STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505299	A. BUILDING _____ B. WING _____	06/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PUGET SOUND HEALTHCARE CENTER	4001 CAPITOL MALL DR SOUTHWEST OLYMPIA, WA 98502

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** - 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 a systemic consistent process to actively monitor all residents, as well as screen staff, for symptoms consistent with COVID-19. COVID-19 is an infectious disease by a new virus causing respiratory illness with symptoms including cough, fever, new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death. In addition, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections. Specifically, 1. Facility failed to develop a consistent system for actively monitoring residents and staff for expanded COVID-19 symptom for 7 of 7 sampled residents (R) (R1, R2, R3, R4, R5, R6, R7), 5 of 5 unsampled residents (R8, R9, R10, R11, and R12) which included all ten residents in the isolation unit (R1, R3, R4, R5, R6, R7, R8, R9, R10, R11) and for 3 of 3 months (April, May and June) for staff monitoring logs. 2. Failed to disinfect reusable forehead thermometer, per manufacturer's instructions, between use on 7 of 7 unsampled residents (R) (R17, R18, R19, R13, R15, R20, R21) observed for temperature monitoring with reusable forehead thermometer. 3. Two of two staff (Certified Nursing Assistant (CNA)2 and CNA3 failed to perform hand hygiene between glove changes during incontinence care for 1 of 1 unsampled resident (R12) observed for incontinence care. 4. Failed to perform hand hygiene when delivering meals to 3 of 8 unsampled residents (R13, R14, and R15). These failures represented systemic failures which increased the risks for delayed identification of COVID-19 and therefore increase the risk for spreading COVID-19 and other communicable diseases and infections amongst residents and staff. Findings include: During an interview on 6/4/20 at 8:30 AM Director of Nursing (DON) stated that facility census was 89, facility was admitting residents, and the facility had no current known or suspected/presumed positive COVID-19 residents or staff. It was further stated that there was an isolation unit for new admissions or residents who frequently leave; such as [MEDICAL TREATMENT] or appointments. The residents stayed on the isolation unit for 14 days and staff wore gown, gloves, surgical face mask unless the resident was positive or suspected to be positive and then staff wore N95 mask and eye protection. DON also stated that preadmission screening includes review of signs and symptoms of COVID-19 and if there are signs and symptoms of COVID-19, the facility requests the hospital to conduct a COVID-19 test, some hospitals are conducting COVID-19 tests prior to admission and the facility does not accept residents with COVID-19 positive test results. Isolation unit has dedicated certified nursing assistant (CNA) staff and up until Monday, 6/1/20, the isolation had dedicated licensed nursing staff but due to vacation allowance, nurses are covering both isolation unit and non-isolation unit. 1. Resident and staff monitoring for COVID-19 symptoms *Resident monitoring During an interview on 6/4/20 at 8:30 AM Director of Nursing (DON) stated that resident COVID-19 symptom monitoring was conducted twice a day and documented on the resident's Medication Admission Record (MAR). When asked to provide facility's policies and procedures on COVID-19 including surveillance, transmission-based precautions, staff monitoring, the facility provided a large three ring binder filled with documents. Facility provided document titled, Cornerstone COVID-19 Interim Infection Prevention and Control Guidance for Residents and Staff with Suspected or Confirmed Coronavirus Disease, updated 5/22/20, showed every resident in our facilities has their temperature taken two times a day and are being monitored for respiratory signs and symptoms of COVID as well as updated signs and symptoms as they are reported by the CDC. (Centers for Disease Control and Prevention). The document further stated under Staff with Symptoms are to leave the facility and be tested that symptoms associated with COVID-19 will be assessed---cough, shortness of breath, and sore throat (other symptoms may include muscle aches, nausea, vomiting, diarrhea, abdominal pain, headache, runny nose and fatigue). CDC's Preparing for COVID-19 in Nursing Homes, https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, accessed 6/10/20, showed Evaluate and Manage Residents with Symptoms of COVID-19: Ask residents to report if they feel feverish or have symptoms consistent with COVID-19. Actively monitor all residents upon admission and at least daily for fever (T?100.0 F) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement Transmission-Based Precautions .Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell .Identification of these symptoms should prompt isolation and further evaluation for COVID-19. Record review of facility document, Minimizing Chance of Exposure for Admissions, updated 3/23, showed upon arrival: timely nursing assessment for respiratory symptoms every shift for 14 day. Observation on 6/4/20 between 9:35 AM and 10:45 AM showed the following residents (R1, R3, R4, R5, R6, R7, R8, R9, R10, and R1) resided on the isolation unit. Record review of R1, R3, R4, R5, R6, R7, R8, R9, R10, R11 and R12's current physician orders [REDACTED].*R4 was admitted from the hospital on [DATE] with [DIAGNOSES REDACTED]. Additional orders showed ok to do COVID-19 testing as needed for following symptoms: fever, cough, shortness of breath, known exposure. While at the facility, resident was on continuous oxygen and received several as needed nebulizer treatments (treatment that generated aerosols, which could increase the spread of COVID-19) for shortness of breath/wheezing. Record review of physician assistant progress notes, dated 5/30/20, showed resident was mildly short of breath when she presented via emergency medical services to the emergency room at the hospital with chest x-ray negative. resident had a history of [REDACTED]. Provider notes included exposure to COVID 19 virus: patient at risk for exposure to COVID 19 virus due to recent hospitalization . Nursing to monitor for signs and symptoms of [MEDICAL CONDITION] infection and notify provider if present. During an interview on 6/4/20 at 3:00 PM when asked for R4's COVID-19 laboratory results, IP stated that R4 was not tested for COVID-19 because the hospital that resident was transferred from does not do COVID-19 testing if there are no signs and symptoms of COVID-19. When asked how the facility knew resident did not have COVID-19 if no laboratory testing was done, especially since the resident did have respiratory symptoms. IP was also asked how the resident's respiratory symptoms was differentiated between COVID-19 and [MEDICAL CONDITION], if there was no COVID-19 testing completed, IP stated that these questions would be best addressed by the admissions coordinator because they don't include me unless there is an active infection. R4 had respiratory symptoms but there was no documented evidence of active monitoring for all symptoms consistent with COVID-19. *R3 was admitted on [DATE] with [DIAGNOSES REDACTED]. There were no documented evidence of monitoring for other COVID-19 symptoms such as cough or shortness of breath. *R9 was admitted on [DATE] with [DIAGNOSES REDACTED]. In addition, some diabetes-related health issues, such as nerve damage and reduced blood flow to the extremities, increase the body's vulnerability to infection) and orders showed conduct COVID-19 testing on resident member PRN (as needed) for the following symptoms: fever, cough, SOB (shortness of breath) or known exposure. Resident used a continuous positive airway pressure device. No documented evidence was found for temperature monitoring either daily or twice daily. *R1 was admitted on [DATE] with [DIAGNOSES REDACTED]. *R8 was admitted on [DATE] with [DIAGNOSES REDACTED]. Additional orders showed conduct COVID-19 testing on resident PRN (as needed) for the following symptoms: fever, cough, SOB (shortness of breath) or know(n) exposure. Resident used a continuous positive airway pressure device. *R10 was admitted on [DATE] with [DIAGNOSES REDACTED]. *R11 was admitted on [DATE] with [DIAGNOSES REDACTED]. *R5 was admitted on [DATE] with

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** - Many	(continued... from page 1) [DIAGNOSES REDACTED]. Orders were shown for conduct COVID-19 testing on resident PRN (as needed) for the following symptoms: fever, cough, SOB (shortness of breath), or known exposure. *R6 was admitted on [DATE] with [DIAGNOSES REDACTED]. *R7 was admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of current physician orders [REDACTED]. There was no documented evidence the facility monitored residents, in accordance with facility provided document, for symptoms associated with COVID-19 including muscle aches, nausea, vomiting, diarrhea, abdominal pain, headache, runny nose and fatigue. In addition, the facility document showed resident monitoring would include updated signs and symptoms as reported by the CDC. The CDC reference source showed additional symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Monitoring of these symptoms was important to facilitate prompt identification and action to contain the spread of COVID-19. During an interview on 6/4/20 at 2:45 PM when asked what COVID-19 signs and symptoms licensed nurse (LN) expects CNAs to report to him, LN1 stated, increased temperature, anything above 100.4 degrees Fahrenheit, headache, shortness of breath or cough. When asked how often residents are monitored for COVID-19 signs and symptoms, LN1 stated that temperatures are taken every shift and if increased temperature, residents are put on alert and then vital signs are taken every shift, residents are monitored, with physician and managers notified. When asked if COVID-19 symptom monitoring includes assessment of oxygen level via pulse oximeter, LN1 stated that only residents on supplemental oxygen get oxygen saturation levels checked, but it is one of vital signs taken when a resident is on alert. When asked if there were any other COVID-19 signs or symptoms that were actively monitored, LN1 shook his head and said, no. When asked about malaise, loss of sense of smell/taste, diarrhea, LN1 stated, I see what you mean, there are more and more signs and symptoms each day. I guess, we look for anything different, anything out of the norm. When asked what was documented to reflect active COVID-19 symptom monitoring, LN1 stated temperature, SOB, cough, and headache is what is was documented. If it wasn't documented, there was no evidence of active assessment or monitoring. During an interview on 6/4/20 at 2:55 PM when asked about resident monitoring for COVID-19 signs and symptoms Infection Preventionist (IP) stated that temperatures were being monitored and about two weeks ago, additional signs and symptoms were added and staff were asked to add the additional signs and symptoms for monitoring. IP stated that COVID-19 symptom monitoring does not require a physician order [REDACTED]. After record review of R4's MAR and physician order [REDACTED]. supplemental COVID-19 signs and symptom monitoring but should have. During an interview on 6/4/20 at 4:30 PM with IP and DON, DON stated all residents have temperature taken and are monitored for shortness of breath, cough and fever twice a day. After record review of R4's MAR and physician order [REDACTED]. DON and surveyor then reviewed R8's records and DON stated that R8 did not have full COVID-19 signs and symptoms monitoring as only vital signs, including temperature and oxygen saturation levels were documented as monitored but did not include an assessment of cough, SOB, headache, or any of the other COVID-19 signs and symptoms. Review of R3's records were reviewed which showed temperatures were monitored twice daily and DON confirmed absence of COVID-19 symptom monitoring including cough, SOB, headache and other signs and symptoms. DON stated that R3 was in isolation unit because of a one-hour doctor's appointment and only needed daily temperature monitoring because we don't suspect COVID for him. *Staff monitoring Facility provided document titled, Cornerstone COVID-19 Interim Infection Prevention and Control Guidance for Residents and Staff with Suspected or Confirmed Coronavirus Disease, updated 5/22/20, showed facility implemented screening for all personnel entering the facility-they are being asked about symptoms and are having their temperatures checked and documented. They are required to sign an attestation stating that they have no symptoms. Staff will enter the facility through a designated entrance and take their temperatures as well as sign a statement that says that they have not been exposed to [MEDICAL CONDITION], have symptoms of [MEDICAL CONDITION] The document further stated under Staff with Symptoms are to leave the facility and be tested that symptoms associated with COVID-19 will be assessed-cough, shortness of breath, and sore throat (other symptoms may include muscle aches, nausea, vomiting, diarrhea, abdominal pain, headache, runny nose and fatigue). CDC's Preparing for COVID-19 in Nursing Homes, https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, accessed 6/10/20, showed Evaluate and Manage Healthcare Personnel (HCP). Screen all HCP at the beginning of their shift for fever* and symptoms of COVID-19. Actively take their temperature and document absence of symptoms consistent with COVID-19 .Watch for symptoms. People with COVID-19 have had a wide range of symptoms reported - ranging from mild symptoms to severe illness . People with these symptoms may have COVID-19: Fever or chills, Cough, Shortness of breath or difficulty breathing, Fatigue, Muscle or body aches, Headache, New loss of taste or smell, Sore throat, Congestion or runny nose, Nausea or vomiting, Diarrhea. *Fever is either measured temperature >100.0 F or subjective fever. Review of Staff self-temperature attestation log, dated 6/3/20, showed I hereby attest that I took my temperature prior to my scheduled shift today. I confirm that my temperature today was less than 100.4 degrees Fahrenheit. Daily staff temperture (sic) must be obtained prior to their scheduled shift. The form showed several columns with column headings for staff name, time in, have you have any respiratory symptoms such as difficulty breathing, sore throat, cough? Y/N temp(erature), signature. The facility screening of staff for fever at 100.4 degrees Fahrenheit was a higher threshold than outlined in CDC's definition of fever as 100.0 degrees Fahrenheit. The facility screening of staff did not include expanded symptoms of COVID-19 including Fatigue, Muscle or body aches, Headache, New loss of taste or smell, Congestion or runny nose, Nausea or vomiting, or Diarrhea. Review of large three ring binder showed months of staff self-temperature attestation logs using the same form as described above. 2. Failed to disinfect reusable forehead thermometer, per manufacturer's instructions, after use on 7 of 7 unsampled residents (R) (R17, R18, R19, R13, R15, R20, R21) observed for temperature monitoring with reusable forehead thermometer. Observation on 6/4/20 between 9:10 AM and 9:25 AM showed Nursing Assistant Registered (NAR)1 in R14's room placing oral thermometer device in R14's mouth, NAR1 then removed and discarded disposable temperature probe, wrote down temperature and then perform hand hygiene before exiting room. NAR1 then entered R16's room and did the same steps. Unidentified staff approached NAR1 and asked if NAR1 was doing hand hygiene in and out of rooms and provided NAR1 with forehead thermometer and took oral thermometer device. NAR1 walked down the hall with forehead thermometer, piece of paper and Super sani cloth wipe container under her arm. NAR1 entered R17's room, placed thermometer on resident's forehead and moved the device about 3-5 inches across the resident's forehead. NAR1 then recorded temperature and removed a wipe from Super sani cloth container and wiped forehead thermometer area that touched resident's forehead. A few seconds later, NAR1 walked to R18's side of the room (R17 and R18 were roommates) and completed the same steps above to take resident's temperature. NAR1 did not provide adequate wet time with germicidal wipe to clean/disinfect thermometer. After registering and recording temperature, NAR1 removed sani cloth and wiped thermometer. NAR1 then moved quickly to R19's room and completed the same process of taking resident's temperature. NAR1 did not provide adequate wet time with germicidal wipe to clean/disinfect thermometer. After taking R19's temperature, NAR1 walked to R19's roommate, R13, side of the room, and took R13's temperature. The same process continued for R15, R20 and R21 (R20 and R21 were roommates). NAR1 did not provide adequate wet time with germicidal wipe to clean/disinfect thermometer. Review of the Super Sani-cloth container showed it was a germicidal disposable wipe to disinfect and deodorize. The container label showed to disinfect nonfood contact surfaces only. Unfold a clean wipe and thoroughly wet surface. Allow treated surface to remain wet for two (2) minutes. Let air dry. During an interview on 6/4/20 at 9:25 AM when asked how long forehead thermometer was wet before using on another resident, NAR1 stated maybe a few seconds. It dries very quickly. When asked what the purpose was for wiping thermometer with wipes, NAR1 stated that she was taught to clean thermometer after using on a resident and before use on another resident. When asked if NAR1 was aware there was a contact time for each disinfection used, NAR1 stated that she was not aware of this. When shown Super sani cloth container label showing two minutes wet time, NAR1 stated that the thermometer was not wet for two minutes. During an interview on 6/4/20 at 3:10 PM when asked about her expectation from staff when disinfecting forehead thermometer, IP stated that staff should be following manufacturer's instructions for disinfecting wipes to ensure wipes are effective. During an interview on 6/4/20 at 4:30 PM with DON and IP, DON stated that staff should be using [MEDICATION NAME] thermometer and not using forehead thermometer which touches resident's foreheads. DON also agreed that manufacturer's instructions dwell or contact time should be followed for cleaning and disinfecting thermometer between residents. Centers for Disease Control and Prevention Guideline for Disinfection and Sterilization in Healthcare Facilities, https://www.cdc.gov/infectioncontrol/guidelines/disinfection/index.html, accessed 6/2/20 showed perform low-level disinfection for noncritical patient-care surfaces (e.g., bedrails, over-the-bed table) and equipment (e.g., blood pressure cuff) that touch intact skin. Disinfect noncritical medical devices (e.g., blood pressure cuff) with an EPA-registered hospital disinfectant using the label's safety precautions and use directions. 3. Failed to perform hand hygiene Observation on 6/4/20 at about 11:30 AM showed CNA2 and CNA3 providing incontinence cares to R12, both CNAs wore gloves, raised bed and lowered the foot of the bed. CNA2 removed resident's soiled briefs and wiped periarea. CNA3 rolled resident on her side while CNA2 wiped resident's rectal area. CNA2 then removed gloves and donned new gloves. No hand hygiene was

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 2) performed between glove changes. CNA2 placed new brief under resident and repositioned resident and then applied barrier cream on resident's periarea. CNA2 removed gloves and donned new gloves. No hand hygiene was performed between glove changes. CNA3 fastened resident's briefs and doffed gloves and donned new gloves. No hand hygiene was performed between glove changes. Both CNAs then dressed resident in pants and shoes and used hoyer (mechanical lift device) to transfer resident from bed to wheelchair. After resident was in chair, both CNAs removed gloves and washed hands. During an interview on 6/4/20 at about 11:40 AM CNA2 stated that she usually sanitizes her hands before touching resident, after touching soiled briefs, and after removing gloves. When asked if hand hygiene was performed between glove changes, CNA2 said, no, but I should have. During an interview on 6/4/20 at 12:10 PM when asked about incontinence observation with R12, CNA3 stated I didn't hand sanitize after taking off gloves and before I put on the new ones. I usually wash my hands or hand sanitize, but I didn't. During an interview on 6/4/20 at 3:10 PM IP stated that facility policy includes staff performing hand hygiene between glove changes, especially during incontinence care. During an interview on 6/4/20 at 4:30 PM with DON and IP, both confirmed expectation is for staff to perform hand hygiene between glove changes. During an interview on 6/4/20 at 6:00 PM with DON and Chief Operations Officer (Administrator was on leave) both confirmed facility expectation of staff performing hand hygiene between glove changes. Record review of R12's current physician orders [REDACTED]. 4. Failed to perform hand hygiene when delivering meals to residents Observation on 6/4/20 at about 12:20 PM showed Nursing Assistant Registered (NAR)1 brought lunch trays to R13, R14, and R15's rooms. NAR1 was not observed performing hand hygiene before and after delivering the lunch trays to the three rooms. NAR1 assisted in setting up the lunch trays on over-bed tables and removed R13's meal tray cover. NAR1 removed meal tray cover, beverage and bowl lids from R14's and R15's meal trays after delivering meals into resident's rooms. During an interview on 6/4/20 at 3:10 PM when told staff were observed not performing hand hygiene while delivering meal trays to residents' rooms, the IP stated that facility policy includes staff performing hand hygiene whenever entering and exiting resident rooms and when delivering meal trays. We teach them to gel in/gel out. During an interview on 6/4/20 at 4:30 PM with DON and IP, both confirmed expectation is for staff to hand sanitize after delivering meal trays. During an interview on 6/4/20 at 6:00 PM with DON and Chief Operations Officer (Administrator was on leave) both confirmed facility expectation of staff performing hand hygiene when delivering meal trays. Facility policy, Handwashing/Hand Hygiene, dated August 2019, showed use of an alcohol-based hand rub or soap and water before and after assisting a resident with meals.