STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505182	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Mount St Vincent	4831 35th Avenue Southwest Seattle, WA 98126

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 - Few	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 to prevent the transmission of communicable diseases. The facility failed to implement and/or follow Transmission Based Precaution (TBP) protocol for 4 of 16 residents (Residents 1, 2, 3, & 4) reviewed for infection control related to COVID-19 (Coronavirus Disease of 2019, an infectious respiratory disease caused by a virus). This failure placed residents at risk of infection and related complications. <Facility Policy>The facility's 08/2024 Transmission-Based Precautions (TBP) policy showed the facility would implement Aerosol Contact Precautions (ACP) for residents with confirmed or suspected infections from COVID-19, which spreads through airborne and droplet routes through coughing, sneezing, talking, and through the provision of care. The TBP policy showed the facility would place a sign on the resident's door to inform staff and visitors of the appropriate Personal Protective Equipment (PPE) to put on and actions to take before entering the resident's room.In an interview on 07/30/2025 at 2:55 PM, Staff C (Infection Control Preventionist) stated a COVID-19 outbreak started in the facility on 07/26/2025 with 10 residents on the third floor south (3-S) testing positive for COVID-19. Staff C stated the residents who tested positive had ACP signage placed on their doors to notify visitors of PPE requirements. Staff C stated on 07/28/2025 five additional residents tested positive, and on 07/30/2025 one more resident tested positive for a total of 16 residents with confirmed COVID-19 infections.In an interview on 07/30/2025 at 4:27 PM, Staff D (Licensed Practical Nurse) provided a 3-S resident census for 07/30/2025 which showed 16 residents, including Resident 1, Resident 2, Resident 3, and Resident 4, had the COVID-19 infection. Staff D stated the 16 residents were isolated to their rooms, staff were required to wear PPE before entering and when providing care to the 16 residents. Staff D stated the nurse on duty was responsible to ensure staff wore the correct PPE when entering the isolated resident's room for care. Staff D stated there were carts with PPE outside the residents' rooms and there were ACP signs on the doors of residents that were in isolation.Observations on 07/30/2025 at 4:35 PM showed rooms 314 (Resident 1), 316 (Resident 2), 315 (Resident 3), and 319 (Resident 4) did not have ACP signage on the door to notify visitors and staff of COVID-19 positive residents. In an interview on 07/30/2025 at 5:43 PM, Staff B (Director of Nursing) stated residents with COVID-19 infections should be on ACP precautions and each door should have signage to notify staff and visitors of PPE use and actions to take before entering the room. Staff B stated no specific staff person routinely monitored for ACP signage or staff use of PPE. Staff B stated all managers and the Infection Control Preventionist oversee the ACP signage and staff use of PPE.REFERENCE: WAC 388-97-1320(1)(a), (2)(a-c).

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