STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505017	A. BUILDING _____ B. WING _____	**08/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WASHINGTON CARE CENTER	**2821 SOUTH WALDEN STREET SEATTLE, WA 98144**

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** - Some	**Provide and implement an infection prevention and control program.** Based on observation, interview and record review, the facility failed to ensure a communicable disease/outbreak was reported to the State Survey Agency (SSA) within the required timeframe. Failure to complete required reporting of ten COVID-19 (Coronavirus - a contagious disease) positive cases did not ensure interventions were in place to protect the residents and/or prevent the spread of COVID-19. In addition, the facility failed to ensure adequate and complete screening of COVID-19 symptoms for two individuals who entered the facility on 07/30/2020. Findings included . REPORTING AN OUTBREAK Review of the October 2015 Nursing Home Guidelines - The Purple Book showed the facility must report any Communicable Disease/Outbreak to DSHS (Department of Social and Human Services - a SSA) Log Within 5 days, and also call the DSHS Hotline [PHONE NUMBER]. According to a Resident Representative (RR) in an interview on 07/13/2020 at 11:20 AM, COVID-19 is not being taken seriously. They have ten new cases of COVID-19 in the facility. Review of a facility electronic communication dated 07/13/2020 showed, These are the new cases of residents with COVID-19 we got here at Washington Care Center: 06/29/20 - 1 new case, 07/06/20 - 10 new cases since the 29th (of June), 07/13/2020 - 1 new case since the 6th (of July). Review of the facility July 2020 Reporting Log Form showed no documentation the SSA was notified of the ten cases identified on 07/06/2020, or the additional case of 07/13/2020, either by log or calling the Hotline. The above findings were shared in a joint interview with Staff A (Administrator) and Staff B (Director of Nursing) on 07/28/2020 at 3:31 PM. Staff A stated, As far as logging, I did not know we had to log in our regular log. The only thing we have not been doing is the logging and only recently calling it in to the Hotline. Staff A acknowledged the facility did not report multiple COVID-19 cases as required by law. COVID-19 SCREENING Observations on 07/30/2020 showed at 6:30 AM, upon approach of the facility Visitor Screening Area, Staff C (Receptionist) and the individual conducting visitor screening for COVID-19, informed the Surveyor, I don't have a temperature probe, but if you go up to the floors they can 'temp' you. Checking the temperature as part of the visitor screening process for COVID-19 is important as a fever is one of the most common symptoms associated with COVID-19 infection. Further observations on 07/30/2020 showed, upon arrival on the Third Floor, Staff D, Licensed Practical Nurse (LPN) approached the Surveyor at 6:43 AM, and did not ask the Surveyor if she was adequately screened. Upon entry into the COVID-19 unit at 6:50 AM, when Staff E, LPN, was asked if she was aware of temperature probe issues at the Visitor Screening area, she stated that she was unaware of any screening issues or the need to ask the Surveyor if she was adequately screened. The Surveyor had to ask Staff E to check her temperature. Additional observations showed, at 6:52 AM, upon return to the Visitor Screening Area, Staff C was sitting behind the counter, his head down, eyes closed, audible deep breathing, and glasses dropped to midnose level. When the Surveyor called Staff C's name twice, his eyes opened in startled fashion. When Staff C was asked if he was sleeping, Staff C mumbled words. When asked what was the issue with the the temperature probe, Staff C stated, The nurse from Third Floor, (Staff D), said he needed to borrow it real quick. When asked how long staff went without having their temperatures taken prior to reporting to their units/departments, Staff C stated, Maybe 15 minutes. When asked how many staff did not get their temperatures taken, Staff C stated, About two or three. Record review of the COVID-19 Screening Log showed, the surveyor and another staff, Staff F, did not have their temperatures taken as part of the screening process. When asked what floor Staff F went to, Staff C stated, I don't know. He said he would be back to get temp'ed (sic). When asked how he ensured staff temperatures were taken before reporting to their assigned areas, Staff C stated, I usually page over to the nurses station and let them know. They have to be by the phone to hear the page. When asked if he did that for Staff F, Staff C stated, I wasn't clear what floor he was going to. Staff C did not ask the Surveyor if her temperature was taken. The Surveyor indicated her temperature on the screening log. In a follow-up interview at 9:28 AM, Staff C confirmed Staff F did not get their temperature taken until after the surveyor left, and that he did not write down the time he took Staff F's temperature upon their return to the receptionist screening area. When asked if he had received training on COVID-19, Staff C stated, I'm new here. This is the first time the temperature probe has been taken to the floor. When asked what kind of training he received for screening individuals who entered the facility, Staff C stated, I would not have given the staff the scanner. I would have asked the First Floor nurse to check the temperature. When asked why he would choose the First Floor nurse to check the temperature over sending the staff to other floors, Staff C stated, It's important to screen. Staff C could not identify the importance of not allowing access to residential areas without adequate screening of individuals who entered the facility, to include checking the temperature. Staff C added, One of the nurses then gave me their personal (temperature) scanner for me to use afterwards. REFERENCE: WAC 388-97-1320 (1)(a)(c). .
F 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	Based on interview and record review, the facility failed to provide notification of new COVID-19 cases and weekly updates of COVID-19 status. This failure deprived the resident, their representatives or families from having the opportunity to choose whether they wanted to move forward with the COVID-19 management plan being proposed by the facility. Findings included . A undated facility policy titled COVID-19 Family and Resident Communication showed, Any significant updates to the facility's COVID-19 status as a whole will be shared on the facility's website www.wacenter.org. The administrator will be responsible for ensuring updates are posted. Review of a 06/13/2020 facility electronic communication showed, These are the new cases of residents with COVID-19 we got here at(NAME)Care Center: 06/29/20 - 1 new case, 07/06/20 - 10 new cases since the 29th (of June), 07/13/2020 - 1 new case since the 6th (of July). Review of the facility website on 07/28/2020 showed a 07/06/2020 update that stated, We have confirmed a new cluster of cases on our 3rd floor unit. All residents on the 3rd floor have been tested and we are still pending some results. As always, all positive and negative results are shared with individual patients and DPOAs (Durable Power of Attorneys). Once all the results are in, patients will be cohorted accordingly to prevent further spread. This website showed no weekly cumulative COVID-19 updates for the 07/06/2020 cluster of COVID-19 cases, or notification for the 07/13/2020 new COVID-19 case. No weekly cumulative updates were observed on the website on 07/20/2020 and 07/27/2020. In addition, review of progress notes between 07/13/2020 and 07/27/2020 for Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10, showed no documentation the facility provided weekly cumulative updates or notification of the new COVID-19 case of 07/13/2020. The above findings were shared with Staff A (Administrator) on 07/28/2020 at 3:31 PM. When asked what was posted on the facility website related to COVID-19, Staff A stated, A change on the floor as a whole is when we do an update on the website. Staff A acknowledged the lack of COVID-19 updates, new and cumulative, for the residents, their representatives and families. No Associated WAC. .

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