STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505085	A. BUILDING _____ B. WING _____	**08/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRESCENT HEALTH CARE, INC	**505 NORTH 40TH AVENUE YAKIMA, WA 98908**

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 develop and implement an effective infection control program related to the Centers for Medicare and Medicaid Services (CMS) required screening of healthcare personnel for COVID-19 (a highly communicable infection). Failure to implement interventions intended to mitigate the risk for the spread of COVID-19 by screening all individuals at an entrance screening station, placed all residents and staff at risk for exposure to COVID-19. Findings included . Review of the CMS April 2, 2020 guidance titled COVID-19 Long-Term Care Facility Guidance showed the following: Long-term care facilities should immediately implement symptom screening for all. - In accordance with previous CMS guidance, every individual regardless of reason entering a long-term care facility (including residents, staff, visitors, outside healthcare workers, vendors, etc.) should be asked about COVID-19 symptoms and they must also have their temperature checked. An exception to this is Emergency Medical Service (EMS) workers responding to an urgent medical need. They do not have to be screened, as they are typically screened separately. - Facilities should limit access points and ensure that all accessible entrances have a screening station. Review of the 7/2020 facility policy titled (Facility name) routine infection prevention and control (IPC) practices during the COVID-19 pandemic showed the following: - The facility will restrict visitors except those visiting residents on hospice or at the end of life. Only the locked front door will provide access to the facility. All visitors will be screened prior to being allowed in resident care areas. - Staff will enter and exit through the front door. - The facility will screen everyone (residents, staff, visitors) entering the healthcare facility for symptoms consistent with COVID-19 or exposure to others with [DIAGNOSES REDACTED]-CoV-2 Infection and ensure they are [MEDICATION NAME] source control. On 08/06/2020 at 9:35 AM, the State investigator entered the facility at the West main entrance door. The investigator observed a screening station for COVID-19 (infectious disease caused by severe, acute respiratory syndrome) at the front entrance. A staff member led the investigator down the hallway and to the right to the nursing station (approximately 30 to 35 feet). The nursing station was adjacent to the South hall of resident rooms. Staff D, Registered Nurse, screened the investigator at the nursing station, and stated the screening station at the front entrance was for visitors, and the one at the nursing station was for staff and consultants. The investigator then questioned Staff A, Administrator, as to why staff and consultants were not being screened at the front entrance, to which she responded, well it's been working as we haven't had any COVID. On 08/07/2020 at 1:55 PM, Collateral Contact A, Public Health Nurse, stated on phone interview that they were not screened by the facility staff during an onsite visit on 08/06/2020. Additionally, Collateral Contact A stated all screening should be done at the facility entrance. On 08/11/2020 at 8:30 AM, two State investigators were let in the front entrance by office staff and escorted to the nurse's station to meet with Staff C, Infection Preventionist. The investigator announced the visit purpose was a Focused Infection Control Survey for their current COVID-19 outbreak. Staff C stated they were very busy and in the middle of testing the residents for COVID-19 that morning. Both State investigators waited for several minutes before prompting the facility staff to screen them. Staff C then initiated screening and stated they screened the consultants there at the nurse's station. On 08/12/2020 at 1:40 PM, the State investigators entered the facility for the second day of the Focus Infection Control Survey and were screened by Staff D at the nurse's station. Staff D stated they were the charge nurse and worked from 10:00 AM to 7:00 PM and would screen the staff, physicians and consultants at the nurses station. Staff D stated that all staff were required to enter the building through West front entrance door for screening prior to their shift. During an interview on 08/12/2020 at 2:35 PM, Staff E, Maintenance Director, stated that he was screened each morning at the nurse's station. When asked if he entered through the west (main entrance), Staff E stated that he did not. My shop is in the back. He would walk in through the East entrance, passing 12 resident rooms to the nurse's station. On 08/17/2020 at 2:15 PM, Staff A was informed of the failure to screen individuals at the facility entrance and Staff A stated that she did not have enough staff to do that. Reference: WAC 388-97-1320 (1)(a)(c) .
F 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	Based on observation, interview and record review, the facility failed to develop a process for notifying residents, their representatives and families by 5:00 PM the next calendar day each time a confirmed COVID-19 test result was identified, or whenever three or more residents or staff with new onset of respiratory symptoms occurred within 72 hours of each other. Further, there was no system in place to notify residents and their representatives of the required weekly cumulative COVID-19 case counts. This failure put residents and their representatives at risk of not being fully informed of COVID-19 activity in the facility. The deficiency occurred during the COVID-19 pandemic and affected 71 of 71 residents. Findings included . On 08/11/2020 at 8:45 AM, Staff A, Administrator, was asked what mechanisms the facility used to meet the Centers for Medicare and Medicaid Services (CMS) 05/08/2020 requirement to inform residents, their representatives and families of confirmed or suspected COVID-19 activity in the facility. Staff A stated the information was posted on their Facebook Internet site and Staff C, Infection Preventionist, also made phone calls. Record review of the facility's Respiratory Surveillance Line List showed positive COVID-19 cases for residents, after the CMS requirement, were on 07/29/2020 and 08/04/2020. The COVID-19 cases among facility staff were documented on 05/08/2020, 05/18/2020, 05/22/2020, 06/17/2020, 06/19/2020, 07/07/2020, 07/24/2020, 07/25/2020 and the final five staff entries were without dates. Review of the facility Facebook Internet site on 08/13/2020 showed updates on 07/17/2020, 07/21/2020, 07/30/2020, 08/03/2020, 08/07/2020 and 08/11/2020. None of the postings included cumulative updates of confirmed COVID-19 cases, nor did they all meet the required notification timelines. Resident #3. Review of the resident's medical record showed they were admitted in April 2020 and was cognitively intact. On 08/12/2020 at 2:55 PM, Resident #3 was observed in their room on the COVID-19 unit and stated they had not heard of any cases of COVID at the facility until last week when they tested positive. On 08/13/2020 at 2:40 PM, Resident #3's representative stated during a phone interview that they were not aware of any cases of COVID in the facility prior to Resident #3's positive result on 08/06/2020. They had not been notified of the facility Facebook Internet site for information. Resident #8. Review of the resident's medical record showed they were admitted to the facility in 2014 and had severe cognitive impairment. On 08/13/2020 at 3:00 PM, the representative for Resident #8 stated during a phone interview that they were not aware of any previous cases of COVID-19 among staff or residents, They were also not aware of the facility Internet site for information. Resident #18. Review of the resident's medical record showed the resident was admitted in June 2019 and was cognitively intact. On 08/13/2020 at 4:15 PM, the representative for Resident #18 stated during a phone interview that they were not aware of the facility Internet information site nor had they received any calls or e-mails regarding the COVID-19 cases among staff and residents at the facility. On 08/17/2020 at 2:25 PM, Staff A was informed that the sampled resident and resident representatives were not aware of previous COVID-19 cases, nor aware of the Facebook page. Staff A acknowledged the facility posting on Facebook did not include the required cumulative COVID-19 case count. No associated WAC reference

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE