STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505236	A. Building B. Wing	04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edmonds Care	21400 72nd Avenue West Edmonds, WA 98026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49619 Based on observation, interview and record review, the facility failed to implement a care plan for 1 of 9 residents (Resident 1), reviewed for comprehensive care plans. The failure to implement a care plan for Activities of Daily Living (ADLs) placed the resident at risk for unmet care needs and a diminished quality of life. Findings included . Review of Resident 1's care plan for ADLs, initiated on 01/04/2024 showed, ADL Self Care Performance Deficit r/t [related to] Dementia [memory loss], Hemiplegia [paralysis/weakness on one side of the body], Limited ROM [Range of Motion], Stroke [occurs when blood flow to the brain is disrupted]. The care plan further showed an intervention initiated on 09/23/2024 for EATING: provide 1 [one] on 1 feeding assistance. An observation and interview on 04/15/2025 at 12:30 PM showed Collateral Contact 1 (CC1) assisting Resident 1 with her meal. CC1 stated that if they were in the facility to visit Resident 1, they would assist them with their meals (lunch and dinner). CC1 stated that they were typically at the facility from 9:00 AM to 7:00 PM. CC1 stated that they would prefer staff to assist Resident 1 with their meals and that many times staff would leave the tray and not come back right away so CC1 would begin assisting the resident with their meal. On 04/15/2025 at 12:50 PM, Staff F, Certified Nursing Assistant, stated they were expected to follow a resident's care plan. Staff F stated that if a resident was 1 on 1, during meals that meant they needed to sit and assist the resident during the entirety of the meal. Staff F stated it was their responsibility to assist Resident 1 with their meal and remain with the entirety of the meal with them. On 04/21/2025 at 10:52 AM, Staff A, Director of Nursing, stated it was their expectation for staff to follow the resident's care plan. Staff A stated if a resident was 1 on 1 assist during meals, staff should remain with the resident for the entirety of their meal. Staff A stated that staff were trained on things such as choking and cardiopulmonary resuscitation (emergency procedure involving chest compressions often combined with artificial ventilation) and they were responsible for assisting the residents with their meals, and that if the resident representative insisted on assisting a resident with their meals, they would expect it to be in the care plan. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	References: (WAC) 388-97-1020(1), (2)(a)(b)

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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** 51090 Based on observation, interview and record review, the facility failed to ensure infection prevention and control practices including proper use of Personal Protective Equipment (PPE-use of gown, gloves and respiratory/N95 respirator-mask) and closure of resident room doors with COVID-19 (an infectious virus causing respiratory illness) were followed to help prevent the transmission of disease during resident care and/or housekeeping for 4 of 5 staff (Staff D, E, F & G), reviewed for infection control. These failures placed the residents, staff, and visitors at risk for facility acquired or healthcare-associated infections and related complications. Review of a policy tilted, COVID-19 Facility Policy and Procedure, revised in April 2024, showed, All staff and essential personnel must wear appropriate PPE are items worn to keep people safe from germs and other hazards, including masks, gloves, gowns and face shields] when interacting with residents. For example: Aerosol [tiny particles that travel through the air]/positive COVID-19, Quarantine [state of isolation in which people that may have been exposed to an infectious disease are placed] Review of the facility's policy titled, Enhanced Barrier Precautions [steps taken to reduce transmission of multidrug-resistant organisms - germs that are resistant to medications that treat infections] (EBP) Policy and Procedure, revised in April 2024, showed that examples of high-contact resident care activities (involve direct contact with the resident's skin, body fluids, or excretions) requiring gown and glove use for EBP included changing linens. According to the Centers for Disease Control (CDC) online document titled, Infection Control Guidance: SARS-CoV-2), dated 06/24/2024, showed that respirators are approved by CDC/NIOSH (National Institute for Occupational Safety and Health), including those intended for use in healthcare and that CDC continues to recommend respiratory protection with a NIOSH-approved particulate respirator with N95 or higher for care of patients [residents] with known or suspected COVID-19. STAFF D Review of an undated posted signage at the main entrance of the facility showed the facility was in Outbreak status [two or more cases of a highly contagious disease] Review of undated posted signage on the employee break room door showed, All staff are mandated to wear N95 mask in the building. Review of Resident 2's undated face sheet showed they were in room [ROOM NUMBER]. Review of Resident 2's nursing progress note, dated 04/15/2025 at 6:54 AM, showed Resident is current on alert for Aerosol [Aerosol Contact -a type of precaution used to prevent the spread of airborne diseases through aerosols] precaution r/t [related to] Covid Positive. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the Northwest hallway on 04/15/2025 at 7:55 AM, showed room [ROOM NUMBER] had an Aerosol Contact Precaution sign posted on the wall next to room [ROOM NUMBER]'s opened door. It showed that the sign instructed to wear appropriate PPE before entering and for the room door to be closed at all times. Further observation showed room [ROOM NUMBER]'s room remained open at 8:03 AM, at 8:16 AM, and at 8:43 AM. Observation on 04/15/2025 at 7:58 AM showed Staff D, Licensed Practical Nurse, was standing in the Northwest hallway and wearing a black colored face mask with ear loops. Staff D then entered room [ROOM NUMBER]. At 7:59 AM, Staff D exited room [ROOM NUMBER] and wore the same black colored face mask with ear loops. Further observations at the following times that day showed: - at 8:11 AM, Staff D entered room [ROOM NUMBER] while wearing a black colored face mask with ear loops. - at 8:21 AM, Staff D donned (applied) PPE and replaced the black face mask with an N95 respirator from the PPE cart before entering room [ROOM NUMBER]. Staff D then exited room [ROOM NUMBER] and donned a black face mask with ear loops. - at 8:28 AM, Staff D was standing at their medication cart while wearing a black colored face mask with ear loops. - at 8:32 AM, Staff entered another room in the Northwest hallway while wearing a black colored face mask with ear loops and exited the room while wearing the same black colored face mask. Observation of the Northwest hallway on 04/15/2025 at 8:44 AM showed Staff C, Infection Preventionist, was walking down the hallway to replenish supplies in the PPE carts. A joint observation and interview on 04/15/2025 at 8:45 AM with Staff C showed room [ROOM NUMBER] had an Aerosol Contact Precautions sign posted on the wall next to room [ROOM NUMBER]'s opened door. It also showed Staff D was standing at their medication cart while wearing a black face mask with ear loops. Staff C stated they expected staff would follow the instructions on the Aerosol Contact Precaution sign to keep room [ROOM NUMBER]'s door closed at all times. Staff C further stated that Staff D was wearing a KN95 (type of respirator mask with ear loops instead of head straps) and that they expected all staff would wear N95 respirators because we're in an outbreak. In an interview and joint observation on 04/15/2025 at 9:00 AM, Staff D stated the facility was in an outbreak status due to having positive COVID-19 cases in the facility. Staff D stated that there were a lot of positive [COVID-19] cases in this [Northwest] hall. When asked what the facility's process was for preventing transmission of COVID-19 during an outbreak, Staff D stated Wearing N95 at all times, in the hallways, in the room. Joint observation of the black colored face mask used by Staff D showed the mask was labeled as KN95. Staff D stated they were instructed by Staff C to wear an N95 and that I should wear an N95. In an interview on 04/15/2025 at 9:22 AM, Staff B, Resident Care Manager, stated the facility was currently in a COVID-19 outbreak, and that N95 respirators were required for all staff right now. Staff B further stated they expected Aerosol Contact Precautions would be followed when indicated and that it included keeping the room door closed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/15/2025 at 2:49 PM, Staff C stated the facility was currently in a COVID-19 outbreak and that the identified positive six cases were in the Northwest hallway, as of 04/15/2025. Staff C further stated that they expected all staff to wear a fit-tested N95 while working in the hallways with positive residents. STAFF E Review of an undated posted signage at the main entrance of the facility showed the facility was in Outbreak status. Review of Resident 2's face sheet printed on 04/04/2025 showed they were in room [ROOM NUMBER]. Review of Resident 2's nursing progress note, dated 04/15/2025 at 6:54 AM, showed Resident is current on alert for Aerosol precaution r/t Covid Positive. Observation of the Northwest hallway on 04/15/2025 at 7:55 AM, showed room [ROOM NUMBER] had an Aerosol Contact Precaution signage posted on the wall next to room [ROOM NUMBER]'s opened door. It further showed that the signage instructed to wear appropriate PPE before entering and for the room door to be closed at all times. Further observation showed room [ROOM NUMBER]'s room remained open at 8:03 AM, at 8:16 AM and at 8:43 AM. Observation on 04/15/2025 at 8:43 AM showed Staff E, Certified Nursing Assistant (CNA), put on PPE prior to entering room [ROOM NUMBER] through the opened door. Further observation showed Staff E standing at door from the inside of room [ROOM NUMBER] while the door was kept open. A joint observation and interview on 04/15/2025 at 8:45 AM with Staff C showed room [ROOM NUMBER] had an Aerosol Contact Precautions signage posted on the wall next to room [ROOM NUMBER]'s opened door. Staff C stated they expected staff would follow the instructions on the Aerosol Contact Precaution sign to keep room [ROOM NUMBER]'s door closed at all times. In an interview on 04/15/2025 at 9:22 AM, Staff B stated the facility was currently in a COVID-19 outbreak, and that they expected Aerosol Contact Precautions would be followed when indicated and that it included keeping the room door closed. In an interview on 04/15/2025 at 12:39 PM, Staff E stated the facility was in a COVID-19 outbreak. When asked how staff protected themselves and others during an outbreak, Staff E replied, By the use of PPE and to follow the precautions. When asked if room [ROOM NUMBER]'s door should have been kept closed, Staff E stated Yes, this morning it was busy and we were rushing in and out, and that, We know it should be closed. In an interview on 04/15/2025 at 2:49 PM, Staff C stated the facility was currently in a COVID-19 outbreak and that the identified positive six cases were in the Northwest hallway, as of 04/15/2025. Staff C stated that staff were informed by signage posted at the entrance of the room when isolation precautions (steps taken to prevent the spread of germs) were indicated. Staff C further stated that room [ROOM NUMBER]'s door should have been kept closed. 49619 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	STAFF F Observation on 04/15/2025 at 8:55 AM, showed an EBP sign outside of Resident 3's room that stated providers, and staff must Wear gloves and a gown for the following High-Contact Resident Care activities . Changing Linens. Further observation showed Staff F, CNA, making Resident 3's bed and was not wearing a gown. Review of Resident 3's Order Summary printed on 04/21/2025, showed a physician order dated 09/18/2023 for Enhanced barrier precautions r/t hx [history] of ESBL [extended-spectrum beta-lactamase- an enzyme (protein) that can make certain antibiotics (medication to treat infections) ineffective] in urine/Hx of MRSA [Methicillin-resistant Staphylococcus aureus- an infection caused by a type of staph bacteria that becomes resistant to antibiotics]. On 04/15/2025 at 12:50 PM, Staff F stated that if they were making a resident's bed and they were on EBP then they needed to put on a gown and gloves. Staff F stated Resident 3 was on precautions for history of MRSA, and that it was important to follow the precautions to prevent the spread to anyone else. STAFF G Observation on 04/15/2025 at 11:19 AM, showed a Contact Enteric Precautions (specific measures taken in healthcare settings to prevent the spread of infections, particularly those transmitted through direct or indirect contact with contaminated surfaces or bodily fluids, often related to fecal-oral transmission) sign outside of Resident 4's room that stated prior to entering, Wear a gown and gloves. Further observation showed Staff G, Housekeeper, was cleaning Resident 4's room and was not wearing a gown. Review of Resident 4's Order Summary printed on 04/21/2025 showed a physician order dated 02/13/2025 for Contact-Enteric Precaution r/t Positive C [Clostridioides] Difficile [a bacteria that causes a serious infection in the colon leading to diarrhea]. On 04/15/2025 at 1:47 PM, Staff G stated they should have worn a gown while cleaning Resident 4's room. On 04/15/2025 at 1:50 PM, Staff H, Housekeeping Manager, stated it was their expectation that staff wear the appropriate PPE (use gown and gloves) when cleaning a room on Contact Enteric Precautions. On 04/15/2025 at 2:31 PM, Staff I, RN, stated if a resident was on EBP and doing a high contact activity like changing linens, they needed to wear a gown and gloves. Staff I further stated they would expect staff to wear a gown and gloves when entering a Contact Enteric Precautions room. On 04/15/2025 at 2:42 PM, Staff C stated they expected staff to follow the EBP and Contact Enteric Precautions signage before entering a resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/21/2025 at 10:52 AM, Staff A, Director of Nursing, stated that they were currently in a COVID-19 outbreak. Staff A stated they expected the facility to follow CDC and local health department guidelines and recommendations. Staff A stated that they expected staff to follow transmission-based precautions, including Aerosol and contact, and enhanced barrier precautions. Staff A stated that they expected staff to wear fit tested and NIOSH-approved respirators when indicated. Staff A stated Staff F should have followed the EBP signage, especially if they are going to be in contact with linens, or where the patient [resident] is. Reference: (WAC) 388-97-1320 (1)(a)(2)(b)(3)