STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505027	A. BUILDING _____ B. WING _____	03/31/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTHSTONE, THE	**6720 EAST GREEN LAKE WAY NORTH SEATTLE, WA 98103**

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	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to operationalize all components of the infection prevention and control program to provide a safe, sanitary environment to help prevent the development and transmission of communicable diseases and infections for one of four sampled residents (R1) and four un-sampled residents (R5, R6, R7, R8). Additionally, the facility failed to wear personal protective equipment (PPE) correctly during resident care under isolation and droplet precautions for a respiratory illness. These failed practices has increased the likelihood for exposure and possibility of contracting [MEDICAL CONDITION] causing Coronavirus Disease 2019 COVID-19 (A new disease caused by a novel coronavirus that has not previously been seen in humans) to all the residents and staff. Findings include: 1). During a concurrent observation and interview on 03/25/20 at 05:04 PM, for R1 who was on isolation precautions for potential COVID-19. R1 was seen sitting on the floor near the bed to his left side and partially leaning back with the wheelchair behind him. NAC5 was seen inside R1's room wearing all required PPE except the eye protection. RN8 and NAC4 donned the appropriate PPE while utilizing an alternative long sleeved patient gown with a plastic apron over. RN8 inquired if R1 had any pain. RN proceeded to assist NAC5 and took R1's hands into their own and attempted to partially lift R1 into a sitting position and then to his bed. RN8 removed R1's urine soiled brief and handed it to NAC5. NAC5 discards the brief into the trash bin and removes a first layer of gloves. NAC5 discarded the brief into the trash bin and removed a first layer of gloves and leaving the second pair of gloves on. RN8 and NAC5 placed a clean brief on R1. NAC5 removed R1's socks, readjusted his gown, and repositioned him. RN8 leaned in beside R1's right ear, asked if had any pain and R1 proceeded to cough towards NAC5. NAC5 was seen to be standing on the left side of the bed at an arm's length away from R1. NAC5 state, I will stay in the room to assist R1 with dinner since I am wearing the last gown. NAC5 sits down to the left of R1's bed and stated that RN8 gave her his goggles to wear prior to RN8 leaving the room. NAC5 proceeded to feed R1 without changing gloves or any hand hygiene. While attempting to assist R1 eating his meal, R1 was seen coughing towards the direction of NAC5. NAC5 was seen to be seated on the left side of the bed about an arm's length away from R1. During an interview on 03/25/20 at 05:20 PM NAC5 acknowledged entering the isolation room without eye protection. NAC5 further explained there were only two goggles left in the PPE cart and her coworkers were wearing the last two goggles. NAC5 confirmed that she entered the isolation and droplet precaution room in a hurry due to R1 having an unwitnessed fall. NAC5 stated she wore double gloves and discarded the first layer after throwing away the dirty brief. NAC5 continued to state that she was unable to leave the room or wash her hands in the sink located beside R1's bed due to isolation and droplet precautions. During an observation on 03/25/20 at 05:51 PM, N95 mask with NAC5's name written on the mask was in a plastic bag inside the top drawer of the PPE cart for room [ROOM NUMBER]. During an interview on 03/25/20 at 05:53 PM, RN8 confirmed that NAC5 was not wearing the appropriate eye protection while in an isolation and droplet precaution room. RN8 further explained NAC5 may have increased her risk of exposure to COVID-19 by not wearing proper PPE. RN8 stated, In cases where there needs to be multiple staff in the (isolation) room, I can see how the lack of supplies in the PPE cart can be a problem. During an interview on 03/25/20 at 06:13 PM, the Director of Nursing Services/Director of Staff Development (DNS/DSD) stated, I can see how there is a risk of exposure when multiple staff have to go in the (isolation) room without enough PPE supplies. I did not think of this. I did not know NAC5 went into the room without goggles. That is not good. The only thing I can think of that she could do is to wash her face. DNS/DSD agreed that NAC5 is exposed by entering an isolation and droplet precaution room with a presumptive COVID-19 resident and increases the risk of spread of COVID-19 to the rest of the residents and/or staff. The DNS/DSD continued to state that the isolation (PPE) carts are refilled as needed and all staff have the responsibility to fill the cart rather than one staff member. The DNS/DSD further explained, There were staff exposed and are positive for COVID-19. At least 4 employees are positive. The DNS/DSD reported that R1's test results for COVID-19 have not been received by the facility yet. During an observation from 03/25/20 to 03/26/20 multiple staff are seen without wearing a mask in the common areas of the facility. Staff seen without a mask includes: DNS/DSD, administrator, CEO, and IC Nurse. During an interview on 03/26/20 at 10:49 PM, the Infection Control (IC) Nurse stated all PPE supplies, which includes gown, gloves, mask, and goggles, should be worn while in a droplet precaution room. The IC Nurse stated, Droplet precautions are within 3 feet and if you get close they (the residents) can cough in your face. We only have 2 face shields in the facility. I have seen glasses on staff and I do see adequate eye protection with glasses. We also have small goggles. Glasses are not ideal but they prevent things from getting into the eyes. During an additional interview on 03/26/20 at 12:17 PM, the DNS/DSD stated that for droplet precautions staff should wear a mask, gown, gloves, and eye protection prior to entering the isolation room. The DNS/DSD stated, (NAC5) should have worn and grabbed the goggles since she was the first on scene (for the fall) and may have missed that step. It was reactive and urgent with the fall. The DNS/DSD agreed that there is an increased risk of exposure for NAC5 and to the other residents she cares for. The DNS/DSD stated, NAC5 could have entered the room with the goggles. R1 is a small man and we only expect 2 people to help him. Unfortunately, (NAC5) entered the room without goggles and that was an oversight. It is an exposure. The DNS/DSD also revealed that she was unaware of the CDC Healthcare Personnel with Potential Exposure to COVID-19 guidelines regarding a medium risk exposure for the healthcare personnel (HCP) without eye protection under patient awaiting testing nor was she aware of the exclusion from work for 14 days after last exposure. When the DNS/DSD was questioned about NAC5's inappropriate double glove practice and lack of hand hygiene/sanitization while in R1's room, she stated, I was not aware (NAC5) thinks that way for exposure and not washing hands. The DNS/DSD further explained, There should have been handwashing in between handling the dirty brief and assisting R1 with his meal. That is standard of practice. There should be sanitization regardless of transmission based precautions. This is food we are talking about now. We cannot guarantee that the second layer of gloves have not been contaminated from the first layer of gloves. When the DNS/DSD was questioned about NAC5's inappropriate storage of her N95 mask in the PPE cart, the DNS/DSD stated, That is a risk of contamination of the PPE cart with her placing her mask into the PPE cart. That is not appropriate. Clean to clean. Dirty to dirty. We did not train on how to store reusable masks. NAC5 is wearing a mask at all times. Everyone is exposed. Everyone is wearing a mask. We are all exposed and we do not want (COVID-19) to spread. The DNS/DSD revealed she was unaware of the Centers for Disease Prevention and Control (CDC) guidelines on how to reuse masks. The DNS/DSD stated, NAC5 is wearing a mask at all times. Everyone is exposed. Everyone is wearing a mask. We are all exposed and we do not want (COVID-19) to spread. During an interview on 03/26/20 at 12:17 PM, the IC Nurse revealed that R1 had a fever of 104 degrees Fahrenheit on 03/17/20 and a second temperature taken the same day was 101.5 degrees Fahrenheit. IC Nurse stated R1 also has an ongoing mild cough as an additional symptom. The IC Nurse also revealed that she was unaware of the CDC Healthcare Personnel with Potential Exposure to COVID-19 guidelines regarding a medium risk exposure for the healthcare personnel without eye protection under patient awaiting testing nor was she aware of the exclusion from work for 14 days after last exposure. The IC Nurse stated, (NAC5) told me that she would use double gloves during patient care. I was not aware that she was doing this during meal times. The IC Nurse continued to state, R1 has a history of aspiration and difficulty swallowing. He has an occasional cough

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 -** Many	(continued... from page 1) associated with dysphagia. The IC Nurse further explained, There should have been handwashing in between handling the dirty brief and assisting R1 with his meal. That is standard of practice. There should be sanitization regardless of transmission based precautions. This is food we are talking about now. We cannot guarantee that the second layer of gloves have not been contaminated from the first layer of gloves. The IC Nurse stated, NAC5 is wearing a mask at all times. Everyone is exposed. Everyone is wearing a mask. We are all exposed and we do not want (COVID-19) to spread. During an additional interview on 3/26/20 at 02:57 PM, RN8 stated, I gave her (NAC5) the goggles right away. She asked for them and I gave it to her right away and I did not clean them before giving it to her. I gave it to her before I walked out of the room. I believe she was more exposed but it was more an urgent situation with the R1 being on the ground. RN8 also revealed that the staff did not receive additional training on 03/25/20 after notification of the improper PPE use in an isolation and droplet precaution room. During an additional interview on 03/26/20 at 03:23 PM, NAC5 confirmed that she entered the isolation and droplet precaution room without wearing any eye protection. NAC5 stated, I did see the goggles in the cart but I did not put them on because I did not want to take them away from my coworkers (RN8 and NAC4). We all arrived at the scene at the same time. I am assigned to both R1 and R2. I did not check R4's PPE cart. I was not told by anybody to wash my face. I did not think about potentially contaminating the rest of the PPE cart with my mask being in a plastic bag. I planned on only using the mask with R1. I took it upon myself to put it in the PPE cart. I was not provided guidance on how to store my mask. I will be finishing my shift for today. NAC5 revealed that the DNS/DSD did not speak with her on 03/25/20 after being notified of risk of exposure due to the lack of eye protection while in a presumptive COVID-19 room. NAC5 also stated her temperature today was 99.1 degrees Fahrenheit. Record review on 03/27/20 of the Hearthstone SNF PPE Supply List dated 03/25/20 stated two face shields were available in the facility. Record review on 03/28/20, R1's medical record reported that he is a [AGE] year old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Continued record review of lab results indicated R1 was diagnosed with [REDACTED]. Record review on 03/30/20 of the NAC Assignments Evening Shift dated 03/25/20 to 03/27/20 revealed that NAC5's assignment included R1, R2, R5, R6, R7, and R8. Record review on 03/30/20 of the Interdisciplinary Notes about R1 dated 03/13/20 reported, (R1) is a 1-person assist with activities of daily living (ADLs), transferring from bed to wheelchair or toilet, toileting, and repositioning in bed. Record review on 03/30/20 of the Interdisciplinary Notes about R1 dated 03/17/20 reported, Staff reported elevated temperature this morning of 104F Recheck of his temp at 0920 found it to be 101.5F. Resident was moved to room [ROOM NUMBER] for precautions. He was also noted to have clear nasal drainage this morning. Record review on 03/30/20 of the Physician order [REDACTED]. Record review on 03/30/20 of the Interdisciplinary Notes dated 03/23/20 reported, (R1) recently noted to have fever in the setting of staff member testing positive for COVID-19. Record review on 03/30/20 of the facility's Infection Prevention and Control and Surveillance Policy dated 03/2020 stated, For [MEDICAL CONDITION]/COVID-19, the facility will follow current CDC guidelines .Any staff member that suspects a breach in infection prevention and control practice or policy is to report this to the person responsible for the infection prevention and control program or the director of nursing as soon as possible .As of 03/2020, the facility will follow the directive of CDC and Public Health regarding the COVID-19 outbreak for infection prevention and control practices. Record review on 03/31/20 of the facility's Handwashing Policy stated, All personnel shall follow the handwashing procedures to help prevent the spread of infections to other personnel, residents, and visitors. Record review on 04/01/20 of the facility's PPE Policy dated 08/2019 stated, The facility promotes appropriate use of PPE to prevent the transmission of pathogens to residents, visitors, and other staff .Perform hand hygiene before donning gloves and after removal. Gloves are not a substitute for hand hygiene .Change gloves and perform hand hygiene between clean and dirty tasks, when moving from one body part to another, when heavily contaminated or when torn .The outside of gloves are contaminated .Wear goggles or face shield as added face/eye protection. Personal glasses are not a substitute for goggles .The outside of goggles and face shields are contaminated. Record review on 04/01/20 of the facility's Transmission-Based Precautions Policy dated 08/2019 stated, Transmission based precautions are a group of infection prevention and control practices that are used in addition to standard precautions for residents who may be infected or colonized with infectious agents that require additional control measures to prevent transmission effectively .Droplet precautions intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions (i.e. respiratory droplets that are generated by a resident who is coughing, sneezing or talking.) Record review on 03/31/20 of the facility's Infection Control in Emergencies Policy dated 03/2020 stated, Hearthstone plans for increased risk of infection and/or spread of infection during emergency or disaster situations and will adapt practices based on guidelines set forth under the direction of Public Health, Department of Health, CDC and collaboration with the Facility Medical Director .Basic principles of infection control and prevention apply during emergencies. This includes hand hygiene, and standard/transmission based precautions. Record review on 03/31/20 of additional resources provided by the facility titled, Washington State Department of Health Checklist for Controlling COVID-19 Outbreaks in Long Term Care Facilities stated, Staff should wear a facemask, eye protection, gown and gloves when entering the room of a patient with suspected or confirmed COVID-19 .This guidance applies to HCP with potential exposure in a healthcare setting to patients with confirmed COVID-19. However, HCP (Health Care Provider) exposures could involve a Person Under Investigation (PUI) who is awaiting. Implementation of monitoring and work restrictions .applied to HCP exposed to a PUI if test results for the PUI are not expected to return within 48 to 72 hours. A record of HCP exposed to a PUI should be maintained and HCP should be encouraged to perform self-monitoring while awaiting test results. Record review on 04/01/20 of additional resources from the facility titled Strategies for Optimizing Extended Use and Reuse in Case of Shortage: Eye Protection published by the CDC stated, Ensure appropriate cleaning and disinfection between users of goggles, eye protectors or face shields .HCP should take care not to touch their eye protection. If they touch or adjust their eye protection they must immediately perform hand hygiene .Employees will disinfect eye protection after each use wearing clean gloves. Record review on 04/01/20 of additional resources from the facility titled Strategies for Optimizing the Supply of Face Mask dated 03/2020 published by the CDC stated, Restrict facemasks to use by HCP, rather than resident for source control. HCP should leave resident care area if they need to remove the facemask. Facemasks should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. The folded mask can be stored between uses in a clean sealable paper bag or breathable container. Record review on 04/01/20 of additional resources from the facility titled Strategies for Optimizing PPE for Extended Use and Reuse in Case of Shortage: Respirator N95 dated 03/2020 published by the CDC stated, Storage paper bags labeled with staff name to prevent accidental sharing of respirators, and will be used to store the mask between uses. Storage containers should be disposed of regularly daily and as needed. Record review on 04/01/20 of additional resources provided by the facility titled, What healthcare personnel should know about caring for patients with confirmed or possible coronavirus disease 2019 (COVID-19) published by the CDC stated, (Spread) is thought to occur mostly from person-to-person via respiratory droplets among close contacts. Close contact can occur while caring for a patient including: being within approximately 6 feet of a patient with COVID-19 for a prolonged period of time. If close contact occurs while not wearing all recommended PPE, healthcare personnel may be at risk of infection. If you have an unprotected exposure (i.e. not wearing recommended PPE) to a confirmed or possible COVID-19 patient, contact your supervisor or occupational health immediately. 2). During an observation on 03/25/20 at 12:55 PM, PPE carts were seen next to R1 and R2 rooms. Outside of R2's room, who is positive for COVID-19 displayed a signage indicating droplet precautions and what PPE was appropriate to wear under these conditions. Droplet precautions are used for patients with known or suspected to be infected with pathogens transmitted by respiratory droplets that are generated by a patient who is coughing, sneezing, or talking. Outside of R1's room, who is presumptive for COVID-19 displayed a signage on the PPE cart for standard precautions. Standard precautions are the minimum infection prevention practices that apply to all patient care, regardless of suspected or confirmed infection status of the patient. During an interview on 03/25/20 at 02:54 PM, the DNS/DSD validated that room [ROOM NUMBER] and R1 was presumptive with COVID-19 and room [ROOM NUMBER] and R2 was positive with COVID-19. The DNS/DSD further explained that the standard precautions signage was inappropriately placed on the PPE cart next to room [ROOM NUMBER] and the correct signage is for droplet precautions. The DNS/DSD stated, I am not sure why the standard precautions sign was placed there. Record review on 04/01/20 of the facility's Transmission-Based Precautions Policy dated 08/2019 reflected, Transmission based precautions are a group of infection prevention and control practices that are used in addition to standard precautions for residents who may be infected or colonized with infectious agents that require additional control measures to prevent transmission effectively .Droplet precautions intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions (i.e. respiratory droplets that are generated by a resident who is coughing, sneezing or talking.) Record review on 03/31/20 of additional resources provided by the facility titled, Washington State

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) Department of Health Checklist for Controlling COVID-19 Outbreaks in Long Term Care Facilities stated, Staff should wear a facemask, eye protection, gown and gloves when entering the room of a patient with suspected or confirmed COVID-19 .This guidance applies to HCP with potential exposure in a healthcare setting to patients with confirmed COVID-19. However, HCP exposures could involve a Person Under Investigation (PUI) who is awaiting. Implementation of monitoring and work restrictions .applied to HCP exposed to a PUI if test results for the PUI are not expected to return within 48 to 72 hours. A record of HCP exposed to a PUI should be maintained and HCP should be encouraged to perform self-monitoring while awaiting test results. Record review on 04/01/20 of additional resources provided by the facility titled, What healthcare personnel should know about caring for patients with confirmed or possible coronavirus disease 2019 (COVID-19) published by the CDC stated, (Spread) is thought to occur mostly from person-to-person via respiratory droplets among close contacts. Close contact can occur while caring for a patient including: being within approximately 6 feet of a patient with COVID-19 for a prolonged period of time. If close contact occurs while not wearing all recommended PPE, healthcare personnel may be at risk of infection. If you have an unprotected exposure (i.e. not wearing recommended PPE) to a confirmed or possible COVID-19 patient, contact your supervisor or occupational health immediately. On 03/27/20 near 12:30 PM, the Administrator and Director of Nursing Services were informed of an immediate jeopardy situation that began on 03/25/2020 related to the failure to operationalize their infection prevention and control practices, specifically appropriate PPE use and hand hygiene to reduce the spread of COVID-19.