STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505315	A. BUILDING _____ B. WING _____	08/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MIRA VISTA CARE CENTER	300 SOUTH 18TH STREET MOUNT VERNON, WA 98274

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 maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections. Failure to clearly identify the type of transmission based precautions of affected residents during an outbreak of the COVID-19 virus, and to report suspected or confirmed cases of COVID-19 to the state agency on two of three hallways, potentially placed residents and staff at an increased risk for transmission of an infectious organism. Findings included . TRANSMISSION BASED PRECAUTION SIGNAGE According to the Centers for Disease Control and Prevention (CDC) 2007 HICPAC (healthcare infection control paractices advisory committee) guidelines for transmission based precautions, when a resident was placed on transmission-based precautions, the staff should implement the following: A. Clearly identify the type of precautions and the appropriate personal protective equipment (PPE) to be used; B. Place signage in a conspicuous place outside the resident's room such as the door or on the wall next to the doorway identifying the CDC category of transmission-based precautions (e.g. contact, droplet, or airborne), instructions for use of PPE, and/or instructions to see the nurse before entering. Ensure that signage also complied with residents' rights to confidentiality and privacy; C. Make PPE readily available near the entrance to the resident's room; and D. Don (put on) appropriate PPE upon entry into the environment (e.g., room or cubicle) of resident on transmission-based precautions (e.g., droplet precautions). Review of the facility policy titled, COVID-19 Infection Prevention and Control Policy & Procedures, (updated date 04/16/2020) showed the facility would follow CDC guidelines for Transmission based precautions as their infection control resource. In an observation of the 300 hall on 06/30/2020 at 3:00 PM, the facility had two residents (#1 and #2) who tested positive for COVID-19 and were on droplet isolation. Observation of the two identified rooms showed PPE carts outside of the rooms containing gowns, gloves, masks and alcohol based hand sanitizer. Employees were observed to enter and exit the rooms donning (putting on) and doffing (taking off) proper PPE and performing hand hygiene as required. There was no signage on or near the doorways to the rooms indicating the category of CDC transmission based precautions and instructions to the staff. In an interview on 06/30/2020 at 3:03 PM, Staff C, Housekeeping supervisor, stated there were dedicated housekeeping staff assigned to the 300 hall and they were aware which rooms were under droplet isolation because they were updated before their shift, they received report from the nurses and there was a green dot placed by the resident's name on the outside of the room. Staff C stated the green dot meant the resident was on isolation and the staff were to wear mask, gown, gloves and face shield in the room. In an interview on 06/30/2020 at 3:05 PM, Staff B, Nursing Assistant, stated they were aware of the two residents on isolation through report and they had a green dot next to their name outside the rooms to indicate that they were on droplet precautions. Further observation showed that on the name plate outside both rooms there was a green sticker dot. In an interview and joint observation on 06/30/2020 at 3:10 PM, Staff A, Registered Nurse, was able to state which residents were on droplet isolation precautions and stated they review the status of the residents at the beginning of each shift and reviewed the PPE. When asked and shown the lack of signs, Staff A stated there should be, I will find out. Staff A returned with droplet isolation precautions signs and placed them on the identified residents' doors. In an interview on 06/30/2020 on or about 3:30 PM, the Administrator was made aware of the lack of transmission (droplet) based precaution signs and stated there should have been signs on the identified residents' doors. In an observation on 07/30/2020 at 10:00 AM, the facility had two residents (#3 and #4) on the 100 unit who had not tested positive for COVID-19 but whose prior roommates had tested positive for COVID-19 in the past 14 days. Resident #3 and #4 were stated to be quarantined in their rooms and on droplet isolation precautions related to their exposure. Observation of Resident #3 and #4s rooms on the 100 hall showed there was no isolation precaution signage indicating that the residents were on droplet isolation. There were PPE carts outside of the resident rooms, a PPE information sheet and there were small green sticker dots next to their name plates outside of the room. In an interview on 07/30/2020 on or about 12:15 PM, Staff D, Nursing Assistant, stated the rooms of affected COVID-19 residents were identified using a green dot to indicate the resident was on droplet isolation. Staff D stated there was adequate PPE and the residents who were on droplet isolation were discussed during their shift report. Staff D stated they have staff who were assigned to only those rooms. Staff D stated there were droplet isolation signs on some rooms as well, but said not all of them have the signs on them. In an interview on 07/30/2020 on or about 12:20 PM, Staff E, Nursing Assistant, also stated that the rooms with residents on isolation were identified using the green dot. When asked what the green dot meant, Staff E stated it meant that they were on quarantine. Staff E stated they were wearing masks all the time, and you have to put on the gown, and face shield to go in. Staff E stated they had PPE assigned for each resident on their shift. In an interview on 07/30/2020 at 10:30 AM, the Administrator was shown the rooms on 100 hall again lacking the isolation precaution signage and stated that although the facility was using the green dots to identify rooms under quarantine, the resident rooms should also have had the CDC droplet isolation signage as required. REPORTING REQUIREMENTS: According to Nursing Home Guidelines, 6th Edition (0ct 2015), AKA the purple book, showed that facilities were required to report suspected or confirmed communicable disease outbreaks to the department hotline, state reporting log within 5 days and to their local health jurisdiction. Further guidance to facilities specific to additional COVID-19 status reporting, issued on 04/20/2020, clarified that additional status reporting was not a replacement for reporting to the department complaint resolution unit (CRU) hotline or their local health jurisdiction. Record review showed the facility's first suspected COVID-19 case was identified on 06/18/2020 and confirmed on 06/19/2020. Additional positive cases were identified on 06/24/2020 and 06/26/2020. Record Review showed a report was not received by the CRU until 07/01/2020. In an interview on 06/25/2020 at 9:00 AM, the Administrator initially stated he was not aware of the CRU reporting requirement and stated he would complete it. In an interview on 06/30/2020 on or about 4:00 PM , the Administrator stated he believed he had completed the required reporting. The reporting had been completed to other required entities, but had not been completed to the CRU. The Administrator stated he had incorrectly identified where to complete the report. Reference (WAC) 388-97-1320 (1)(a)(2)(b)

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.