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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505327 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/07/2025 |
| NAME OF PROVIDER OR SUPPLIER Avamere Olympic Rehabilitation of Sequim | | STREET ADDRESS, CITY, STATE, ZIP CODE 1000 5th Avenue South Sequim, WA 98382 | |

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

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| (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 - Many</p> | <p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45203</p> <p>Based on observation, interview, and record review the facility failed to maintain an effective infection control program by ensuring staff had appropriate personal protective equipment (PPE) available for 3 of 3 units and that staff donned (put on) appropriate PPE for residents on droplet precautions (infection control precaution of wearing mask and eye protection upon entering the room and gown and gloves for potential for exposure to secretions) for 2 of 5 residents (Resident 3 and 9) reviewed for infection control practices. Also, the facility failed to include the Infection Preventionist (IP) on the water management panel and ensure all control measures of the Legionella Water Management Program were implemented when routine chlorine testing and routine resident room faucet inspections and cleaning were not performed. These failures placed residents at risk for spread of infection, health complications, and a diminished quality of life.</p> <p>Findings included .</p> <p>The facility policy titled, Isolation-Categories of Transmission Based Precautions, revised September 2022, documented transmission-based precautions were initiated when a resident developed signs or symptoms of, or a confirmed infection and was at risk of transmitting an infection to other residents. Transmission based precautions (TBP) were additional measure to protect residents, staff and visitors.</p> <p><PPE></p> <p><Resident 3></p> <p>Resident 3 was admitted to the facility on [DATE]. Review of the Facility's Line listing for an Influenza (a common respiratory illness you get from the influenza in which symptoms often include: fever, head and body aches, coughing and a stuffy or runny nose) outbreak that started on 12/26/2024 and continued until 01/07/2025 showed Resident 3 was added to the list on 12/28/2024 due to fever and malaise.</p> <p><Resident 9></p> <p>Resident 9 was admitted to the facility on [DATE]. Review for the facilities line listing of the influenza outbreak showed Resident 9 was presumed positive on 01/01/2025 due to cough and congestion.</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.

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| 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 - Many</p> | <p>On 01/02/2025 at 11:46 AM, Staff E, Nursing Assistant (NA), was observed outside of room [ROOM NUMBER], a room with a droplet precautions sign, Staff E was observed with a mask and gloves on, they reported they were waiting for the resident to turn on the call light to signal they were done. When asked what PPE they would don prior to entering, Staff E replied, gown gloves and mask. When asked if they would normally use eye protection, they responded they would. Staff E began to look for eye protection on the cart. No eye protection was located on the cart. When asked if they would disinfect or dispose of the eye protection, Staff E said they would use wipes to clean the eye protection. No wipes were located on the cart for room [ROOM NUMBER]. No eye protection or wipes were located on the nearest carts of room [ROOM NUMBER] and 218, both of which were also designated as droplet precaution rooms.</p> <p>At 12:00 PM, Staff F, NA, was observed coming out of Resident 9's room (a droplet precaution room) wearing a mask and gloves and then immediately entering Resident 3's room (a droplet precaution room)</p> <p>At 12:03 PM, Staff F said they should wear a mask, gloves, and goggles when entering a droplet precaution room. They did not change their mask and gloves between the rooms and were not wearing eye protection. Staff F said they were wearing them but thought they left them in one of the rooms because they were only going back in to retrieve a washcloth from Resident 9's room to use for Resident 3. Staff F said they did not don the needed PPE because, they were just busy. Staff F said the carts were usually stocked with needed supplies.</p> <p>At 1:00 PM, Staff C, Infection Preventionist (IP), Registered Nurse (RN), said PPE carts were restocked by the central supply staff and NAC staff whenever they need to be restocked. Staff C said she expected staff to don/doff (take off) the appropriate PPE when exiting/entering transmission-based precaution rooms and she would not expect staff to remove linen from a TBP room and take it into another room.</p> <p>On 1/07/2025 at 11:50 AM, room [ROOM NUMBER] had a droplet precaution sign up outside the room and the cart did not contain eye protection, gloves or gowns.</p> <p>At 11:52 AM, room [ROOM NUMBER] had a sign indicating droplet precautions and did not contain disinfection wipes.</p> <p>At 11:59 AM, room [ROOM NUMBER] had a sign indicating contact precautions (instructing staff to wear gowns and gloves upon entering) the cart had no gowns or gloves.</p> <p>At 12:01 PM, Staff I, Central Supply/Staffing said they restocked the PPE carts weekly and night shift staff were to do it daily and that staff have access to all necessary supplies any time they might run out.</p> <p>At 12:08 PM, Staff B, Director of Nursing, RN, said she would expect all carts to have needed PPE at all times and that it was the responsibility all of the staff to ensure they were restocked. Staff B said she would expect all staff to don/doff indicated PPE prior to entering/exiting the TBP resident rooms. Staff B would not expect staff to remove linen from a TBP room and take it into another room.</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>At 1:44 PM, Staff G, Occupational Therapist Assistant, was observed exiting Resident 9's room (designated as droplet precautions) without mask or eye protection on. Staff H, Restorative Aid, was observed without mask or eye protection on and remained in the room and closed the door. Staff B, DNS was nearby and alerted to the concern and Staff B knocked on the door and requested Staff H come out of the room and put on the appropriate PPE. Staff H placed a mask on but no eye protection and returned to the room. Staff B instructed Staff H they needed to wear eye protection. Staff H was overheard telling Resident 9, I guess we are supposed to wear masks now.</p> <p>At 1:52 PM, the isolation cart for room [ROOM NUMBER] (contact precautions) was observed to have been stocked with gowns, but no gloves.</p> <p>At 1:53 PM, Staff B said they would begin in-services on TBP.</p> <p>At 2:02 PM, Staff H, Restorative aide, said they did not realize Resident 9 was on droplet precautions. Staff H said they did see the sign but was confused as to what was needed as they were not doing direct patient care.</p> <p><Water Management Program></p> <p>Review of the CDC's Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings, dated June 5, 2017 was both guidance for the facility and a place for the facility to document their plans and showed the following:</p> <p>1. Water Management Team</p> <p>Page 7 showed the expectation that the water management team should include a clinician with expertise in infection prevention and infectious diseases.</p> <p>Page 8, dated March 12, 2024, identified four staff members on the water management team and Staff C, the Infection Preventionist, was not included.</p> <p>2. Control Measures</p> <p>Page 25 showed the expectation the facility was to ensure 25% of electronic or manual faucets were visually inspected for biofilm or debris and cleansed with a mild biocide, weekly.</p> <p>Page 30 showed the expectation staff were to measure and record chlorine levels of city water coming into the building as well as the most distal location in the facility, to ensure adequate disinfectant levels, weekly.</p> <p>On 01/02/2025 at 1:00 PM, Staff B, Registered Nurse (RN), Infection had gone over all of the control measures. When asked if there were any concerns regarding implementation of any of the control measures, Staff C did not recall there being any issues. When asked about weekly chlorine testing, Staff C said they did not do any testing but that the new water management program included it. When asked to review page 30 of the March 2024 water management program, Staff C reviewed and said, no, we were not doing that.</p> <p>(continued on next page)</p> |

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