department received an anonymous Report that: Supposedly the facility is in lockdown yet they are admitting patients from St. Elizabeth Hospital in Enumclaw where the coronavirus has affected a patient. According to the facility Timeline, On [DATE] Resident #14 and #15 were admitted to the facility. On [DATE] Resident #13 was readmitted to the facility from St. Elizabeth Hospital. Staff B, interviewed on [DATE] at 10:00 AM, stated that the facility stopped admitting residents on [DATE] because residents exhibited symptoms of suspected COVID-19. On [DATE] at 7:18 PM the Department received notification from the facility of seven Residents (#s 8, 9, 10, 11, 12, 13 & 14) who presented with acute fever and/or respiratory symptoms. According to the report, Per Medical Director, all symptomatic residents were placed on Droplet/Contact isolation and sent to the Emergency Department for COVID testing. Review of the line listing showed Resident's #s 12, 13, & 14 first exhibited symptoms on [DATE], but review of the resident's clinical records showed on [DATE] that Residents #12 and #13 had elevated temperatures and Resident #14 had other reported symptoms that were present. During an interview on [DATE] at 1:04 PM Staff D stated that she and Staff B called the DOH on [DATE] after they received a resident's COVID-19 positive test result. The DOH representative sent the facility the Long Term Care (LTC) Tool Kit to use and said if the facility had questions or needed help to call. Staff D stated that she had been emailing the line lists, but the facility had not called and requested assistance, and had not spoken with a DOH representative since [DATE]. During an interview on [DATE] at 10:00 AM, Staff B stated that DOH called the facility back and said they wouldn't go out to the facility because there were only three COVID-19 positive residents of seven tested . Review of the documents provided by Staff C on [DATE] included the LTC (Long Term Care) Tool Kit included Aggressive Infection Prevention and Control Actions for Facilities with Suspected or Confirmed Cases of COVID-19,

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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) which directed the facility to Treat all other residents in that same section or unit as if they have been exposed and implement Droplet and Contact Precautions with eye protection in the entire unit. Review of facility Infection Control (IC) documentation showed Resident #1 was in room [ROOM NUMBER], bed B on [DATE]. On [DATE] Resident #2 was also in room [ROOM NUMBER], bed A. On [DATE] Resident #2 was symptomatic for COVID-19, and moved to room [ROOM NUMBER]A on the 200 unit, which the facility dedicated to the care of COVID-19 positive residents. Resident #2 tested positive for COVID-19 on [DATE]. Resident #1 remained in room [ROOM NUMBER], and was not placed on precautions until Resident #1 exhibited symptoms on [DATE]. Resident #1 tested positive on [DATE]. On [DATE] Resident #3 and Resident #4 were roommates in room [ROOM NUMBER]. On [DATE] Resident #3 exhibited symptoms, was moved to the 200 unit and tested positive for COVID-19. On [DATE] Resident #4 was not observed on precautions. During an interview on [DATE] Staff B stated that Resident #4 was exhibiting symptoms and was placed on isolation this morning. On [DATE] Resident #5 and Resident #6 were roommates in room [ROOM NUMBER]. On [DATE] Resident #5 was observed in room [ROOM NUMBER], on precautions, pending COVID-19 test results. On [DATE] Resident #5's COVID-19 test results were positive. On [DATE] Resident #6 was observed in room [ROOM NUMBER] still not on any isolation precautions. During an interview on [DATE] at 1:04 PM when asked why roommates of symptomatic residents were not placed on precautions until symptomatic, Staff D stated that they were told by corporate not to start the roommate on isolation, and continue with surveillance to conserve PPE (Personal Protective Equipment). Corporate Nurse, Staff C, interviewed on [DATE] at 1:45 PM, stated that roommates, of residents who were positive for the COVID-19 virus, were not placed on any isolation precautions unless the roommates presented with symptoms of COVID-19, to conserve PPE's. On [DATE] all staff were observed wearing masks. Review of documents Covid-19 Timeline provided by the facility showed that on [DATE] all staff that had contact with positive residents were issued a facemask to be worn, and education was provided. In an email on [DATE] at 3:11 PM, when asked when the facility implemented universal face masks were to be worn by all staff, Staff A replied, [DATE]. STANDARD and TRANSMISSION-BASED PRECAUTIONS On [DATE] Resident #7's room was observed with posted precautions, and an infection control (IC) cart outside the room. Staff F, Lead Aide was observed to donn and doff Personal Protective Equipment (PPE) to respond to Resident #7's request for potato chips. Staff F was wearing a N95 mask, donned disposable gown and gloves but there was no eye protection in the IC cart. Staff D went down the hallway and retrieved goggles, which Staff F donned over N95 mask. Staff F entered the resident's room, provided the potato chips, and removed the gown and gloves prior to exiting the room. Outside the room, Staff F removed the goggles, and disinfected them. Staff D cued Staff F that the removal and cleaning of goggles should have been conducted before leaving the room. Refer to WAC [DATE](1)(a)(2)(a)(b)(c)