STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505263	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prestige Post-Acute & Rehab Ctr - Kittitas Valley	1050 E Mountain View Ellensburg, WA 98926

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48368 Based on interview and record review, the facility failed to notify the provider of an elevated heart rate and a low blood pressure for 1 of 3 residents (Resident 4) reviewed for change in condition This failure placed the resident at risk of inappropriate medication dosages, health complications, and timely care of services from the physician, resulting in a delay of treatment. Findings included . Review of a policy titled, Managing Acute Condition Change, dated 07/11, showed: .Assess the resident experiencing an acute change including vital signs . Notify physician without delay . <Resident 4> Review of the resident's medical record showed the resident was admitted to the facility on [DATE] with diagnoses including pneumonia (an infection of the lungs that may be caused by bacteria, viruses, or fungi), chronic obstructive pulmonary disease (a lung disease causing restricted airflow and breathing problems), and hypertension (high blood pressure - when your blood is pumping with more force than normal through your arteries). The comprehensive assessment dated [DATE] showed the resident had intact cognition and required assistance of one staff member for activities of daily living. Record review of a nursing progress note, dated 05/02/2024, showed vital signs were taken by Staff P, Registered Nurse, with a heart rate of 131 beats per minute ([BPM], normal heart rate range is 60-100) in the supine [lying flat on their back] position, 136 BPM while sitting, and 110 BPM while standing. Record review of a nursing progress note, dated 05/03/2024, showed Resident 4 ' s heart rate was in the 160 ' s (BPM) after one minute of standing and was sent out the Emergency Department (ED) for further evaluation. Record Review of the ED discharge notes, dated 05/03/2024, showed a new onset diagnosis of atrial fibrillation (an irregular heartbeat) and was ordered new medications to control the heart rate. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/20/2024 at 3:30 PM, Staff P, stated they did not notify the Physician with a change in condition for Resident 4 on 05/02/2024 related to an elevated heart rate. Staff P further stated the normal process was to notify the physician of changes and they did not follow the correct process. Review of a physician ' s order dated, 04/20/2024, showed Resident 4 was to have their blood pressure monitored every day and to notify the physician if the systolic (top number) was less than 100 millimeters of mercury (mmHg-unit of measure). Record Review of Resident 4 ' s April through May 2024 Medication Administration Record, showed staff L, Licensed Practical Nurse, obtained and documented Resident 4 ' s blood pressure on 04/30/2024 with a reading of 96/89 mmHG and 96/69 mmHg (Normal blood pressure range is 120 to 129/ 80-84 mmHg) on 05/01/2024. Record review of the progress notes for April through May 2024, showed no documentation of the physician being notified of Resident 4 ' s systolic blood pressure below 100 mmHg. During an interview on 05/21/2024 at 12:45PM, Staff L, Licensed Practical Nurse, stated they did not recall notifying the Physician and the normal process was to follow the Physician ' s order. Staff L further stated, I did not do that, so the correct process was not followed. During an interview on 05/17/2024 at 12:34 PM, Staff E, Advanced Registered Nurse Practitioner, stated they wrote the specific order with parameters so they would be notified right away for any changes in Resident 4 ' s condition. Staff E stated they were not notified of the abnormal heart rate and low systolic blood pressure. Staff E further stated they would expect for the nurses to follow their orders and notify them as directed, and for any changes of conditions. During an interview 0n 05/17/2024 at 2:22 PM, Staff B, Interim Director of Nursing Services, stated their expectation was for the nurses to follow the physician ' s orders and to notify the provider with any change in condition. Staff B further stated, we have a broken system. Reference: WAC 388-97-0320 44922

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on observation, interview, and record review the facility failed to ensure residents received physician ordered medication, had necessary laboratory values (labs) drawn as ordered, and received timely treatment for abnormal labs for 4 of 4 residents (Residents 1, 2, 3, and 5) reviewed for quality of care. This failed practice resulted in harm for Residents 1 and 2 when their treatment was delayed, conditions worsened, and required hospitalization . Residents 3 and 5 were at risk for their condition to worsen and experience inaccurate or a delay in treatment. Findings included . <Resident 1> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include removal of the left leg below the knee and kidney failure. The 04/19/2024 comprehensive assessment, showed the resident's cognition was intact and required one staff assistance for bed mobility and transfers. Review of Resident 1's 04/12/2024 hospital notes, showed the resident was admitted to the hospital, from the facility, for diagnoses to include hyponatremia (decreased level of sodium [salt] in the blood) and an infected abscess (a painful lump filled with pus that can form anywhere on your body due to an infection or injury) to the left buttock. The discharge notes on 04/18/2024 showed the resident was to have weekly blood draws completed to monitor the hyponatremia and the infection, the first one to be drawn on 04/25/2024. Review of Resident 1's April 2024 Medication Administration Record (MAR) showed orders as follows: 04/18/2024, obtain weekly labs. Scheduled to be drawn every Thursday morning, first one scheduled for 04/25/2024. The box on the 25th was documented with a 5 (a five means see progress notes, progress notes on 04/25/2024 showed need supplies). 04/19/2024, obtain weekly labs. Scheduled to be drawn every seven days, first one scheduled for 04/24/2024. The box on the 24th was blank. (No nursing note to show why the lab had not been obtained). 04/24/2024, obtain a Basic Metabolic Panel ([BMP], a blood test that measures eight different substances in your blood [sodium is one of them]). Scheduled to be drawn on 04/27/2024. Lab was drawn. (sodium lab value was low and no documentation to show notification to the provider). 05/02/2024, obtain labs on 05/03/2024. Lab was drawn. (no documented notification to the provider for the low sodium level). 05/02/2024, Sugar free Gatorade at bedside every shift for hyponatremia (ordered for the low sodium level from 04/27/2024, five days after lab drawn, when provider reviewed abnormal lab results on rounds 05/01/2024). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	05/06/2024, Sodium Chloride (a fluid that provides sodium replacement), given intravenously ([IV], administered through the veins) for hyponatremia. Review of Resident 1's completed sodium lab draws showed on 04/27/2024 sodium result was 126 milli-equivalents per liter ([mEq/L, a unit of measure], a normal sodium result is 136-145 mEq/L), on 05/03/2024 sodium result was 122 mEq/L, and on 05/07/2024 sodium result was critical at 117 mEq/L. Review of Nursing progress notes showed as follows: 04/28/2024 at 6:33 AM (one day after labs obtained on 04/27/2024), lab will fax BMP results. (no further notes to show the labs were received or provider was notified, sodium was low at 126 mEq/L). 05/06/2024 at 10:21 PM, provider called facility after review of 05/03/2024 low sodium level and ordered IV hydration and a follow up BMP lab in the AM. (the orders showed no order had been processed for the BMP lab in the AM on 05/07/2024). 05/07/2024 at 3:24 PM, resident was observed to be lethargic and pale, called provider, since labs had not been drawn in the AM as ordered, the provider added additional labs. Labs sent to lab at 3:15 PM. 05/07/2024 at 4:39 PM, lab called facility with critically low sodium results and provider gave an order to send resident to the hospital. 05/07/2024 at 8:21 PM, call placed to hospital and Resident 1 had been admitted for hyponatremia and would require replacement therapy. During an interview on 05/17/2024 at 1:39 PM, Staff K, Licensed Practical Nurse, stated their process for lab draws were to draw the blood, drive the labs to the hospital to be processed, review the results when they returned to the facility, and update the provider with any abnormal lab values. Additionally, on 05/21/2024 at 12:54 PM, Staff K stated I do not know for sure if the labs ordered on 04/25/2024 were obtained because they needed additional blood drawing supplies from the lab. Staff K assumed the evening nurse would have obtained the supplies and completed the blood draw if it had not been completed prior to their shift ending. Further, Staff K stated they did not recall why the BMP lab was not obtained until late evening on 05/07/2024 and verified there was no lab order for the morning of 05/07/2024. During an interview on 05/20/2024 at 3:25 PM, Staff Q, Resident Care Manager (RCM), stated they did not process the order for Gatorade (a brand of drink used to replace fluids and minerals such as sodium in the body) that was given on 05/01/2024 until the following day on 05/02/2024 when they reviewed the provider's notes. Additionally, Staff Q stated they did not recall why they did not obtain the labs on 04/24/2024 and usually would keep notes as to why something was not done during their shift but could not find any. Staff Q could not recall why the labs on 04/27/2024 were not followed up on. Staff Q did not receive or review the labs obtained on 05/03/2024 and on 05/04/2024 they called the provider with the lab results for the infection but not for the abnormal sodium level. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/16/2024 at 2:38 PM, Staff E, Advanced Registered Nurse Practitioner, stated they would expect nursing to call them for any abnormal lab results. Staff E further stated they received the results as well but did not prioritize reviewing them because they presumed if they were abnormal, the facility would have called. Staff E stated the low sodium lab result for Resident 1 on 04/27/2024 was not called to them and did not review them until their visit with Resident 1 on 05/01/2024 (four days after labs were obtained). Staff E gave new orders to start Pedialyte (a brand of drink used to replace fluids and minerals such as sodium in the body) for oral rehydration and gave the okay to use Gatorade if Pedialyte was unavailable, I can see that didn't happen. Staff E stated follow-up labs were drawn on 05/03/2024 and they did not receive any calls or results until they reviewed the labs themselves late in the evening on 05/06/2024 when the sodium level had dropped to 122 mEq/L. Staff E stated they called the facility on 05/06/2024 in the evening, and gave orders to start IV hydration and repeat labs on 05/07/2024 in the AM. The provider further stated they were not aware the follow up sodium lab had not been drawn until the evening of 05/07/2024, when they received the call that the resident had become lethargic and pale. Additionally, the provider stated the hydration with the drink and IV solution would have presumably corrected the hyponatremia had they been given timely and as ordered. <Resident 2> Review of the resident's medical records showed the resident admitted to the facility on [DATE] with diagnoses to include asthma (a lung disorder characterized by narrowing of the airways, the tubes which carry air into the lungs, that are inflamed and constricted, causing shortness of breath, wheezing and cough) and low blood pressure. The 04/29/2024 admission assessment showed the resident's cognition was intact and required one to two staff assistance for bed mobility and transfers. Review of Resident 2's 04/30/2024 hospital notes, showed the resident experienced a fever and productive cough at the facility and was sent to the hospital to be evaluated, one day after admission. Resident 2 was diagnosed with an infection in their urine, ([bacteremia], the presence of bacteria in your blood, which can be serious and require antibiotics), and pneumonia (an infection that inflames the air sacs in one or both lungs, causing cough, fever, chills, and difficulty breathing). Upon discharge from the hospital on 05/03/2024, the resident was ordered Fluconazole (a brand of antifungal medication) for the pneumonia (next dose on 05/04/2024) daily for seven days and Vancomycin (a brand of antibiotic) IV antibiotics to be given every 12 hours for 11 days (22 doses) for the bacteremia. Review of Resident 2's May 2024 MAR, showed an order for Fluconazole 100 milligrams daily by mouth to start on 05/04/2024. The MAR showed the Fluconazole had not been given on 05/04/2024, 05/05/2024, and 05/06/2024. Three doses were missed. Additionally, the MAR showed an order for Vancomycin IV antibiotics to be given every 12 hours to start on 05/03/2024 in the evening, with no duration noted. Review of Nursing progress notes showed as follows: 05/04/2024 at 2:20 PM, and 05/05/2024 at 3:23 PM, Fluconazole had not arrived from pharmacy. Resident 2 experienced trouble breathing at rest and had labored breathing. No oxygen required. 05/06/2024 at 10:00 AM, Fluconazole was on order, at 12:54 PM, no oxygen was required, and lung sounds clear. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	05/07/2024 at 12:40 PM, continuous oxygen required, no breathing issues, and lungs sound clear. First dose of Fluconazole given. 05/08/2024 at 9:30 AM, Staff H, LPN, documented, Resident 1 does not look well, they were pale, had chills, heart rate at 110 (normal heart rate at rest is 60-100) and respirations at 32 (normal is 12-20). Received orders to send resident out to hospital. Review of the 05/08/2024 hospital admission records, showed the resident had diagnoses of pleural effusions (an excessive collection of fluid in the pleural cavity, the fluid-filled space that surrounds the lungs) and worsening fungal pneumonia (a lung infection caused by fungal spores. It occurs when these spores mix with the air and are inhaled, or when an inactive infection is reactivated). Additionally, the hospital documented Resident 2 had received treatment with Fluconazole since discharged back to the facility on [DATE]. (Resident only received two of the five doses that should have been received). Upon discharge on 05/12/2024, Resident 2 was to continue the IV Vancomycin that was ordered on 05/03/2024. During an interview on 05/17/2024 at 1:39 PM, Staff K stated their process for receiving new medications from the pharmacy would be to input the orders, the orders then go directly to the pharmacy once inputted, and if it was not too late in the day, they would come in that evening or the next day. Staff K stated if the medication did not come in, they would call the pharmacy and they would let them know if the medication was on back order. Staff K stated they would normally call the provider and request a different medication that was available or ask if it was okay to wait to give the medication until it was delivered from the pharmacy. Staff K stated they did not recall why the Fluconazole did not come in until three days later, and they did not recall notifying the provider. During an interview on 05/17/2024 at 12:33 PM, Staff E stated they were unaware Resident 2 had not received three of the four doses of Fluconazole prior to being sent to the hospital. Staff E presumed if all doses had been given as ordered the infection may not have worsened. Staff E stated the hospital should have been made aware of the missing doses upon transfer, this could have changed Resident 2's treatment plan during their hospital stay, but considering the hospital's documentation, that was not done. Staff E further stated Vancomycin should have been continued to complete the 11 days (22 doses) that was ordered. Staff E was informed at that time that only 15 doses of the 22 doses had been administered and stated, that would be a perfect reason why Resident 2 is running fevers. Staff E further stated their expectation was for staff to report timely lab results and administer medications as ordered. <Resident 3> Review of the resident's medical record showed the resident was admitted to the facility on [DATE] with diagnoses including hypothyroidism (the thyroid gland cannot make enough thyroid hormone to keep the body running normally) and end stage renal disease (kidney function has declined to the point that the kidneys can no longer function on their own). The comprehensive assessment dated [DATE] showed the resident had moderately impaired cognition and required assistance of one-two staff members for activities of daily living (ADLs). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of a nursing progress note dated 05/13/2024, showed Staff B, was advised by Staff E to send Resident 3 to the hospital for evaluation of a thyroid crisis (when the thyroid gland releases a large amount of thyroid hormone in a short amount of time) after Staff E had reviewed the critical thyroid stimulating hormone (TSH) lab results obtained on 05/10/2024. The lab results showed an elevated TSH level at 45.5 milli-international units per liter ([mIU/L], a unit of measure) (normal range is 0.5-5.0 mIU/L). Record review of the hospital discharge instructions dated, 05/13/2024, showed Resident 3 had been discharged back to the facility with new orders to change Levothyroxine (a brand of medication used to treat hypothyroidism) from 88 micrograms ([mcg], unit of measure) every morning to 122 mcg every morning. Record review of the May 2024 progress notes showed no documentation of the discharge instructions, or the dose change on the Levothyroxine order from the hospital visit on 05/13/2024. Record review of Resident 3's May 2024 MAR showed Levothyroxine 122 mcg was not started until 05/17/2024 (four days after the medication change was ordered). During an interview on 05/17/2024 at 12:34 PM, Staff E stated they did not receive any notification from the facility of a critical lab value for Resident 3 on 05/10/2024. Staff E stated they noted the lab in the office on 05/13/2024 and immediately called the facility for a transport out to the hospital for evaluation of a thyroid crisis. Staff E further stated their expectation was for staff to update them with any critical lab values as soon as they received them. During an interview on 05/17/2024 at 3:08 PM, Staff B stated the TSH lab for Resident 3 was drawn on 05/09/2024 and was not called into Staff E when the critical results came back on 05/10/2024. Staff B stated their expectation was for staff to immediately notify the provider with critical labs/change in conditions and document in the resident's medical record. Staff B stated when a resident returned from the hospital it was the Resident Care Managers (RCM) responsibility to review hospital discharge instructions if they were in the building. Additionally, Staff B stated if the RCMs were gone during the time of readmission, it would be the responsibility of the nurse on the floor to review for any changes, that did not get done. Staff B further stated staff did not follow the correct process for resident 3. <Resident 5> Review of the resident's medical records showed the resident admitted to the facility on [DATE] with diagnoses to include atrial fibrillation (an irregular and often very rapid heart rhythm that can lead to stroke, heart failure and other complications) and a fracture of the right leg. The 05/03/2024 comprehensive assessment, showed the resident had severe cognitive impairment and required assistance of two staff with bed mobility, toileting, and transfers. The assessment further showed the resident received Coumadin, an anticoagulant (a high-risk medication that prevents or breaks down blood clots). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's 05/15/2024 hospital discharge summary, showed the resident was sent to the hospital due to an unwitnessed fall out of their bed. During the hospital visit, Resident 5 was found to have an elevated international normalized ratio ([INR], a test that measures how long it takes for your blood to clot and monitor if the anticoagulant was working], when elevated, it indicates that your blood is taking longer to clot and there is an increased risk of bleeding). Review of Nursing progress notes specific to the Coumadin orders, showed on 04/30/2024 at 11:27 AM, the order was to give Coumadin 2.5 mg every evening and recheck INR on 05/03/2024 (should have received Coumadin on 04/30/2024, 05/01/2024, and 05/02/2024). A note on 05/03/2024 at 11:57 AM showed, hold the Coumadin for two days (hold on 05/03/2024, and 05/04/2024, and resume 2.5mg ([mg] a unit of measure) on 05/05/2024) and recheck INR on 05/06/2024. Review of Resident 5's April 2024 through May 2024 MARs, showed no Coumadin was administered on 05/02/2024, 05/03/2024, 05/04/2024, and 05/05/2024. The MAR further showed there were no Coumadin orders entered for 05/03/2024. During an interview on 05/21/2024 at 12:54 PM, Staff K stated their process was to draw the INR's the morning they were due, call the provider with the results, and obtain new orders. The provider's order would be documented under the nursing progress notes titled Coumadin note. Staff K verified they obtained the Coumadin orders on 04/30/2024 and 05/03/2024 and processed them. When Staff K was questioned about the accuracy of the orders, Staff K reviewed the order from 04/30/2024 and confirmed they had entered the order incorrectly and Resident 5 should have had a dose of Coumadin on 05/02/2023. Staff K continued to review the order for the 05/03/2024 INR and confirmed they did not process an order for Coumadin, and they should have, causing the resident to miss a 2.5 mg dose that should have been given on 05/05/2024. Staff K further stated the INR results were accurate but the information the provider was given from previous orders, for ordering the next dosing of Coumadin, would have been inaccurate. During an interview on 05/17/2024 at 3:10 PM, Staff B, Interim Director of Nursing Services (IDNS), stated their expectation would be for the nurses to give the medications as ordered and if that was not possible, they would expect the nurses to call the provider for additional directions. Staff B stated when medication orders were input into the system, they did not go directly to the pharmacy, the orders needed to be printed and faxed over to the pharmacy. Staff B stated they were unaware the nurses were not following the correct process. Additionally, Staff B would expect the nurses to process the orders correctly and right when they were received. Staff B further stated if the nurses had issues in obtaining medications timely, they would expect that communication from the nurses . Reference: WAC 388-97-1060(1) 48368

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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** 48368 Based on observation, interview, and record review, the facility failed to ensure staff compliance with current infection control guidelines and standards of practice by 1) incorrectly donning/doffing (to put on/to take off) personal protective equipment (PPE) for 4 of 7 staff (Staff K, F, T, and U), 2) not adhering to fit testing (to ensure a proper fit) guidelines for N-95 respirator (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) for 5 of 5 staff (Staff G, I, M, N, and O), and 3) improper hand hygiene and glove changes for 4 of 7 staff (Staff K, F, T, and U) between dirty and clean tasks when providing care and services to residents on transmission based precautions ([TBP], safeguards to prevent spread of diseases) during a COVID- 19 (an infectious disease-causing respiratory illness with symptoms including cough, fever, new or worsening malaise, headache, dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases, difficulty breathing, that could result in severe impairment or death) outbreak. These failures placed residents at an increased risk for exposure to cross contamination (harmful spread of illness) and transmission of diseases. Findings included . Review of the facility policy titled COVID-19, dated 04/23/2024, showed N-95 respirators that were in use for source control were removed and discarded and a new N-95 respirator was to be placed following resident care. Review of the facility policy titled Respiratory Protection Program, dated 07/06/2021, Showed: Fit testing is completed initially and repeated annually. Documentation of all fit-testing results is maintained in each employee's personnel file. Fit testing will be repeated each time a different respirator is chosen. Facial hair is not allowed. Review of the Centers for Disease Control and Prevention (CDC), Hand Hygiene for Healthcare workers, dated 02/27/2024, showed that all staff should implement hand hygiene to help reduce the spread of infections to others. Further review showed that staff should perform hand hygiene for situations like, before and after contact with a resident or a resident's immediate environment, after contact with objects in the immediate vicinity of a resident, after contact with a contaminated surface, and after removing gloves. <Personal Protective Equipment/Hand Hygiene> (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and concurrent interview on 05/15/2024 at 12:53 PM, showed Staff T, Nursing Assistant (NA) exiting a COVID-19 positive room, removed disposable face shield, and placed on the PPE cart across the hall from the room, sanitized hands, placed new gloves, cleaned the disposable face shield front and back, and hung on the back of the PPE cart to dry. Staff T stated they used the same disposable face shield for their entire shift and disposed of it at the end of the shift. Staff T walked away and did not cleanse the top of the PPE cart where the soiled mask was set prior to cleaning. During an interview on 05/15/2024 at 3:00 PM, Staff C, Infection Preventionist, stated the facility was currently in a COVID-19 outbreak. Staff C stated the face shields are to be used only once and then thrown away. Staff C stated the facility had more than enough PPE supplies, including face shields. An observation on 05/15/2024 at 3:24 PM, showed outside of room [ROOM NUMBER] (a COVID-19 positive room), there was a used disposable face shield hanging on the back of the PPE cart. During an observation and concurrent interview on 05/15/2024 at 3:29 PM, showed Staff U, Nursing Assistant Registered, exited room [ROOM NUMBER], a COVID-19 positive room, removed their face shield with their ungloved hands and placed it on the PPE cart outside the room. No hand hygiene was observed. Staff U then cleaned the face shield front and back and hung it on the back of the PPE cart. No sanitizing of the PPE cart was done. Staff U stated they were a new NA and their normal process would have been to sanitize their hands prior to removing their mask and after cleaning the face shield. Staff U stated they re-used the face shields during their shift and disposed of them at the end of the shift. Staff U stated they were taught that process by the other NAs and there was also a sign on the top of some of the carts that stated that was the process. Additionally, at 3:35 PM, Staff F, NA, exited room [ROOM NUMBER] with an N-95 respirator on, no face shield, and no gloves. Staff F did not perform hand hygiene, went to the cart of clean linens, obtained clean linens , and was re-entering room [ROOM NUMBER]. Staff F stopped and set the clean linens on the top of the PPE cart that Staff U had placed their dirty face shield on, applied a gown, removed the soiled N-95 respirator mask, and placed a new one without performing hand hygiene. Staff F stated their normal process would be to sanitize their hands when removing their N-95 respirator and they did not know the other NA had placed a dirty face shield on the cart previously without sanitizing it. During an observation on 05/15/2024 at 3:44 PM, showed outside of room [ROOM NUMBER], a PPE cart had a taped sign on the top that read Don't forget to Disinfect. The sign further showed the disinfectant was to be used to disinfect goggles and face shields upon exiting the room. During an observation and concurrent interview on 05/16/2024 at 11:13 AM, Staff K, Licensed Practical Nurse, exited a COVID-19 positive room with the same N-95 respirator on and continued working. When asked what the doffing process was, Staff K stated they removed their gloves, gowns, face shield, and washed their hands prior to leaving the room. Staff K grabbed the front of the contaminated N-95 respirator with non-gloved hands and placed it in an open garbage bin, then placed a new N-95 respirator without performing hand hygiene. Staff K further stated they did not change their N-95 respirator after exiting the COVID-19 room, nor performed hand hygiene after touching the contaminated respirator. <Fit testing> (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505263	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prestige Post-Acute & Rehab Ctr - Kittitas Valley	1050 E Mountain View Ellensburg, WA 98926

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Respirator Trainin (includes fit-testing and education on proper respirator use) records upon hire and annually for 2023 through May 2024 showed: Staff G, NA, was hired on 01/11/2024 with no documented fit testing in their employee personnel file. Staff I, NA, was hired 08/29/2023 with no documented fit testing in their employee personnel file. Staff M, Activities Director, was hired on 08/24/2015 with a Respirator Training record dated 11/09/2022. Staff M did not have the required annual fit testing for 2023 or 2024. Staff N, NA, was hired 11/28/2022 with a Respirator Training Record dated 01/24/2023. Staff N did not have the annual fit testing for 2024. Staff O, Housekeeper, was hired 04/17/2023 with no documented fit testing in their employee personnel file. During an observation and concurrent interview on 05/16/2024 at 10:45 AM, showed Staff G, NA, had a full-facial beard wearing an N-95 respirator with the numbers 3M 1870. Staff G stated they were fit-tested with their full beard, and they were unaware they would have to shave their current beard when wearing an N-95 mask or when getting fit-tested . Review of the Respiratory Training Record for staff G dated 05/15/2024, showed staff G was fit-tested and approved to use the 3M 8210 N-95 respirator only. During an observation and concurrent interview on 05/17/2024 at 4:02 PM, showed Staff I, NA, had an N-95 respirator on with a full-facial beard. Staff I stated they were fit-tested without a beard but had grown one since and they did not feel the N-95 respirator was protecting them any longer. During an interview on 05/17/2024 at 12:20 PM, Staff C stated that fit-testing for N-95 respirators should be done on hire and annually, and that the facility was behind on fit testing the staff. Staff C stated they tried many different kinds of masks when fit testing someone with a facial beard. Staff C stated the training they received for the fit-testing process showed (staff) should be shaved when getting fitted for a respirator. Additionally, at 1:27 PM Staff C stated they expected all staff to follow the Centers for Disease Control and Prevention (CDC) guidelines for donning and doffing PPE and for hand hygiene. Staff C further stated that Staff F and Staff K did not follow the correct process for proper PPE and hand washing and Staff G did not follow the correct process for the type of N-95 respirator they were to be wearing. During an interview on 05/17/2024 at 3:08 PM, Staff B, Interim Director of Nursing Services, stated their expectation was that all staff were fit-tested on hire and annually and Staff C was to follow the CDC guidelines for fit-testing, Staff B further stated they expected all staff to follow CDC guidelines for donning and doffing of PPE and hand hygiene (continued on next page)

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	505263	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/17/2024 at 4:36 PM, Staff A, Administrator, stated their expectation for the use of disposable face shileds would be that they are worn by all staff entering a COVID-19 positive room. Staff A ststed upon exit of the room the face shields hsould have been doffed and discarded. Staff A further stated only goggles could be sanitized and reused. Reference: WAC 388-97-1320 (1)(a)(c) 44922