# Department of Veterans Affairs State Veterans Home Survey Report

This survey report and the information contained herein, resulted from the State Veterans Home (SVH) Survey as a Summary Statement of Deficiencies. (Each Deficiency Must be Preceded by Full Regulatory or applicable Life Safety Code Identifying Information.) Title 38 Code of Federal Regulations Part 51 is applied for SVHs applicable by level of care.

**General Information:**

**Facility Name:** Washington Veterans Home

**Location**: 1141 Beach Drive E., Port Orchard, WA 98336

**Onsite / Virtual:** Onsite

**Dates of Survey:** 9/24/24 – 9/27/24

**NH / DOM / ADHC:** NH

**Survey Class:** Annual

**Total Available Beds:** 240

**Census on First Day of Survey:** 196

| VA Regulation Deficiency | Findings |
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| | Initial Comments:<br><br>A VA Annual Survey was conducted September 24, 2024, through September 27, 2024, at the Washington Veterans Home in Port Orchard, Washington. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes. |
| **§ 51.190 Infection control.**<br>The facility management must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>**Level of Harm** – Actual Harm that is not immediate jeopardy<br>**Residents Affected** – Many | Based on observations, interviews, and record review, the facility failed to maintain an infection control program that prevented the spread of infections to all residents within the facility. This affected all residents within the facility.<br><br>The facility failed to ensure that facility policy and procedure for COVID-19 was followed to prevent the potential spread of infections to all residents.<br><br>The facility failed to ensure that all staff, visitors, and guests were notified of a COVID-19 outbreak, and did not implement precautions to prevent the spread of infections.<br><br>The facility failed to ensure that all infections within the facility were closely monitored, and interventions were implemented to prevent the spread of infections.<br><br>The facility failed to ensure that recommendations from the Washington Public Health Department to test close contacts of all COVID-19 positive residents, which included staff, were followed during a COVID-19 outbreak. |

The findings include:

An observation was made, on 9/24/25, at 9:15 a.m., of the [LOCATION] and noted the following: No COVID-19 outbreak signage was placed outside or inside the [LOCATION].

An interview was conducted during the Entrance Conference with the facility, on 9/24/24, at 9:30 a.m., with both Administrative Nurse A and Administrative Staff D. Administrative Nurse A stated the facility did have two (2) COVID-19 positive residents, but the facility was not currently in a COVID-19 outbreak status. Administrative Staff D stated the facility was not in a COVID-19 outbreak status and masks were not required by staff and guests if they were on the units and not entering the positive residents' rooms. Administrative Nurse A stated staff were required to follow aerosol precaution requirements when entering a COVID-19 positive resident's room, which included wearing an N95 respirator mask. Administrative Nurse A stated Resident #1 had tested positive for COVID-19 and was in a private room, and Resident #25 had also tested positive, but was in a shared room. Administrative Nurse A stated Resident #25 had curtains in the room that remained shut to protect the roommate from the spread of illness.

Review of the facility policy titled, "Sars Cov-2 (COVID-19) Guidelines for Washington State Veterans Homes," dated June 27, 2023, noted the following: "Purpose: To provide guidance to use to prevent transmission of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)…Definitions: …Epi-linkage (HCP [healthcare personnel]): the potential to have been within 6 [six] feet for 15 minutes or longer while working in the facility during the 7 [seven] days prior to the onset of symptoms…Outbreak - A facility acquired SARS-CoV-2 infection in a resident or $\geq$ 3 [three] HCP cases that are epi-linked and at least one [1] has no other likely source. Personnel Protective Equipment (PPE)- Worn to reduce exposure to hazards that cause serious workplace injuries and illnesses…Source Control- Well-fitting cloth face coverings, facemasks, or respirators that cover a person's mouth and nose to prevent spread of potentially infectious respiratory secretions when they are breathing, talking, sneezing, or coughing… Procedure…4. Vaccines WSVH [Washington State Veterans Home] will educate staff, residents and visitors on COVID-19 and offer to help get them vaccinated. 5. Testing Facilities will follow DOH [Department of Health] and CDC [Centers for Disease Control and Prevention] COVID-19 recommendations for testing. New admissions and residents who leave the facility for more than 24 hours will be tested at admission/return and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. 6.

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| | Reporting WSVH will report in the following situations: To residents, families, and caregivers upon being notified of a single new confirmed COVID-19 case or cluster of symptomatic staff or resident cases. Report COVID-19 information to the CDC using the NHSN [National Healthcare Safety Network] per https://www.govinfo.gov/content/pkg/FR-2020-05-08/pdf/2020-09608.pdf. 7. Visual alerts and signs will be posted at the entrance and strategic places so everyone entering the facility is aware of infection prevention and control practices. Signs will include a publication or posting date to alert people that signs reflect current recommendations. Visitors entering the facility regardless of vaccination status must screen at the kiosk and report any of the following: A positive test for COVID-19; Symptoms of COVID-19; Symptoms of respiratory infection (e.g., those with runny nose, cough, sneeze); Close contact with someone with COVID-19 infection; and A higher-risk exposure (for HCP) …10. Person Protective equipment is recommended as described in CDC's interim Infection Prevention and Control Recommendations for HCP During the COVID-19 Pandemic, in the following circumstances: Approved particulate respirators with N95 filters or higher will also be used by HCP working in situation where additional risk factors for transmission are present, such as healthcare-associated SARS-CoV-2 transmission is identified, and HCP are working in affected areas. Eye protection will be used facility-wide during patient care encounters during periods of high levels of community SARS-CoV-2 or other respiratory virus transmission or as based on a facility risk assessment. Have otherwise had PPE as recommended by public health authorities."<br><br>Review of the facility policy titled, "COVID Outbreak Guidelines," received 9/24/24, at 9:30 a.m., noted the following: "Staff Positive: …7 [seven] days at home than 3 [three] days with N95 on. Day of symptom onset or day of positive test (whichever is first) is day 0 [zero]. Example: Symptom onset 7/1/24. 7/1 = day 0 [zero], 7/2-7/8 at home, 7/9-7/11 wear N95. Able to work normally starting 7/12. Resident Positive: 10 days of isolation. Day of symptom onset or day of positive test (whichever is first) is day 0 [zero]. Example: Symptom onset 7/1/24. 7/1 = day 0 [zero] place on isolation, 7/2-7/11 on isolation, 7/12 isolation discontinued. Testing staff: Testing is completed on days 1 [one], 3 [three], and 5 [five]. Example: 7/1/24 exposure. Test exposed on 7/2, 7/4, and 7/6. If negative, they are cleared. If positive see above. Testing Residents: Unit testing is completed on days 1 [one], 3 [three], 5 [five] and then weekly until 14 days pass with no new positives. (If new positive just continue with current testing dates, do not restart the 1 [one],3 [three],5 [five]-day testing) Example: 7/1/24 exposure/new positive on unit. Test unit on 7/2, 7/4, 7/6, 7/13, 7/20 and continue weekly testing until 14 days pass with no new positives. N95 Carts: Rounds need to be completed on the units at the beginning of your shift and then again at the end of |

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| | your shift to restock N95 carts. On Friday's make sure there are extra supplies on units to refill the iso [isolation] carts as needed over the weekend. N95 carts need to have at least 3 [three] boxes of each type of N95. ALL Isolation Carts Rounds need to be completed on the units at the beginning of your shift and then again at the end of your shift to restock all isolation carts. On Friday's make sure there are extra supplies on units to refill the iso carts as needed over the weekend. All carts need to have dedicated vital sign supplies, gowns, gloves, goggles, masks, bootie covers, sanitizing wipes, etc." [sic].<br><br>Review of the "Aerosol Precautions" sign noted the following: "Aerosol Precautions: Clean hands when entering and leaving room. Respirator – use a NIOSH (National Institute for Occupation Safety and Health) approved N95 or equivalent or higher-level respirator especially during aerosolizing procedures. Mask: Face mask is acceptable if respirator is not available and for visitors. Wear eye protection. Gown and glove at door. Keep door closed. PPE cart outside door with garbage can."<br><br>Review of the facility COVID-19 infection control line listing from [DATE], and [DATE] was conducted and noted the following:<br><br>- [DATE] COVID-19-line listing:<br>o [DATE]: Residents #36 and #37 tested positive for COVID-19.<br>o [DATE]: Residents #38, #39 and #40 tested positive for COVID-19.<br>o [DATE]: Resident #41 tested positive for COVID-19.<br>o [DATE]: Residents #42 and #43 tested positive for COVID-19.<br>o [DATE]: Resident #44 tested positive for COVID-19.<br>o [DATE]: Resident #45 tested positive for COVID-19.<br>o [DATE]: Residents #46 and #47 tested positive for COVID-19.<br>o [DATE]: Resident #48 tested positive for COVID-19.<br>o [DATE]: Resident #49 tested positive for COVID-19.<br>o [DATE]: Residents #50, #51 and #52 tested positive for COVID-19.<br>o [DATE]: Resident #53 tested positive for COVID-19.<br>o [DATE]: Resident #14 tested positive for COVID-19.<br>o [DATE]: Resident #32 tested positive for COVID-19. |

- [DATE]: Resident #55 tested positive for COVID-19.

- [DATE] COVID-19-line listing:
  - [DATE]: Resident #33 tested positive for COVID-19.
  - [DATE]: Resident #6 tested positive for COVID-19.
  - [DATE]: Resident #34 tested positive for COVID-19.
  - [DATE]: Resident # 35 tested positive for COVID-19.
- [DATE] COVID-19-line listing:
  - [DATE]: Resident #28 tested positive for COVID-19.
  - [DATE]: Residents #29, #30 and #31 tested positive for COVID-19.
  - [DATE]: Resident #1 tested positive for COVID-19.
  - [DATE]: Resident #25 tested positive for COVID-19.
  - [DATE]: Resident #26 tested positive for COVID-19.

Review of facility internal correspondence, received 9/24/24, sent to staff members updating them on COVID-19 within the facility noted the following:

- "[DATE] at 11:35 a.m.: From: [Licensed Nurse A]. To: DVA (Department of Veterans Affairs) DL (distribution list) WVH (Washington Veterans Home). Subject: Facility COVID Outbreak Status WVH. Good Morning, ***Routine Staff Testing is not required at this time. ***All staff are encouraged to self-monitor and test if and/or when they become symptomatic. There are test kits available to all staff in the clinic…F2- No active COVID…1. Positive Residents: 1. F202 (+) 9/22 ([DATE]), isolation through [DATE] ([DATE])."

An interview was conducted with Administrative Nurse A on 9/24/24, at 10:20 a.m. Administrative Nurse A stated the above noted correspondence was how the facility communicated with all staff members on infections and outbreaks within the facility. Administrative Nurse A stated all department heads would send emails to their direct staff letting the staff know if there were positive COVID-19 cases within the facility, what the PPE requirements were, and if an outbreak had occurred.

Review of the medical record for Resident #31 identified the following: Resident #31 was admitted on [DATE], with a diagnosis of Anemia, Acute and Chronic Respiratory Failure, Dementia, and Protein-Calorie Malnutrition. The Power of Attorney (POA) for Health Care was activated and identified

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| | within the medical record. Progress Notes, dated from [DATE] – [DATE], noted the following:<br><br>- [DATE] at 15:08 p.m.: "POA called unit requested to send res. [resident] to the hospital for further evaluation r/t [related to] changes of mentation, general weakness, poor appetite, notified NP [Nurse Practitioner] for family requested, called 911 for transport to Hospital."<br>- [DATE] at 22:16 p.m.: "Resident returned from SAH/ER@2210, alert, smiled to staff and made a few verbal statements but difficult to understand, per paramedics stating they could not find anything wrong…Hospital dx [diagnosis] is generalized weakness."<br>- [DATE] at 14:03 p.m.: "Res. on alert for ER [emergency room] visit, declining condition, poor appetite, unable to swallow, seen by ST [Speech Therapy], [family member] at bed side, assisting with eating, res. is alert but not speaking when asking. Skin intact, able to cough and offered liquids, denies any pain or discomfort, no acute distress, resting in bed. Afebrile."<br>- [DATE] at 15:14 p.m.: "tested positive for COVID."<br>- [DATE] at 13:39 p.m.: "Res. on alert for declining condition, COVID Positive for infection, notified NP…unable to administer PAXLOVID tabs r/t res. not swallowing, offered Honey thickened liquid still cough on thickened liquid texture, in bed resting, skin is warm and dry, in bed resting comfortably."<br>- [DATE] at 14:53 p.m.: "Spoke with [POA] and at this time [they wand] comfort only, there will be no IV or feeding tube. [They want] [Resident] comfortable."<br><br>Review of the medical record for Resident #35 identified the following: Resident #35 was admitted on [DATE], with a diagnosis of Protein-Calorie Malnutrition, [DIAGNOSIS], Anemia, and History of Disease of the Digestive System. The POA for Health Care was activated and identified within the medical record. Progress Notes, dated from [DATE] – [DATE], noted the following:<br><br>- [DATE] at 9:49 a.m.: "Resident vomited large coffee like emesis and complained of throat pain. Requested to go to the hospital…received verbal order to send resident to ER."<br>- [DATE] at 22:33 p.m.: "Resident readmitted with dx [diagnosis] of COVID +19 infection and hematemesis."<br><br>An observation was noted, on 9/25/24, at 9:15 a.m., of a sign outside the [LOCATION] which noted the following: "Caution VISITORS! COVID OUTBREAK. In effect within facility. Report to [LOCATION] for guidance upon entering resident areas. Thank you." |

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| | An interview was conducted, on 9/25/24, at 9:30 a.m., with Licensed Nurse A and Administrative Nurse A. Licensed Nurse A stated the facility acquired a new COVID-19 positive resident last night on [DATE]. Licensed Nurse A stated Resident #26 tested positive for COVID-19 last night and was put on aerosol precautions. Licensed Nurse A stated the facility was then placed on COVID-19 outbreak status. Licensed Nurse A stated they were new to the Licensed Nurse A position and started on [DATE]. Licensed Nurse A stated they did not know the exact definition of a COVID-19 outbreak and did not know how many positive residents would determine an outbreak. Licensed Nurse A stated they would have to refer to Administrative Nurse A for further clarification regarding the details of a COVID-19 outbreak. Licensed Nurse A stated they did complete the Nursing Home Infection Preventionist Training course through the Centers for Disease Control and Prevention (CDC). Licensed Nurse A stated they did notify the Washington Department of Public Health of all positive residents, along with the local county health department. Administrative Nurse A stated a COVID-19 outbreak would consist of one (1) positive resident or three (3) positive staff members. Administrative Nurse A stated they had made a mistake, on [DATE], regarding the facility not being in a COVID-19 outbreak status. Administrative Nurse A stated there was a sign on the facility entrance door that stated the facility was in a COVID-19 outbreak on [DATE], but was unaware of who may have taken the sign down. Administrative Nurse A stated a new COVID-19 outbreak sign had been placed on the [LOCATION] this morning. Administrative Nurse A stated that positive COVID-19 residents who share a room were not moved to a different room to protect the other resident, but the positive COVID-19 resident's curtains were to be closed to prevent the spread of illness to the roommate. Administrative Nurse A stated Resident #1 was the first to be diagnosed with COVID -19, on [DATE], and resided on the [LOCATION] in [LOCATION]. Administrative Nurse A stated Resident #25 was the second to be diagnosed, on [DATE], and resided on [LOCATION] in [LOCATION]. Administrative Nurse A stated that if a resident tested positive for COVID-19, then all residents on that unit were tested for COVID-19. Administrative Nurse A stated that staff were not required to test for COVID-19. Administrative Nurse A stated staff were encouraged to self-monitor for signs and symptoms of COVID-19, and report all signs and symptoms to their respective supervisors. Administrative Nurse A stated that the facility contacted the Washington State Department of Health Licensed Nurse D for all guidance when residents tested positive for COVID-19. Administrative Nurse A stated that not all discussions with the Licensed Nurse D were documented. Administrative Nurse A stated staff were required to wear N95 masks when they entered a resident's room that was positive for COVID-19. Administrative Nurse A stated staff were not |

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| | required to wear a mask when they entered units or when they went in and out of residents' rooms who did not have COVID-19, even if there was a positive COVID-19 resident on the unit. Administrative Nurse A stated all COVID-19 positive residents were required to eat in their rooms. Licensed Nurse A stated they received the last correspondence from Licensed Nurse D on [DATE], and were advised that all staff wear an N95 when entering a COVID-19 positive room.<br><br>Review of the certificate for completion of the Nursing Home Infection Preventionist Training Course through the CDC for Licensed Nurse A found that it was completed, and noted Licensed Nurse A had completed the course on [DATE].<br><br>An interview was conducted, on 9/25/24, at 10:10 a.m., with Dietary Staff A. Dietary Staff A was inside the [LOCATIONS] on the [LOCATIONS] preparing for lunch for residents. Dietary Staff A stated they were not aware of any COVID-19 outbreak in the facility, and had not been informed of any outbreak. Dietary Staff A was not donning PPE at the time of the interview.<br><br>An interview was conducted, on 9/25/24, at 10:13 a.m., with Maintenance Staff B. Maintenance Staff B was noted to be in the [LOCATIONS] on [LOCATIONS]. Maintenance Staff B stated they were not aware of any COVID-19 outbreak within the facility, and if residents tested positive for COVID-19, staff were to keep the residents' doors closed and provide appropriate signage and PPE for staff. Maintenance Staff B stated sometimes if residents tested positive, they assisted in sanitizing equipment. Maintenance Staff B was not donning PPE at the time of the interview.<br><br>An interview was conducted, on 9/25/24, at 10:15 a.m., with Dietary Staff C. They stated they were aware of one (1) resident who was positive for COVID-19 within the facility, and was not notified that the facility was in a COVID-19 outbreak status. Dietary Staff C stated that if they developed signs and symptoms of a sore throat, or allergy type symptoms, they would take a COVID-19 test at home prior to coming to the facility. Dietary Staff C was not donning PPE at the time of the interview.<br><br>An interview was conducted, on 9/25/24, at 10:19 a.m., with Certified Nurse Aide A. They stated they were aware of a couple of cases of positive COVID-19 residents within the facility, but was not aware of the facility being in a COVID-19 outbreak status. Certified Nurse Aide A stated they were informed by either an email from their supervisor or by the nurse at change of shift. Certified Nurse Aide A stated they had not yet logged into the computer to check their emails for the day, and was not aware if an email had been sent identifying an |

outbreak within the facility. Certified Nurse Aide A was not donning PPE at the time of the interview.

Review of correspondence sent to Administrative Nurse B, on July 12, 2024, from Licensed Nurse D noted the following: "I'm following up on our conversation from yesterday morning. Yesterday we discussed a grouping of your COVID cases in [LOCATION], and a few cases in [LOCATION], and what the appropriate measures are for response. I recommend making [LOCATION] into a closed COVID unit, and [LOCATION] should be considered following your next round of testing. I got some confirmation from the DOH on the best practices for your staff and residents to follow.
In your closed unit:

- The CDC recommends implementing universal use of

o N95s
o Eye protection
o Standard precautions based on exposure history
o Transmission based precaution based on suspected COVIDCOVID

§ *As SARS-CoV-2 transmission in the community increases, the potential for encountering asymptomatic or pre-symptomatic patients with SARS-CoV-2 infection also likely increases. In these circumstances, healthcare facilities should consider implementing broader use of respirators and eye protection by HCP during patient care encounters as described below."*

- Do staff members need to wear eye protection upon entering a closed unit (but are outside patient rooms)?
    - Staff do not need to wear eye protection upon entering the unit, however, if there are residents exposed or wandering the halls that staff must interact with in close proximity, the facility should consider wearing eye protection upon entering the unit and make sure to write this into their policy with rationale. Otherwise they only need to wear eye protection during direct patient care in the rooms.
    - *"Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) worn during all patient care encounters."*

- Do staff members need to change N95s when entering a COVID positive room?
    - Best practice and CDC recommendation is to change all PPE to prevent spread of illness. So, if staff are wearing PPE into a COVID Positive room, they need to be aware of what other sources of germs other residents may carry.
    - If you have a shortage of N95s for any reason, then your facility needs to look at these policies and document why they are not changing their N95 when entering a COVID positive room.

- Do staff members need to change N95s when entering and exiting a COVID negative room?
  - Same answer as above, best practice and CDC recommendation is to change all PPE to prevent spread of illness.
- Is it best practice to encourage residents to wear surgical masks while exiting their rooms into a closed unit?
  - Yes, if residents are negative for COVID-19 and cannot be moved off the closed unit, they should be educated on the importance of wearing a mask and encouraged to do so. The facility should make sure to chart this education and rationale for why they cannot be moved off the unit.
- *'Source control is recommended more broadly as described in CDC's Core IPC Practices in the following circumstances: By those residing or working on a unit or area of the facility experiencing a SARS-CoV-2 or other outbreak of respiratory infection; universal use of source control could be discontinued as a mitigation measure once the outbreak is over (e.g., no new cases of SARS-CoV-2 infection have been identified for 14 days)'."*

A telephone interview was conducted, on 9/25/24, at 10:36 a.m., with Licensed Nurse D. Licensed Nurse D stated they had had contact, written and verbal, with both Licensed Nurse A and Administrative Nurse A of the facility regarding positive COVID-19 residents. Licensed Nurse D stated correspondence was sent to the facility on July 12, 2024, outlining COVID-19 outbreak requirements. Licensed Nurse D stated if a resident tested positive for COVID 19 on a unit, the facility should test all residents along with close contacts. Licensed Nurse D stated close contact referred to all staff working on the infected unit. Licensed Nurse D stated guidelines for a COVID-19 outbreak consisted of two (2) residents who tested positive for COVID-19.

An interview was conducted, on 9/25/24, at 1:54 p.m., with Licensed Nurse C. They stated that if they developed a runny nose, fever, or gastrointestinal disturbances, they would call the physician and get tested for COVID-19. Licensed Nurse C stated that if the COVID-19 test was negative, they would then contact their supervisor at the facility to see if a PCR (polymerase chain reaction) test would be required.

An interview was conducted, on 9/25/24, at 1:56 p.m., with Certified Nurse Aide B. They stated that if they developed signs and symptoms of COVID-19, such as a headache, sore throat, fever, cough, or fatigue, they would call their supervisor at the facility for further guidance.

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| | An observation was made, on 9/25/24, at 2:10 p.m., and noted the following: Resident #25 was in their room; the door to the room was open and the resident was sitting in a wheelchair watching television. An aerosol precaution sign was placed outside of the door. A PPE cart and garbage can were located outside the resident's door in the hallway.<br><br>An observation was made, on 9/25/24, at 2:12 p.m., and noted the following: Curtains to Resident #26's room were open, and Resident #26 was lying in bed with no mask on. An aerosol precaution sign was placed outside of the door, and a PPE cart and garbage can were located outside the resident's door in the hallway. Per the medical record, Resident #26 had tested positive for COVID-19 as noted above. Resident #26's roommate, Resident #27, was not present in their room, and Resident #27's curtains were also open in, Resident #27's room. Per facility policy, as noted above, the resident's curtains were to remain closed if a resident had tested positive for COVID-19.<br><br>An interview was conducted, on 9/25/24, at 2:15 p.m., with Licensed Nurse E. They stated staff were required to don appropriate PPE prior to entering the doorway of any room for residents who were on isolation. Licensed Nurse E stated that staff should not be entering the room for either residents who have private rooms, or residents who shared a room, without appropriate PPE, if required.<br><br>An observation was conducted, on 9/25/24, at 2:18 p.m., and noted the following: Certified Nurse Aide C donned gloves and entered the room of Resident #26 and Resident #27 and walked to the sink, which was between the two (2) rooms. Both Resident #26's and Resident #27's room had the curtains open, exposing the inside of both Resident #26's and #27's room. Resident #26 was lying in bed with no mask. Resident #27 was not present in their room. Certified Nurse Aide C walked to the sink, took trash bags from on top of the sink, and then walked back out into the hallway. Certified Nurse Aide C did not don a gown or N95 mask, and did not don eye protection prior to entering the room.<br><br>An interview was conducted, on 9/25/24, at 2:18 p.m., with Certified Nurse Aide C. They stated that it was ok for staff to walk into a room that had two (2) rooms, without PPE, if required; and it was ok to don PPE in the area between the two (2) rooms that contained the sink.<br><br>An interview was conducted, on 9/25/24, at 2:22 p.m., with Certified Nurse Aide D. They stated they donned PPE for residents who were on aerosol precautions prior to entering the main door from the hallway. Certified Nurse Aide D stated they |

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| | would not enter a room with double occupancy to don PPE, and would don PPE in the hallway.<br><br>An observation was noted, on 9/26/24, at 9:45 a.m., of a sign outside the [LOCATION] which noted the following: "Caution VISITORS! COVID OUTBREAK. In effect within facility. Report to [LOCATION] for guidance upon entering resident areas. Thank you."<br><br>An interview was conducted, on 9/26/24, at 10:00 a.m., with Administrative Staff B, Administrative Staff A, Administrative Nurse A, Administrative Staff D, Administrative Staff C, Administrative Staff E, and Licensed Nurse A. Licensed Nurse A stated the facility did float staff from one (1) unit to another when there were positive COVID-19 residents within the facility and staff had not been tested when in close contact to the residents who tested positive for COVID-19. Licensed Nurse A stated aerosol precaution signs were placed outside of the rooms for residents who tested positive for COVID-19, and the signs also indicated in which bed (A or B) the positive resident was located. Licensed Nurse A stated the aerosol precautions signs stated that the door to the COVID-19 positive resident's room was to remain closed, and they would have to investigate the guidance to make sure that having the resident's door closed at all times was correct. Licensed Nurse A stated the facility followed CDC guidelines, and they would have to research those guidelines for clarification as to if the aerosol precaution sign was the correct sign for the facility to use with COVID-19 positive residents. Licensed Nurse A stated that the facility's current method of communicating via email to all staff for outbreak and infection updates was not currently working, as not all staff read their emails. Licensed Nurse A stated they were not rating infections, and was not mapping infections within the facility. Licensed Nurse A stated that the facility used McGeers to identify an infection, but nursing staff was not always completing the McGeers when signs and symptoms of infection were present for the residents. Licensed Nurse A stated they were new, and was having difficulty in catching up with infection control tasks. Administrative Staff E stated the facility completed a skills fair on [DATE], which covered PPE, handwashing, and infections, but not all staff members had received the education. Administrative Staff E stated it was a battle for the facility to get all staff to come into the facility to complete education and to maintain compliance. Administrative Staff E stated the facility had not been doing any formal infection control audits on the floor, and would need to start doing them immediately. Licensed Nurse A stated staff were to don PPE in the hallway prior to entering a COVID-19 positive resident's room, and staff should not be entering the room to don PPE. Licensed Nurse A stated the facility's current infection control program was not working properly, and a |

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| | Performance Improvement Plan would need to be implemented immediately to ensure the safety of all residents.<br><br>An interview was conducted, on 9/26/24, at 1:55 p.m., with Administrative Nurse A. They stated two (2) more residents tested positive within the facility for COVID-19. Administrative Nurse A stated both Residents #59 and #60 tested positive for COVID-19 on [DATE], and were currently on aerosol precautions.<br><br>An interview was conducted, on 9/26/24, at 1:58 p.m., with Dietary Staff B. Dietary Staff B stated they would be contacted by the nursing staff if an outbreak in the facility was present. Dietary Staff B stated they had not been notified of any current infection control outbreaks, and the facility currently was not in an infection control outbreak of COVID-19.<br><br>An interview was conducted, on 9/26/24, at 2:02 p.m., with Maintenance Staff C. They stated they were notified by their manager if the facility was in a COVID-19 outbreak. Maintenance Staff C stated they had not been told that an outbreak of COVID-19 was currently in effect.<br><br>An interview was conducted, on 9/26/24, at 2:04 p.m., with Licensed Nurse B. They stated they would get a report from the prior shift nurse on any infections or outbreaks within the facility. Licensed Nurse B stated they were not aware of any outbreaks of COVID-19 within the facility. Licensed Nurse B reviewed the COVID-19 outbreak sign on the [LOCATION] and stated they were not advised of the sign, and did not know the facility was currently in a COVID-19 outbreak.<br><br>An interview was conducted, on 9/26/24, at 2:07 p.m., with Licensed Nurse A and Administrative Nurse A. Licensed Nurse A stated all department heads were updated on the current COVID-19 outbreak today, and that each department head was responsible for updating their staff. Licensed Nurse A stated they were not sure why the above noted staff were not aware of the facility's current COVID-19 outbreak.<br><br>An interview was conducted, on 9/26/24, at 2:40 p.m., with Administrative Staff A. They stated they would ensure that all staff were educated immediately on the facility's current COVID-19 outbreak requirements. Administrative Staff A stated the facility reviewed the facility's infection control program every month during their QAPI meeting. Administrative Staff A stated that they had seen challenges within the infection control program, and Administrative Nurse A had been working weekly with Licensed Nurse A to assist them with the transition into their new role as Licensed Nurse A. |

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| | An interview was conducted, on 9/27/24, at 10:00 a.m., with Administrative Staff A. They stated the facility was advised by the Washington Public Health Department to close the [LOCATION] due to four (4) positive COVID-19 cases, and to implement appropriate PPE guidelines such as eye protection, gloves, gowns, and N95 masks. Administrative Staff A stated all staff were now being tested for COVID-19 daily, per the recommendations from the Washington Public Health Department, and thus far, no staff had tested positive. Administrative Staff A stated that staff on the closed [LOCATION] were wearing required PPE, and on the remaining units, masks were not required. |
| **§ 51.200 (a) Life safety from fire.**<br>(a) Life safety from fire. The facility must meet the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code.<br><br>**Level of Harm** – No Actual Harm, with potential for more than minimal harm<br>**Residents Affected** – Few | **<u>Smoke Barriers and Sprinklers</u>**<br><br>1. Based on observation and interview, the facility failed to maintain the kitchen hood extinguishing system in accordance with the code. The deficient practice affected zero (0) of 12 smoke compartments in [LOCATION], one (1) of two (2) smoke compartments in [LOCATION], staff, and no residents. The facility had a capacity for 240 beds with a census of 196 on the first day of the survey.<br><br>The findings include:<br><br>Observation, on 9/25/24, at 9:45 a.m., during the building tour of the [LOCATION] revealed the wheeled, gas-fired, griddle and the wheeled, gas-fired two (2) bin, deep fat fryer located on the cooking line were under the cooking hood. These items were not provided with an approved method that would ensure the appliances were returned to an approved design location after they had been moved for maintenance and cleaning, as required by sections 12.1.2.3 and 12.1.2.3.1 of NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations.<br><br>An interview, on 9/25/24, at 9:46 a.m., with Maintenance Staff A revealed the facility was not aware of the requirement for an approved method that would ensure the appliances were returned to an approved design location after they had been moved for maintenance and cleaning.<br><br>The census of 196 was verified by Administrative Staff A on 9/24/24, at 9:00 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 9/25/24, at 4:00 p.m.<br><br>**Actual NFPA Standard: NFPA 101 Life Safety Code (2012) 13.3.2.2 Cooking Equipment.** Cooking equipment shall be protected in accordance with 9.2.3, unless the cooking equipment is one of the following types: |

(1) Outdoor equipment
(2) Portable equipment not flue-connected
(3) Equipment used only for food warming
**9.2.3 Commercial Cooking Equipment.** Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless such installations are approved existing installations, which shall be permitted to be continued in service.

**Actual NFPA Standard: NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (2011)**
**12.1.2 Installation.**
**12.1.2.1** All listed appliances shall be installed in accordance with the terms of their listings and the manufacturer's instructions.
**12.1.2.2*** Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system.
**12.1.2.3** The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual.
**12.1.2.3.1** An approved method shall be provided that will ensure that the appliance is returned to an approved design location.

**Building Services (Elevators, Escalators, Laundry Chutes, etc.)**

2. Based on observation and interview, the facility failed to properly install gas equipment and appliances. The deficient practice affected zero (0) of 12 smoke compartments in [LOCATION], one (1) of two (2) smoke compartments in [LOCATION], staff, and no residents. The facility had a capacity for 240 beds with a census of 196 on the first day of the survey.

The findings include:

Observation, on 9/25/24, at 9:48 a.m., during the building tour of the [LOCATION] revealed the wheeled, gas-fired, griddle and the two (2) bin, deep fat fryer located on the cooking line under the cooking hood were not provided with a restraint system to limit the movement of the appliances to prevent strain on the connections, as required by sections 9.6.1.2 and 10.12.6 of NFPA 54, National Fuel Gas Code.

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| | An interview with Maintenance Staff A, on 9/25/24, at 9:50 a.m., revealed that the facility was not aware a restraint system for the wheeled, gas fired equipment was required.<br><br>The census of 196 was verified by Administrative Staff A on 9/24/24, at 9:00 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 9/25/24, at 4:00 p.m.<br><br>**Actual NFPA Standard: NFPA 101 (2012), Life Safety Code**<br>**13.5 Building Services.**<br>**13.5.1 Utilities.** Utilities shall comply with the provisions of Section 9.1.<br>**9.1.1 Gas.** Equipment using gas and related gas piping shall be in accordance with NFPA 54, National Fuel Gas Code, or NFPA 58, Liquefied Petroleum Gas Code, unless such installations are approved existing installations, which shall be permitted to be continued in service.<br><br>**Actual NFPA Standard: NFPA 54 (2012), National Fuel Gas Code**<br>**9.6.1.1 Commercial Cooking Appliances.** Commercial cooking appliances that are moved for cleaning and sanitation purposes shall be connected in accordance with the connector manufacturer's installation instructions using a listed appliance connector complying with ANSI Z21.69/CSA 6.16, Connectors for Movable Gas Appliances. The commercial cooking appliance connector installation shall be configured in accordance with the manufacturer's installation instructions.<br>**9.6.1.2 Restraint.** Movement of appliances with casters shall be limited by a restraining device installed in accordance with the connector and appliance manufacturer's installation instructions.<br>**10.12.6 Use with Casters.** Floor-mounted appliances with casters shall be listed for such construction and shall be installed in accordance with the manufacturer's installation instructions for limiting the movement of the appliance to prevent strain on the connection. |
| **§ 51.200 (b) Emergency power.**<br>(1) An emergency electrical power system must be provided to supply power adequate for illumination of all exit signs and lighting for the means of egress, fire alarm and medical gas alarms, emergency communication systems, and generator task illumination.<br>(2) The system must be the appropriate type essential electrical system in accordance with the applicable provisions of NFPA 101, Life Safety | Based on records review and interview, the facility failed to properly inspect and test all components of the emergency generator. The deficient practice affected 12 of 12 smoke compartments in [LOCATION], and two (2) of two (2) smoke compartments in [LOCATION], staff, and all residents. The facility had a capacity for 240 beds with a census of 196 on the first day of the survey.<br><br>The findings include:<br><br>Record review, on 9/24/24, at 10:15 a.m., of the monthly emergency generator inspection and testing records dating back 12 months prior to the survey, revealed there was no documentation of monthly specific gravity testing or |

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| Code and NFPA 99, Health Care Facilities Code.<br>(3) When electrical life support devices are used, an emergency electrical power system must also be provided for devices in accordance with NFPA 99, Health Care Facilities Code.<br>(4) The source of power must be an on-site emergency standby generator of sufficient size to serve the connected load or other approved sources in accordance with NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code.<br><br>**Level of Harm** – No Actual Harm, with potential for more than minimal harm<br>**Residents Affected** – Many | conductance testing for the lead-acid generator batteries, as required by section 8.3.7.1 of NFPA 110, Standard for Emergency and Standby Power Systems.<br><br>An interview, on 9/24/24, at 10:15 a.m., with Maintenance Staff A revealed the facility staff was unaware of the requirement to perform monthly conductance testing of the emergency generators' lead-acid maintenance free batteries.<br><br>Observation, on 9/25/24, at 1:39 p.m., during the facility tour revealed the emergency generator had lead-acid maintenance free batteries.<br><br>The census of 196 was verified by Administrative Staff A on 9/24/24, at 9:00 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 9/25/24, at 4:00 p.m.<br><br>**Actual NFPA Standard: NFPA 101, Life Safety Code (2012)**<br>**19.5 Building Services.**<br>**19.5.1 Utilities.**<br>**19.5.1.1** Utilities shall comply with the provisions of Section 9.1.<br>**9.1.3 Emergency Generators and Standby Power Systems.** Where required for compliance with this Code, emergency generators and standby power systems shall comply with 9.1.3.1 and 9.1.3.2.<br>**9.1.3.1** Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems.<br><br>**Actual NFPA Standard: NFPA 110, Standard for Emergency and Standby Power Systems (2010)**<br>**8.3.7.1** Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted. |