STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505533	A. BUILDING _____ B. WING _____	**05/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EVERETT TRANSITIONAL CARE SERVICES	**916 PACIFIC AVENUE EVERETT, WA 98201**

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 0561 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of one resident's (#201) choice of bathing frequency was honored. The facility failed to: 1). provide and honor the resident's bathing preference of receiving a bath at least once a week, 2). failed to update the resident's bath preference on his care plan, 3). failed to re-offer the resident a bath after the resident refused a bath on a given day, and 4). failed to accurately document the resident's baths and refusals of baths. This failed practice placed the resident at risk for a diminish quality of life. Findings included . Resident #201 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Progress Notes from admission through 05/13/2020 showed the following information: - On 04/10/2020 at 1:08 PM, noncompliance with meds (medications) at times, refused shower, stated he only takes a shower once a week and had a shower on Tuesday (Care Plan was not updated); - On 04/11/2020 at 2:15 PM, cooperative with care; - On 04/11/2020 at 5:19 PM, the resident was taken to the shower room for shower (not documented by the Certified Nursing Assistant (NAC)); and - On 04/12/2020 at 11:04 AM, 04/13/2020 at 1:03 PM, 04/14/2020 at 6:10 AM, 04/14/2020 at 1:58 AM, 04/15/2020 at 12:22 PM, 04/16/2020 at 12:39 PM, 04/17/2020 at 10:54 AM, 04/20/2020 at 11:02 AM, 04/21/2020 at 11:11 AM, 04/25/2020 at 10:53 AM, 04/26/2020 at 10:16 AM, 04/29/2020 at 11:25 AM, 04/30/2020 at 10:26 AM, 05/01/2020 at 4:45 PM, 05/03/2020 at 6:24 AM, 05/05/2020 at 3:35 PM, noted that the resident was cooperative with care. Review of the resident's April 2020 Documentation Survey Report V2 (a type of facility report) Bathing and Shower log, showed the resident received a bath on 04/14/2020, and 04/24/2020. The resident refused a bath twice during the month of April on 04/13/2020, and on 04/20/2020, with no noted follow up to offer to bathe until 04/24/2020. In an interview on 05/13/2020 at 10:41 AM, the resident stated that he had not had a bath in a couple of weeks and would like a shower once a week. He continued to state that he had been in a prior room but his roommate kept his TV loud all the time and at midnight he would turn up the volume. The resident stated that he walked out of his prior room and found the room he currently was in but had not had a bath since he made the room change. Review of the resident's care plan printed on 05/14/2020, showed the resident had an Activity of Daily Living (ADL) self-care performance deficit related to activity intolerance, dementia and fatigue. The interventions showed the resident required one-person extensive assistance with showers on Monday and Friday day shift which was his preference, and as necessary. The care plan further directed staff to provide a sponge bath when a full bath or shower could not be tolerated. In a follow up interview on 05/15/2020 at 8:54 AM, the resident stated that he got a bath yesterday around 4:00 PM, and a bit of a shave. He stated, I feel clean and feel good. I told them not having a shower is bull. The resident was asked about the circumstances around his refusal of showers and he stated that he had not refused showers. In an interview on 05/15/2020 at 2:15 PM, Staff A, NAC, stated that she used the resident's Care Plan to know the care the resident needed. Staff A stated that if a resident refused care they were to document the refusal of care, let the nurse know, should also do a follow up offer of the care with the resident and document the results. Staff A, stated that the resident refused care sometimes on particular days and that he wanted his baths on Friday. Staff A, stated that she had not told the nurses about his preferred shower day. In an interview on 05/15/2020 at 2:31 PM, Staff E, NAC, stated that she followed the resident's care plan to know the care the resident required. Staff E, stated that the resident had the right to refuse care, but would try to provide the needed care a little later, usually would try at least three times, report the refusal to her nurse and document as well. Review of the resident's May 2020 Documentation Survey Report V2 Bathing and Shower log on 05/19/2020, showed the resident received a bath on 05/01/2020 and on 05/18/2020. The resident was noted to refuse a bath on 05/06/2020 with no follow up offer to bathe until 05/17/2020 when he then refused to bath until 05/18/2020. Reference: (WAC) 388-97-0900 (1)(3) .
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Based on observation and interview, the facility failed to ensure residents rooms for one of one resident (#201) was maintained at a comfortable room temperature between the required 71 to 81 degrees F (Fahrenheit). This failed practiced placed the resident in an uncomfortable environment and at risk of a diminished quality of life. Findings included . In an interview on 05/13/2020 at 10:48 AM, Resident #201 stated they said they had fixed the heater but it has not come on for two to three weeks. He stated, A lot of people think this is the perfect temperature but I get cold fast. They know the heater does not work and no one has come to fix it. In a follow up interview and observation on 05/19/2020, on or about 2:00 PM, the resident stated that he continued to be cold. The resident stated that the staff brought him in extra blankets which was okay while he was in bed. The resident was observed to be lying in bed and pulled up several blankets that were covering him. The resident continued to state that when he would get up from his bed to walk to the bathroom he would get very cold. In an observation and interview on 05/19/2020 at 2:42 PM, Staff J, Environmental Maintenance Manager checked the temperature in the resident's room. Staff J was observed to use a digital thermometer and scanned the resident's room. Staff J took readings at the foot of the resident's bed which read 61 to 62 degrees F and 63 degrees F in the resident's room by the thermometer on the wall next to the resident's bathroom. Staff J confirmed the temperature readings were between 61 to 63 degrees F. Reference: (WAC) 388-97-0880 (3)(a)(b) .
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to assist two of three residents (#201, #202) with their Activities of Daily Living (ADLs) related to oral hygiene/care and shaving. The facility failed to 1). follow the residents ADL care plan regarding their pretences regarding shaving and oral care, 2). failed to provide adequate oral care. This failed practice placed the residents at risk for potential gum disease, infection and at risk for potential diminished quality of life. Findings included . DEFINITIONS: Oral care refers to the maintenance of a healthy mouth, which included not only teeth, but the lips, gums, and supporting tissues. This involved not only activities such as brushing of teeth or oral appliances, but also maintenance of the oral mucosa (which was the mucous membrane lining the inside of the mouth). Review of the facility's undated, Standards of Care and Best Practice, procedures showed that each task was based on the abilities of the resident to participate in their care and needs based on their physical and mental limitations. The

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 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) daily morning care included a shave as needed and oral care was provide every morning and evening. RESIDENT #201 Resident #201 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Record review of the Case Manager Associate: Long Length of Stay note dated 04/05/2020, showed Resident #201 was unable to return to his home due to his inability to care for himself independently and Guardianship was in process. Review of the resident's Care Plan printed on 05/14/2020, showed the resident had an Activity of Daily Living self-care performance deficit related to activity intolerance, dementia and fatigue. The interventions were for the resident to receive, ORAL CARE ROUTINE rinse mouth 2 times a day after set up offer soft tooth brush to brush gums, date initiated on 04/07/2020 and revised on 04/20/2020, and the resident preferred to be clean shaven except for his mustache, date initiated on 04/07/2020 and revised on 04/27/2020. Review of the April 2020, Documentation Survey Report V2 (a type of facility report) ADL- Personal Hygiene from admission which included how the resident maintained personal hygiene including brushing teeth and shaving. The document showed no personal hygiene documented for day shift on 04/11/2020, day shift and evening shift on 04/12/2020, evening shift on 04/14/2020, and evening shift on 04/20/2020. Further review of the documentation showed there were 26 occurrences throughout the month where the resident did not receive his personal hygiene care per his Care Plan directive (which directed staff to provide set up assistance) and no noted documentation that the resident refused personal hygiene. Review of the May 2020, Documentation Survey Report V2 ADL- Personal Hygiene from 05/01/2020 through 05/14/2020, showed 27 occurrences where the resident did not receive his personal hygiene care per his Care Plan directive and no noted documented the resident refused personal hygiene. In an observation and interview on 05/13/2020 at 9:15 AM, the resident complained that he was not getting the help he needed. Resident #201 stated that he Felt grubby and he used to get help with shaving. Resident #201 stated that he did not like having facial stubble. The resident was observed to have a mustache but had beard stubble approximately inch in length. In an observation and interview on 05/13/2020 at 10:59 AM, the resident stated that he did not have any teeth and had not been offered assistance to brush his gums or his tongue. The resident was observed to have no teeth. In an observation on 05/14/2020 at 1:03 PM, the resident continued to be unshaven with beard stubble across the lower portion of his face and cheeks. In an interview and subsequent observation beginning on 05/14/20 at 2:09 PM, Staff F, Nursing Assistant Certified (NAC), stated that she knew how to provide the resident's needed individual care and services from the resident's Care Plan which was computerized and there was a hard copy by the nurse's station. Staff F stated that if there was something she did not understand she would asked the charge nurse. Staff F stated that residents had the right to refuse care but would re-approach the resident and offer the care at a later time. Staff F stated that she would document if the resident refused care and could strike out a refusal if the resident decided to receive the offered care and services after being re-approached. Staff F stated that she would offer up to three times, sometimes the resident might be more comfortable with someone else, the staff had gotten to know the residents and they all collaborated to provide the resident's care. Staff F was asked specifically about Resident #201, she stated that he was a sweet heart and he was independent, he had a hard time chewing so he needed a soft diet. Staff F stated that he did most of his personal care, he could do his own oral care, that she would cue him to brush his teeth and he received a shave on his shower days. Staff F confirmed that the resident's tooth brush was in his bath basin under a pile of numerous items, unopened from its original packaging, as was his mouthwash. Review of a progress note dated 05/14/2020 at 5:53 PM, by the Director of Nursing Services (DNS), (which was after the DNS was informed of the lack of the resident's care), showed that the DNS and the facility Administrator spoke with the resident regarding his oral hygiene. The resident stated that he did not have any teeth so did not need brushing and preferred to do his own oral hygiene by rinsing his mouth with warm water and sometimes cold water. The resident was offered mouthwash and he stated that it was too sweet and declined any kind of mouthwash. In a follow up interview on 05/15/2020 at 8:54 AM, the resident stated that he was not aware of the need to have oral care even though he did not have any teeth. Resident #201 stated that he would need to learn about the need for oral care. RESIDENT #202 Resident #202 was a newly admitted resident with [DIAGNOSES REDACTED]. Review of the resident's hospital discharge summary dated 05/12/2020, showed the resident's principal problem was total self-care deficit. Review of the resident's Care Plan showed the resident had an ADL self-care performance deficit related to disease process of [MEDICAL CONDITION] and chronic right lower leg wounds initiated on 05/11/2020, which showed the resident was able to use toothettes (disposable single use oral care sponge swab attached to a stick to be used for oral care) independently after set-up for oral care. Review of the resident's ADL Personal Hygiene showed no documented refusals of personal hygiene and had the following documented personal hygiene assistance: - Set up assistance on 05/12/2020 at 9:10 PM; - Two person assistance on 05/13/2020 at 7:13 AM; - No set up or assistance on 05/13/2020 at 9:59 PM and - One person assistance on 05/14/2020 at 1:48 AM. In an observation and interview on 05/13/2020 at 2:38 PM, the resident was observed to have missing teeth and the resident stated that no one had offered to set him up or had offered care or assistance with oral care. In an observation and interview on 05/14/2020 at 2:26 PM, Staff H, NAC, confirmed the resident's tooth brush was still in the original package. Additionally, there were no toothettes observed in the resident's room. In an interview on 05/14/2020 at 3:01 PM, Staff I, Registered Nurse, stated that if there were any discrepancy in the residents' care, out of the norm, she directed her staff to tell her immediately. Staff I stated that she tried to be open so the staff could and would let her know. Staff I stated that if the staff were having a problem providing care for a resident they would try another staff member to provide the resident's care. In a co-interview on 05/14/2020 at 3:08 PM, the DNS and the Administrator were asked what the expectation was for the residents' care needs. They stated to make sure to have the staff to provide AM and PM ADL care. They continued to state that a report was reviewed and the Nurse Manager and the DNS were out on the floor to see how the residents were groomed. The Administrator stated that the managers did weekly rounds, referred to as Angel Rounds, where they gauged the cleanliness of the rooms on environmental rounds. Both the DNS and the Administrator were informed of the identified failed practice of the lack of oral care for both Resident #201 and Resident #202. Additionally, they were notified of the lack of shaving assistance which had not been provided for Resident #201. The DNS and the Administrator stated that they would check in each of the resident's rooms because sometimes there was other toothbrushes in the resident's rooms. The DNS and Administrator were informed that the floor staff had looked and were not able to identify any additional supplies. Review of a progress note dated 05/14/2020 at 6:34 PM, the DNS documented that the Administrator and the DNS had a discussion with the resident about his oral care. The resident stated he preferred to rinse his mouth with warm water and was in agreement to try mouthwash for rinsing his mouth and stated that he only had one tooth and did not want to brush due to sensitivity. In an interview on 05/15/2020 at 9:03 AM, Resident #202 stated that he had not received mouthwash and had used a toothette prior to being at this facility and would use toothettes now. In a follow up interview on 05/19/2020 at 12:28 PM, the resident stated that the staff had offered him toothettes but he had not received them. Resident #202 stated that they run out of all kinds of things. Reference: (WAC) 388-97-1060 (2)(c) .
F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three residents (#202) had adequate [MEDICAL CONDITION] medication monitoring for potential adverse side effects and failed to attempt non-pharmacological interventions prior to the use of as needed antianxiety medication usage. This failed practice placed the resident at potential risk of inadequate monitoring of potential adverse side effects and at risk of unnecessary medications. Findings included . Resident #202 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of the resident's Order Summary Report, printed on 05/18/2020, showed the resident had the following physician ordered medications: [REDACTED]. Additional review of the Order Summary Report showed a physician order [REDACTED]. Staff were to document a N if monitored and no side effects were observed, and to document a Y if monitored and any of the listed side effects were observed. Staff were directed to select the chart code Other/See Nurses Notes and they were to make a progress note every shift of the noted findings (side effects) for the following medications: [REDACTED] Antianxiety ([MEDICATION NAME]) Medication-Monitor for (side effects) lethargy and confusion; Antidepressant Medication (duloxetine) -Monitor for (side effects) sedation and dry mouth; Antipsychotic (aripiprazole) Medication- Monitor for (side effects) dry mouth, suicidal ideation and

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F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) [MEDICAL CONDITION]; and Non-med (medication) interventions must be offered prior to giving an as needed pain medication. Document interventions used on the Medication Administration Record [REDACTED]. Distraction, 3. Offer food/fluids of choice, 4. Re-positioning, 5. Other (describe in progress note). Review of the May 1 through May 18th 2020 MAR indicated [REDACTED]. - The antianxiety medication monitor for side effects had only check marks noted without indicating if there was or was not noted side effects; - The antidepressant medication monitor for side effects had only check marks noted without indicating if there was or was not noted side effects; - The antipsychotic medication monitor for side effects had only check marks noted without indicating if there was or was not noted side effects; - The sedative/hypnotic medication monitor for side effects had only check marks noted without indicating if there was or was not noted side effects; and - Additionally, there was no Non-Med interventions identified or indicated as used prior to the as needed antianxiety medication administration. In an interview on 05/15/2020 at 2:00 PM, Staff C, Registered Nurse (RN), stated that they were to document a yes or no on the medications side effect monitor. If yes, the license nurse made a note in the progress notes. Staff C stated that they should assess what helped the resident alternatively before giving an as needed medication. In an interview on 05/19/2020 at 2:01 PM, Staff D, RN/Nurse Manager, stated that they should assess the resident, redirect, and try alternative interventions prior to the use of as needed antianxiety medications. Staff D stated that the resident's symptoms could be related to pain or emotionally they might need to talk. Staff D continued to state that they should document yes if the resident had demonstrated side effects and no if had not. Staff D stated that if the residents did have side effects the nurse was to document this information. Reference: (WAC) 388-97-1060 (3)(k)(i)(4)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 ensure appropriate infection control practices were maintained for six of 13 residents (#51, #52, #151, #152 #154, and #155) reviewed for infection control procedures, and potentially for all residents residing in the facility. Failure to: 1) ensure the alcohol-based hand rub (ABHR) and soap dispensers were not empty, 2) to do hand hygiene after removing soiled gloves, 3) to manage Personal Protective Equipment (PPE) donning (putting on)/doffing (removing)appropriately and in a safe location, and to have garbage cans readily accessible, 4) to use/care for blood pressure cuff equipment appropriately, 5) to implement a complete Water Risk Management Program, all of which placed the residents at risk for contracting infectious diseases and for diminished quality of life. Findings included . DEFINITIONS: ENHANCED BARRIER PRECAUTIONS (EBP): transmission-based precautions that required the use of PPE for certain residents who were at increased risk for Multidrug Resistant Organisms (MDROs) transmission, specifically gown and gloves, that were used during specific high-contact resident care activities, such as dressing, bathing, showering, transferring, providing hygiene such as brushing teeth and combing hair, changing linens, changing briefs or assisting with toileting, device care or use such as catheters, feeding tubes, [MEDICAL CONDITION]/ventilator, and wound care. DROPLET PRECAUTIONS: transmission-based precautions for residents known or suspected to be infected with pathogens transmitted by respiratory droplets that were generated by a person who was coughing, sneezing, or talking. Droplet precautions required the patient to wear a mask and care givers were to don a mask upon entry into the patient room or patient space. Review of the facility's undated policy titled Hand Hygiene Table, revealed staff were to do hand hygiene before applying and after removing personal protective equipment, including gloves. HAND HYGIENE/ALCOHOL-BASED HAND RUB In an observation on 05/13/2020 at 8:45 AM, when the survey team entered the skilled nursing facility, the COVID-19 screening station outside the 4th floor elevators had an empty ABHR dispenser. In an observation/interview on 05/13/2020 at 9:15 AM, the Director of Nursing Services (DNS) was notified the ABHR was empty, she checked herself by activating the dispenser, but nothing came out. The DNS stated she would take care of it right away. In an observation on 05/13/2020 at 9:20 AM, the ABHR dispenser in hallway between room [ROOM NUMBER] and 409 was empty. On 05/13/2020 at 11:50 AM, after an interview with Resident #52 and before exiting the room, the surveyor attempted to dispense soap at the sink in the resident's room to wash hands. There was no soap in the soap dispenser. It was immediately reported to Staff D, Registered Nurse (RN)/Resident Care Manager. RESIDENT #151 The resident admitted to the facility on [DATE] with a surgical wound on his left upper arm from a spider bite that required surgical intervention, and the wound was covered with a dressing. In an interview and a dressing change observation on 05/15/2020 at 10:03 AM, Staff D was observed changing the dressing on the resident's left upper arm. Staff D removed the soiled dressing, then removed her soiled gloves, then she donned new clean gloves without hand hygiene, and she proceeded to finish with the dressing change. In an interview after the dressing change, Staff D stated I did change my gloves, but I did not do hand hygiene and I should have. INFECTION CONTROL SIGNAGE On 05/13/2020 at 9:45 AM, during a brief tour of the unit hallways, carts containing PPE were located at intervals in both hallways where residents resided. There were residents who reportedly were on droplet precautions, secondary to potential exposure to COVID-19, but none of the resident rooms had any signage, indicating which rooms were affected. On 05/13/2020 at 10:25 AM, Staff G, the Infection Control Preventionist, was interviewed regarding lack of required signage on resident rooms that were reported to be on droplet precautions. Staff G stated the signs were accidentally taken down. On 05/13/2020 at 1:05 PM, an observation and interview were conducted with Resident #155, residing in room [ROOM NUMBER]. Upon exiting the room at 1:20 PM, this surveyor went to the sink in the resident's bathroom to wash hands. There was no trash receptacle by the sink. The only one in the room was next to the resident's bed. The resident was on Droplet Precautions. On 05/13/2020 at 3:45 PM, the following rooms had signage indicating the transmission precautions in place for that room: Droplet Precautions for rooms 413, 414, 415, 416 and 417. Enhanced Precautions for room [ROOM NUMBER]. MEAL SERVICE During an initial observation of meal service on 05/13/2020 beginning at 12:25 PM, the following was observed. Due to the COVID-19 pandemic all residents dined in their rooms. At 1:25 PM, Staff A and Staff B, Nursing Assistants, were observed delivering the meal tray to Resident #51. Resident #51 was on droplet precautions, secondary to a potential exposure to COVID-19. Both Staff members donned gown, gloves and wore a surgical mask. The resident was repositioned in bed; his meal tray was set up on the overbed table in front of him. The resident was asked if he needed anything opened up or prepared to eat. Resident #51 answered, No. Both aides proceeded to the sink, located in the resident's room, removed their gown, gloves and masks, discarding in the trash by the sink, washed their hands and proceeded to exit the room. Staff A exited first and left the room door open for Staff B. Resident #51 called to Staff B that he needed some packaging opened. Staff B donned clean gloves and exited into the hallway to get a gown and mask. She re-entered the room and assisted the resident with his request to open some items on the tray. When done, Staff B proceeded to the sink in the resident's room, removed the gown, gloves and mask, discarded in the trash by the sink and exited the room. The resident's room door had remained open. Review of the Physician Orders, as of 05/13/2020, found an order which stated, Maintain Droplet precaution: resident wears mask for weight/shower and when out of room. Assist with hand hygiene before and after leaving room every shift. The Care Plan/Kardex, which provided care directives as of 05/14/2020, stated, Strict Droplet Precaution 5/10 due to potential exposure: door closed and res (resident) wears mask for shower/weight. Staff to don full PPE (personal protective equipment) when providing direct care, including meal pass. Full PPE included mask, gown and gloves. During an interview with the DNS and Administrator on 05/13/2020 at 3:50 PM, they were informed of infection control concerns related to the above observations, lack of required signage for infection control transmission precautions, empty ABHR and soap dispensers and lack of appropriately-placed trash receptacles for acceptable removal and disposal of PPE equipment. MEDICATION ADMINISTRATION All resident individual bed areas were equipped with a blood pressure measuring device, mounted on the wall at the head of the bed. On 05/15/2020 at 9:20 AM, during observation of a medication pass with Staff C, RN, Resident #154 required a blood pressure and apical pulse before administering a medication to ensure the blood pressure and pulse were within parameters set by the physician. Staff C obtained a wrist blood pressure device and a stethoscope, cleaned both with a disinfecting wipe, placed the stethoscope around her neck and the blood pressure device in the right pocket of her uniform top. The resident was on droplet precautions and Staff C would have direct contact with the resident so she donned gown and gloves in addition to wearing a mask. Staff C proceeded to the resident's room and took the necessary vital signs, placed the wrist blood pressure device on the resident's right wrist. When done taking the blood pressure, Staff C removed it from the resident's wrist and placed it back into the right pocket of her uniform top. Staff C listened to the resident's heart rate by placing the disc of the stethoscope on the resident's chest. The stethoscope was placed back around her neck. Staff C administered medications to the resident, proceeded to the sink in the room, removed the gown and gloves, washed her hands and exited the room. Staff C proceeded to the medication cart, removed the blood pressure cuff from her uniform pocket, the stethoscope from around her neck and cleaned both devices with

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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	(continued... from page 3) a disinfecting wipe. During a subsequent observation of medication pass with Staff C on 05/15/2020 at 12:00 PM, Staff C needed to check an apical pulse before administering medications to Resident #152, who was not on any specific infection precautions. Staff C went to the bedside, checked the resident's heart rate, placing the disc of the stethoscope on the resident's chest. The stethoscope was placed back around her neck and she administered medications to the resident, washed her hands and exited the room. Staff C proceeded to the medication cart and without disinfecting the stethoscope began preparing medications for another resident. On 05/15/2020 at 2:05 PM, the DNS and Administrator were informed of the above observations. WATER RISK MANAGEMENT Review of the facility's policy titled, Providence Health System / Facility Engineering Water Safety - Legionella Risk Mitigation, dated 10/21/16, showed the facility would establish a Water Safety Management team to include the Infection Preventionist, Facility Engineering Leader, Safety Manager and they were to meet at least once a quarter. Assign a responsible person to manage the water safety program, the Facility Leader or the Safety Manager. Develop a water system distribution drawing. Test the facility's water once per month for free chlorine levels at the incoming point and the outlets farthest from the incoming point. Document the test date and test results at both locations. Run water in faucets and showers in unoccupied areas at least weekly. In an interview on 05/15/2020 at 12:39 PM, Staff G, RN/Infection Control Preventionist, stated that the short answer was no, that she was not involved in the Water Risk Management of the facility. Staff G stated that it was done by the hospital who owned the building and would give them the results of the Legionella testing. In a co-interview on 05/19/2020 at 12:47 PM was done with the the Administrator, Staff K, Contracted Maintenance Supervisor, and Staff J, facility's Environmental Service Maintenance Manager. All staff present was asked to describe the facility's Water Risk Management Process and to demonstrate how the facility identified areas where potential water could become stagnant, along with the facility's water testing monitors. Staff K, stated that they test for multiple bacteria monthly on the seventh floor of the building, (the facility is on the fourth floor of the building). Staff K, stated that they had not assessed the fourth floor for any dead legs or areas of potential stagnant water. Staff K, stated that he had not reviewed the Centers for Disease Control water risk management toolkit. He continued to state that they had a contract to help with the water management plan which was more tailored for the Joint Commission (another type of survey). Staff K, stated that he was not part of the facility's Water Risk Management Team. The Administrator, stated that Staff K should be part of the Water Risk Management Team. At this time the facility was not able to demonstrate that they had assessed their facility for their Water Risk Management Plan, or demonstrate their documented chlorine testing. On 05/19/2020 at 1:10 PM, the Administrator, requested a follow up interview. The Administrator stated that since Staff K tested the end of the water line on the seventh floor that should suffice for the water testing. The expectations were reviewed for a facility's Water Risk Management system and the Administrator stated that they were going to get right on it. On 05/19/2020 at 1:35 PM, the Administrator stated that Staff L, Contracted Operations Director for Pacific Northwest, was going to bring in his logs. The Administrator, continued to state that the facility got their water from the City and the City did the chlorine testing of the facility's water. On 05/19/2020 at 3:08 PM, the Administrator stated that they absolutely followed the facility's water risk management policy and provided a single test from 2018 for Legionella. Reference: (WAC) 388-97-1320 (1)(a)(c)(2)(a)