

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505017	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/12/2024
NAME OF PROVIDER OR SUPPLIER Washington Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2821 South Walden Street Seattle, WA 98144	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>45987</p> <p>Based on observation, interview, and record review, the facility failed to establish and maintain infection control practices necessary to provide a safe and sanitary environment and prevent transmission of communicable diseases by having Personal Protective Equipment (PPE) available to staff for 12 of 19 residents (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10,11, &12) observed requiring Enhanced Barrier Precautions (EBP) with specific diagnoses including wounds and indwelling medical devices. The facility failed to ensure alcohol-based hand sanitizer dispensers were properly functioning for 25 of 46 rooms (Rooms 202, 203, 204, 209,211, 208, 215, 216, & 218; and outside rooms 219, 250, 251, 252, 255, 256, 257, 263, 264, 265, 266, 267, 268,270, 273, & 274) observed inside and along the hallway outside occupied resident rooms. These failures placed residents at risk for acquiring and developing communicable diseases, medical complications from infection, and a decreased quality of life.</p> <p>Findings included .</p> <p><Facility Policy></p> <p>According to the Enhanced Barrier Precautions-F880, facility policy, revised March 2024, EBP was used as an infection prevention and control intervention to reduce the transmission of Multi-Drug-Resistant Organisms (MDROs) to residents. The EBPs were indicated for residents infected or colonized with a Centers for Disease Control and Prevention (CDC) targeted diagnoses, wounds and/or indwelling catheters. The policy showed PPEs would be available outside of the resident rooms.</p> <p><Unit 2 East And 2 West></p> <p>During multiple observations of units 2 East and 2 [NAME] on 11/08/2024 from 10:35 AM to 3:00 PM, 25 hand sanitizer dispensers were observed faulty and unable to dispense hand sanitizer when tested .</p> <p>Observations on 11/08/2024 from 10:35 AM to 3:00 PM of multiple isolation carts posted outside resident rooms designated as EBP showed they were not stocked with proper PPE for staff to provide safe care to residents.</p> <p>During an interview on 1/08/2024 at 11:04 AM, Staff C (Certified Nursing Assistant - CNA) stated the aids should have access to PPE but the supply was not always consistent, .sometimes we [staff] do, sometimes not .have to go look for them.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 11/08/2024 at 11:08 AM, Staff D (CNA) stated they disregard the isolation sign when providing resident care such as brief changes or linen changes, they did not have an Infection Preventionist (IP) Nurse to ask, and they did not know where to get the PPE supplies from.</p> <p>In an interview on 11/08/2024 at 11:15 AM, Staff E (CNA) stated there was not a lot the staff could do about PPE supply and accessibility, and they were not sure the isolation sign should be posted on the door.</p> <p>In an interview on 11/08/2024 at 11:20 AM, Staff F (CNA) stated they work three days a week on the 2nd floor, and it had been a while since the isolation carts were stocked with PPE. Staff F stated they had not been stocked since the Infection Preventionist Nurse (IP) nurse left.</p> <p>In an interview on 11/08/2024 at 12:05 PM, Staff B (Director of Nursing) stated they would expect the isolation signs to be accurate and that staff would follow the directions provided on the signs and restock PPE as needed. Staff B stated the signs were there to protect staff and other residents, and to reduce the transmission of infections to high-risk individuals. Staff B stated the IP nurse left on 10/28/2024 and the position had not been filled.</p> <p>On 11/08/2024 at 12:10 PM, Staff A (Regional Administrator) stated all staff should know where supplies were kept, should be able to re-stock isolation carts and rooms, and that all hand sanitizer dispensers should function properly to prevent the spread of infection.</p> <p>In an interview on 11/08/2024 at 3:07 PM, Resident 1 stated the staff did not wear a gown and gloves at times when they changed their wound dressing or provided care for their urinary catheter.</p> <p>In an interview on 11/08/2024 at 3:10 PM, Resident 2 stated staff did not wear a gown to change their bed linens, and it was not unusual for the hand sanitizer dispenser to malfunction. Resident 2 stated they brought up the malfunctioning dispenser to the staff's attention, but it did not get fixed or filled.</p> <p>REFERENCE: WAC 388-97-1320 (1)(a), -1320 (2)(b), -1320 (1)(c).</p>		